TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

x

GLOSSARY OF TERMS

Term	Definition
Aotearoa	New Zealand
Aroha	Love
Atua	Māori gods
Awhi	Support, trust
Hapu	Sub-tribe
Hau	Property, wind
Hauora	Wellbeing
Haurangi	Under the influence of alcohol or drugs
He tangata he tangata	The people, the people
Hinengaro	The mental dimension
Iwi	Tribe
Ka nohi ki te ka nohi	Face to face
Karakia	Prayer
Kaumatua	Elder
Kawa	The processes of tikanga
Kehua	Ghosts
Kuia	Elders
Makutu	Curse
Mamae	Pain
Mana atua	Power derived from the gods
Mana Māori	Power of Māori as a collective
Mana tangata	Power derived from ones own life story
Mana tupuna	Power derived from ancestors
Mana whenua	Power of the land
Māori	Indigenous peoples of New Zealand
Māramatanga	Understanding/Clarity
Matakite	Seer, gifted person
Matauranga	Knowledge
Mate atua	Illness of the gods
Mate Māori	Māori illness
Mauri	Vital essence
Mirimiri	Māori healing via touch and massage
Moemoeā	Dreams
Mōhiotanga	Knowing
Ohonga	Part of the person e.g. hair
Pa	Traditional communal site
Pākehā	European New Zealanders
Papakainga	Home
Pohauhau	Form of mate Māori
Pōrangi	Form of mate Māori
Poroporoaki	Farewell ceremony

Rāhui	Restriction in order to restore mauri
Ritenga	Customary practice
Rongoa	Medicinal plants
Tangata	People
Tangata whaiora	People seeking wellness
Tangi	Funeral
Taonga	Treasure
taonga tuku iho	Treasures passed on by ancestors
tapu	Sacred, being with potentiality for power
Tatau	The collective
Tauiwi	Non-European New Zealanders
Tautoko	Support
Tikanga	Principles and practices set out by atua
Tinana	The physical dimension
Tino rangatiratanga	Self determination
Tohu	Signs
Tohunga	Traditional Healer
tuakana	Older sibling
Turangawaewae	A place to stand
Utu	Reciprocity
Wai	Water
Waiata	Song
Waiora	Wellbeing
Wairangi	Form of mate Māori
Wairua	The spiritual dimension
Wairuatanga	Spiritual practices
Waka	Vessel for travel
Whaiwhaia	Form of makutu
Whakama	Ashamed, embarrassed
Whakapapa	Genealogy
Whakawatea	Cleansing ceremony
Whakawhanaungatanga	The practices of family
Whanau	Family
Whare	House
Whare marie	House of learning the dark arts
Whare wānanga	House of learning
Whatumanawa	Emotional dimension of the self
Whenua	Land

THESIS OVERVIEW

Over the last couple of centuries a single paradigm, the medical model, has come to dominate the explanation and treatment of illness in Western society. Via legal and political means, indigenous models of illness and wellness have been wiped out or forced to the margins of many societies. This thesis aims to challenge the dominant medical model that has privileged psychiatric knowledges while suppressing others by repositioning indigenous construction at the centre of the research via a Kaupapa Māori framework.

Chapter One aims to deconstruct current medical constructions by presenting psychiatry as a culture in itself as opposed to a discipline dedicated to scientific truths. This chapter posits that t he culture of psychiatry has lead many clinicians to suffer from "cultural blindness" when working with indigenous and ethnic minority groups. Chapter One uses the tools of science to question the scientific validity and reliability of the construct "schizophrenia". I conclude that this construct is "unscientific" in itself. I will also look at three themes highlighted by other researchers regarding the treatment of mental illness throughout Western history: treatments are used as a form of social control; treatments can be dehumanising; and the dominance and power of the medical model to define who and what is considered ill. Chapter One also acknowledges the significant role of the consumer movement in developing more humane treatments.

Interactions between culture and psychiatry via colonisation are outlined in Chapter Two. I also critique research that is conducted cross culturally in terms of whether researchers attempt to establish the reliability of universal diagnoses or recognise local and unique constructions. Chapter Two challenges the commonly cited finding of higher rates of schizophrenia for ethnic minorities and indigenous peoples by questioning the validity of foreign cultural constructs to explain indigenous forms of illness. This chapter recognises indigenous and cultural constructions of what psychiatry labels 'schizophrenic'. To illustrate, three 'culture bound syndromes' will be discussed. The development of indigenous psychological paradigms is also presented to position the current research within this wider international movement.

Chapter Three summarises Māori constructions of illness and wellness. This chapter predominantly draws from early anthropological literature and subsequent psychological studies to represent the resilience of Māori constructions of experiences commonly labelled schizophrenic. In accordance with the experiences of other indigenous populations, this chapter also recognises the impact of colonisation on Māori beliefs and practices relevant to maintaining wellness. To illustrate the effect of colonisation, disparities in statistics between Māori and non-Māori for admissions and readmissions to inpatients units for psychotic disorders will be discussed. Explanations for these disparities will also be outlined. Within Chapter Three, the resistance and revival of Māori constructions is also recognised as a function of the development of bicultural and Kaupapa Māori Services.

Chapter Four, summarises the theoretical orientation of the research. This research is qualitative and assumes a post-modern critical paradigm. Two theoretical frameworks were used within this research (Kaupapa Māori Theory and Personal Construct Theory) to represent the two worlds in which the research was conducted (Indigenous and Western).

Chapter Five outlines the methodology by recounting a somewhat layered journey. Within the first section, 'Who am I', I have positioned myself by sharing my journey towards conducting this project. The second section, 'Where did I want to go', outlines the research aims and process of consultation. The final section summarises 'What I did' in terms of qualitative interviews and the process undertaken for interpretation and presentation of the data.

Chapter Six presents the results of the research according to the four categories developed from qualitative analysis. These were: 'Making sense of extra-ordinary experiences', 'Pathways of healing', 'Making sense of the statistics' and 'What can we do about the statistics'. Within this chapter I have attempted to present quotes with as little interpretation as possible (over and above sorting of themes) to allow the reader to make their own interpretations before reading the discussion.

Chapter Seven summarises the major findings from each category and relates the results to the national and international literature. Clinical and theoretical implications are discussed with

recommendations for future research. The limitations and strengths of the research are highlighted and conclusions drawn from the research journey. The plan for dissemination is also presented.

Finally, I want to share a somewhat personal reflection of the process of this research to provide the reader with an idea of my orientation to this topic. When I was younger I would play a game on the shore of the ocean that reminds me of my journey throughout this thesis. The goal of the game was to try and stand on the sun's reflection in the wet sand. No matter how much I chased the reflection, I was never closer to it. Sometimes I would stand in one spot, very still, as though the sun would be tricked if I snuck up on it. If I remained very patient and quiet and lifted my leg slowly it always felt as though I could get just that much closer to my target and maybe, for the first time, I would stand on it. But just as soon as I stamped my foot in a swift motion to capture the sun, it's reflection would escape and stop just as far away from me as it was in the first place. I am not sure about the physics of this phenomena but it kept me entertained for hours. This thesis truly felt like my old game. Each time I felt as though I was closer to 'standing' on the 'answers' they would slip away from me in an ocean of complexity. Just as I learnt to accept that the sun would always run away from me as a child, I have learnt to accept over the course of this research that complexity is the very essence of the experiences I have chosen to write about. The experiences I have written about change in shape and form depending on who we are researching, who is conducting the research, the approach undertaken, the setting, the time and so on. I suspect extra-ordinary experiences (experiences variously defined as psychotic, cultural or spiritual depending on our orientation) will never be clearly defined (as is the goal of biological psychiatry). So, in writing this thesis I am not attempting to put my foot down definitively upon *the* Māori way of understanding extra-ordinary experiences. I simply want to share my journey of understanding more about this set of experiences at a particular time, in a particular way with a particular group of people.

1   WESTERN CONSTRUCTIONS OF SCHIZOPHRENIA

> Mental illness is not simply 'out there', waiting to be described and theorised by psychiatrists; it interacts with psychiatric theories, clinical entities waxing and waning in accordance with diagnostic fashions, institutional practices and methods of treatment. This should be a warning to historians of psychiatry, who can no longer be content with writing the history of ready-made syndromes and psychiatric theories. They must, if they want to remain faithful to their improbable 'object', study the complex interactions from which those syndromes and those theories emerge, somewhere between the doctors, the patient and the society that surrounds them. In short they must study the making of psychiatric history, and understand that they participate in it, (2001, P.19)

The literature surrounding schizophrenia is varied with many pathways and signposts that have been forged. Within this chapter I do not intend to cover this terrain in it's entirety. Instead, I seek to plot what I consider to be the key historical signposts towards the development of a critical theory of schizophrenia. Pilgrim (1990) indicated this perspective forms a revisionist history that aims to uncover the hegemonic assumptions that have determined 'normality' and 'abnormality' in the past. He compared this 'revisionist' position to the positivist 'public relations' perspective when writing psychiatric history,

> Self-congratulatory versions of history compare modern progress and enlightenment in a field with the ignorance of the past [public relations perspective]. In total contrast, the past may be invoked to uncover the historical roots of present misconceptions and inadequacies [revisionist perspective]. In one version of history, the past comforts the present; in the other, the past is found guilty for it's legacy. It is likely that there are political motives on both sides (Pilgrim, 1990, p. 212)

The Kaupapa Māori paradigm adopted in this thesis (explained further in Chapter Four) aims to deconstruct the power displacements throughout the history of Western psychiatry. The following provides a brief overview of this history highlighting the diagnostic and treatment methods of the time and how these may have been related to specific social, historical and political factors. For more detailed accounts of revisionist psychiatric histories the reader can refer to Borch-Jacobsen (2001) Porter (1987), Read, Mosher, & Bentall (2004) and Shorter (1997). Within this chapter, particular focus will be on the emergence of the diagnosis of schizophrenia and how this construction has been variously defined, contested and treated since it's inception.

1.1 A BRIEF HISTORY OF MADNESS

1.1.1 Spirits and shamans of prehistoric times

Symptoms of what is now called schizophrenia have been noted throughout the ages. Some of the earliest accounts reveal these experiences were interpreted through a mystical/religious/spiritual lens (Alexander & Selesnick, 1996). Various cultures around the world explained manifestations of illness (mental and physical illnesses and retardation were often all considered within the same group of illness) as warnings, signs or retribution from the gods, spirits and demons for one's actions. The predominant explanatory model for abnormal behaviours of the time typically externalised the causes of illness and deviant behaviours.

During this period, shamans and priests held the power to define who was mad. As a result, treatment of madness (predominantly delivered by shamans) involved ridding the individual of the spiritual affliction through rituals of prayer and sacrifice (King, 1999). Palaeontology has provided some clues regarding treatment methods such as trephining, a practice of drilling a hole into the skull of the patient to release evil spirits (King, 1999). The code of Hammurabi, used during 1795-1750 BC, is now interpreted as a prehistorical code of ethics for healers and shamans (John, 1903). This document diagnosed illness by understanding which god was involved in the cause and subsequently labelled the individual as being "struck by the hand of …" (the relevant god).

1.1.2 The age of reason: knowledge versus beliefs

Within the period 1000 BC to 200 AD, a gradual shift from mystical explanations towards a scientific approach to illness occurred. Significant contributions were made by Greek philosophers and physicians who began to draw the line between 'knowledge' and 'beliefs'. Mind – body dualism was proposed by Hippocrates who saw the mind as a separate entity from the body. He further argued the mind resided in the brain due to observations of behaviour in patients with head injuries (D. N. Robinson, 1986). Hippocrates used his observations to propose that the control of human behaviour lay within the body as opposed to external forces. During this period, physicians held the power to delineate what was considered normal and abnormal as opposed to shamans and priests of ancient history.

During the Age of Reason, a number of categories were developed that are still used today (such as melancholia). Hippocrates proposed a biological aetiology for psychiatric illnesses (indicating current constructions of chemical imbalance are not new) within his theory of the four humours. According to the "humours theory" mental disturbances were caused by an imbalance of the four humours (Kemp, 1985) which were blood, phlegm, black bile and yellow bile (King, 1999). 'Treatments' were directed at correcting the imbalance and included blood letting, induced vomiting and uncontrollable defecation (Read, Mosher et al., 2004).

During the same period, the diagnostic category of the "wandering uterus" was suggested by Socrates to explain the "hysteria" of women of the time (Ducey & Simon, 1975). The oppression and devalued roles woman experienced for centuries has been proposed as an alternative explanation for their 'hysterical' behaviour (Read, 2004b). McIntosh (2004, p.16), a female Māori researcher, referred to 'hysteria' as a political act of medicalising and internalising individual and collective reactions towards powerlessness. She described hysteria as a "socially constructed condition of marginality as well as a reaction to it." Hysteria is therefore an example of a construct used by those in power to mask inequality in society and people's reactions to it,

> Hysteria is not a random reaction, neither is it a totally irrational response. It is a learnt response to people and actions, which to it's intensity and immediacy is understood as both instinctive and natural. It is a product of ideology, myth, narrative: it emerges from discourses of power. It cloaks and distorts reality both for the oppressed and the oppressor (McIntosh, 2004 p.16).

1.1.3 The Church and State: Sinners and saints

The next period of history provides further insight into the pendulum of power that has constantly swayed between giving precedence to either scientific or mystical ways of understanding madness. During the Middle Ages (approximately 300 AD to 1500 AD), there was a distinct resurgence of spiritual explanations within a religious context. This was a result of the power of the Church which was inseparable from the State at the time. Christian philosophers argued one should seek a desireable afterlife. The Church was given power through a punitive and restricted ideology of God to determine those behaviours that would enhance or reduce one's chances of a harmonious after life. Experiences that are now labelled as symptoms of

schizophrenia, such as auditory hallucinations and delusions, indicated one was either blessed or cursed, a saint or sinner.

Male priests held significant powers in communities for healing as well as the power to punish people for sinful behaviours. If one was considered a sinner they were often treated by purification (Shorter, 1997). This was in the form of exorcisms and prayer, methods that are still used throughout the world today (Kemp, 1985). Little scientific advancement occurred during this period. Physicians and scientists were often persecuted for theories that were not in line with the religious ideology of the time. Public trials were held for "heretics" who challenged or threatened the role of the church (Kemp, 1985).

One such group of heretics were labelled "witches" (Zilborg & Henry, 1941). The publication of the 'Malleus Maleficarum' or Witches Hammer in 1486 legitimised the torture and killing of individuals who engaged in witchcraft (which included the experiences of auditory and visual hallucinations). Confirmed by successive Catholic Popes, this document became part of European law for three hundred years and lay on the bench of every judge and magistrate. Those labelled as witches were predominantly poor and female (E. Taylor, 1982). The Witches Hammer has been criticised as a form of social control to silence those who challenged the dogmatism of the Church. Snell (cited in E. Taylor, 1982, p.116) criticised the Malleus as a document that justified the torturing and killing of women for over four hundred years:

> It is one of the most curious works that has come from the hand of man. No primeval animal, no cuneiform writing, no tool of a primitive culture will appear to us as so completely incomprehensible as this book. It is impossible to conceive that for four hundred years...in Germany there were people subject to this kind of delusion and bad judgement as well as cruelty, who stood so low as the Malleus proves on every page.

By contrast, during the same period, poor houses were developed in the name of Christian charity where the mentally ill could find shelter. While this period of treatment represents a relatively compassionate orientation towards the care of the mentally ill, it appears there was no fundamental change in regards to who held the power to decide who and what was mad. The unequal distribution of power according to gender, religion and socio-economic status

determined who was committed to an asylum for treatment (typically the poor, women and disabled) and who had power over delivering the treatment (often male priests) (Foucault, 1965).

1.1.4 The great confinement

Foucault (1965) referred to this period as "the great confinement". Poor houses turned into asylums and began to serve a social and political function. Treatment methods served economic and political gains by operating under the guise of "occupational therapy" and using patients, who were predominantly poor, for cheap labour (Read, 2004b; Shorter, 1997). Foucault (1965, p. 39) commented that those admitted to asylums in Paris were predominantly "the poor of Paris, of both sexes, of all ages and from all localities, of whatever breeding and birth in whatever state they may be."

Treatment of mental illness during this period was dehumanising. The Bethlem hospital became known as Bedlam due to the horrific stories of the purification treatments used and overcrowded dwellings. Asylums all over Europe resembled this picture as chains and horrific punishments were used to control patients (Shorter, 1997). By the 19th Century, public asylums were a place of little hope and were characterised by long-term confinement. Accounts from the perspectives of those who were confined paint an oppressive picture. In a letter to his mother John Perceval wrote:

> I have been compelled to witness the mental and bodily agonies of those whom I could not relieve. Ay - I have seen them strangled, shaken and beaten by ruffians...I say, I was given over in weakness, in helplessness and in nervousness, to be harrowed by the sight of a menial attendant throttling a poor young lunatic gentleman til his face was bloated with blood, and his eyes started from their sockets; whilst a humane butcher spares even the cattle appointed for the knife the sight of their fellow creatures' agonies, (Bateson, 1962, p.226).

1.1.5 The birth of psychiatry

Before discussing the birth of psychiatry, the brief history outlined thus far indicates that there had been no prior consensus regarding nature of madness. What I attempt to argue is that there remains no such consensus or *fact* after the development of psychiatry. Psychiatry is merely another cultural and political way of understanding a particular set of experiences. Porter (1987, p.8) commented upon the constantly changing landscape of madness by stating,

> Madness has been and remains an elusive thing...it is equally possible to think in terms of the manufacture of madness, that is, the idea that labelling insanity is primarily a social act, a cultural construct...it is noteworthy that the book called *The Manufacture of Madness,* was not written, as one might imagine, by a revolutionary relativist but by a practicing psychiatrist and indeed a University Professor of Psychiatry, Dr Thomas Szasz.

Some have argued Physicians and Doctors, later known as psychiatrists, were introduced to the large asylums as a political act of the State to legitimate the separation of the mad and the treatment practices of the time (Foucault, 1965; Shorter, 1997). One significant finding during this period seemed to increase the power of psychiatrists within asylums. Syphilis was found to lead to a form of madness which subsequently increased the impetus in the search for an underlying biological cause of a range of deviant behaviours (Boyle, 1990). Medical dominance in asylums was not originally formed for scientific means but in response to a political struggle for the power to intervene in deviant behaviours. Reflecting upon the relationship between mental illness and psychiatry Boyle (1990, p.4) commented,

> It was not that psychiatry developed more humane ways of dealing with the 'mentally ill' or more scientific ways of understanding 'mental illness' but that medical dominance over deviant behaviour contributed to the later widespread adoption of the idea that it should be viewed as illness.

By the beginning of the 20th Century, psychiatry had found it's place in the world. The 'culture of psychiatry' had been firmly established with a "mechanistic view of life, a materialistic concept of mind, a segmented approach to the individual and a model of illness which assumed a bio-medical change and a natural causation" (Fernando, 1988, p.7). Incarceration continued to prevail as the preferred treatment for severe mental illness. During this period, the number of people being hospitalised rose dramatically (Shorter, 1997). This is not surprising if one considers some of the legislation of the time. The Royal Commission on the Care and Control of the Feeble Minded (1904-1908) reported that mental defectives were often prolific breeders and allowing them so much freedom lead to delinquency, illegitimacy and alcoholism. They rejected sterilisation as a solution, and called for separation and control (Goddard, 1909). Standard forms of psychiatric treatment in asylums during the 1920's and 30's were malaria therapy, insulin shock, electro convulsive therapy (ECT) and the prefrontal lobotomy (Culleberg, 2006).

By the 1950's, The Georgia State Sanatorium (The largest asylum in America at the time), held 10,000 beds (Shorter, 1997). The "Georgia power cocktail", a form of ECT, was the predominant form of treatment in this setting. Recent research suggests that having a diagnosis of schizophrenia and being female increased one's risk for receiving this form of treatment (American Psychiatric Association, 2001). Again, it is evident that being in a certain demographic increases one's risk of receiving inhumane treatments.

Within the short history of psychiatry, it is evident that certain themes arise in terms of who has the power to define wellness and illness and how these conditions are treated. Read and colleagues (2004) reviewed the treatments of mental illness throughout psychiatric history and found three predominant themes: social control exerted by those in power; dehumanising treatments; And, the ability of experts to control the ways in which mental illness is understood and treated.

1.2 SCHIZOPHRENIA: A HISTORICAL PERSPECTIVE

Although mental illness has been constructed in various ways for well over 2000 years, it is only within the last 100 years or so that the construct of "schizophrenia" has emerged. Throughout the last century schizophrenia has come to represent one of the most researched mental illnesses within biological psychiatry (Boyle, 1990).

1.2.1 Schizophrenia according to Kraeplin and Bleuler

In the 19th and 20th Centuries, German psychiatrist Emil Kraeplin (1919) developed the diagnosis of "dementia praecox", later labelled the "group of schizophrenias" by Bleuler (1913 translated in 1950). Kraeplin suggested 36 symptoms that covered the range of what was considered abnormal including hallucinations and delusions (Kraepelin, 1919). He categorised the behaviours he observed into those that were; 'simple' (slow decline and withdrawal); 'paranoid' (fear and persecutory delusions); 'hebephrenic' (onset during adolescence followed by rapid deterioration) and 'catatonic' (poverty of movement and experience) (Bentall, 2003).

Bleuler (1913/1950) renamed the group of behaviours as "schizophrenia" due to his observation that dementia was a misleading term as not all patients experienced an extreme form of

deterioration. Schizophrenia literally translates to split personality or split mind, however, Bleuler did not intend for the term to be used in this manner. Instead, he indicated that schizophrenia represented the separation between functions of the personality, thinking, memory and perception (Bentall, 2003). Bleuler (1913/1950) further categorised the behaviours he observed into the four 'A's' . These being, blunted <u>A</u>ffect (reduced emotion) loosening of <u>A</u>ssociation (disorganised patterns of thought), <u>A</u>mbivalence (inability to make decisions) and <u>A</u>utism (preoccupation with the self) (Boyle, 1990). The vast range of symptoms originally categorised as dementia praecox and schizophrenia by Kraeplin and Bleuler have been criticised by Read (2004, p.28) who noted,

> As a list of unacceptable behaviours and experiences, the writings of Kraeplin and Bleuler are frightening. What is left? What is considered healthy? We must be heterosexual, abide by rigid roles for males and females, obey our superiors, speak in a way that even psychiatrists can understand, want to work, like certain colour combinations, not feel too much or too little, not get interested in new ideas, not show too much compassion for other people, be well behaved...not write poetry, not play music and not want to change the world. (p. 28)

Moreover, their observations cannot be removed from the context of incarceration in which they were developed. The lack of stimulation, inhumane treatments, the Hawthorne effect (doing what you think your clinician wants you to) and simply following direct orders (to stand still and not move) may better explain some of their observations regarding the symptoms of schizophrenia (Read, 2004c).

Both Kraeplin and Bleuler acknowledged that a cause for the conditions they constructed was yet to be determined. Kraeplin (1919, p. 224) commented, "the causes of dementia praecox are at the present time still wrapped in impenetrable darkness." At the same time, both gave a number of indications as to their *opinion* of what the causes were. Genetics and biology were popular explanations outlined by the 'fathers of schizophrenia'. Both referred to personal observations of schizophrenia running in families. Germs, infections or fevers and sexual activity, especially excessive masturbation, were also indicated as possible causes (Bleuler, 1913/1950; Kraepelin, 1919).

Alternatively, Kraeplin and Bleuler either totally ignored or minimised psychosocial explanations. Kraeplin (1919) cited the increased rates found within the prison population and prostitutes however he argued that being a criminal or prostitute was actually a consequence of dementia praecox. He rejected the proposition that psychosocial environmental factors such as a loss of freedom, conditions of isolation, and the disempowerment of these individuals could have contributed to the development of schizophrenia. In a similar vein, Bleuler outright rejected psychosocial factors as playing a causal role when he stated, "schizophrenia seems to be independent of external conditions and circumstances," (Bleuler, 1913/1950, p.342).

In the absence of a specific cause, treatments were recommended as a form of 'controlling' rather than 'curing', patients' behaviours (Bleuler, 1913/1950). Bleuler (1950) commented on his ad hoc search for a cure, "we are forced to grope in the dark; indeed, it might be said that the only way is to offer chance itself a great many opportunities, so that it may seize one of them," (p. 476).

In sum, Bleuler and Kraeplin were advocates of trial and error. Treatments such as induced fevers, prolonged baths (sometimes for days), isolation and even castration were prescribed.

> In the states of excitement prolonged baths are suitable, the employment of which, it must be admitted, often meets with great difficulties, as the patients do not remain in the bath, but always jump out again, perform neck breaking gymnastics, rolling about on the floor, (Kraepelin, 1919, p.279).
>
> This procedure [rotating patients between wet packs, restrained in wet materials, and baths] in severe cases, helped in the beginning by sedatives, is continued day and night without interruption,(Kraepelin, 1919, p.280).
>
> Amorphine is a chemical restraint of a special type...I must mention this remedy, although I cannot recommend it on ethical grounds; but then, again, I must ask whether it is not more unethical to permit a whole roomful of patients to be annoyed by a single agitated patient than to cause the offender to vomit, (Bleuler, 1913/1950, p.486).
>
> It is to be hoped that sterilisation will soon be employed on a larger scale in these cases as in other patients with a pathological anlage for eugenic reasons,(Bleuler, 1913/1950, p.473).

The above treatment methods indicate clearly that Bleuler and Kraeplin ascribed to a biological explanation for the broad range of behaviours they observed despite an absence of scientific evidence. 'Whatever works' seemed to be their principle of treatment. The subjective

experiences of these treatments were of little concern. The following indicates how these themes permeate the understanding and treatment of schizophrenia today.

1.2.2   Schizophrenia today

Schizophrenia is characterised in the DSM-IV (Diagnostic and Statistical Manual Fourth Edition) by positive and negative symptoms for a period of six months or more (American Psychiatric Association, 1994). Only one month of active positive symptoms are required for a diagnosis. Positive symptoms are described as "distortions or exaggerations" of thinking (delusions), perception (hallucinations), communication (disorganised speech) and behaviour (disorganised behaviour). Negative symptomology includes withdrawal, restrictions in expressed emotion and reduced engagement in everyday life. Schizophrenia is reported to occur in 0.2 to 2.0% percent of the general population (World Health Organisation, 1996). Urban populations, ethnic minorities, the poor and homosexuals are reported to experience higher levels of diagnosis (Culleberg, 2006). This represents a continuation of the pattern where certain groups are ascribed labels of mental illness more than others. The prevalence of schizophrenia in ethnic minority groups will be discussed further in Chapter Two.

1.2.3   Scientific constructs: reliability and validity

According to scientific criteria, validity and reliability must be established for the efficacy and credibility of a construct to be upheld. Schizophrenia has failed on a number of accounts to meet these criteria. A number of critical commentaries already exist that aim to deconstruct schizophrenia as a scientific construct (Bentall, 1986;, 1990;, 2003; Boyle, 1990; Read, 2004a). A summary of these arguments are outlined in the following.

In terms of reliability, research has revealed that the diagnosis of schizophrenia is largely dependant on who is doing the assessing and what measures are being used. For example, Copeland and colleagues (1971) asked 134 American and 194 British psychiatrists to provide a diagnosis from a vignette of a patient. Overall, 69% of US psychiatrists assigned the diagnosis of schizophrenia while only 2% of British Psychiatrists did so (Copeland, 1971).

Although some may argue that reliability has improved with the refinement of the DSM-IV criteria and the development of structured interviews, recent research has found that this is not the case. Herron (1992) used 16 various diagnostic systems with 284 patients and found significant variability in the number of patients diagnosed schizophrenic depending on the diagnostic system used. In another study, a Jamaican psychiatrist conducted a clinical assessment on African and African–Caribbean individuals who had already received a diagnosis from a British psychiatrist (Hickling, McKenzie, Mullen, & Murray, 1999). Inter-rater reliability was only 0.45. The British psychiatrist was more likely to diagnose individuals with schizophrenia. These investigations indicate that characteristics of the diagnoser, and the selection of tools to make a diagnosis, may affect the reliability of 'schizophrenia' as a scientific construct.

Without reliability, validity cannot be established. If we cannot agree on who has the condition we cannot begin to try and describe it's nature in a meaningful way. Validity attributes meaning to a construct. Within a mental health context, validity is measured by symptoms correlating with one another, clinicians having the ability to predict the course and outcome of diagnoses and determining whether conditions respond to particular treatments (Bentall, 1990). Furthermore, there should be a relationship between the diagnosis and what is believed to have caused it (Bentall, 1990).

Construct validity refers to the ability of a diagnosis to measure a discrete entity (Bentall, 1990). Even the DSM-IV acknowledges there are no symptoms of schizophrenia that are pathognomic to the syndrome and that the symptoms may occur frequently in other diagnoses. Indeed, Ellason and Ross (1995) found that those diagnosed with dissociative identity disorder have more schizophrenic symptoms than those diagnosed with schizophrenia. Boyle (1990, p.91) referred back to the inception of the diagnosis and argued that validity has never been met for a syndrome by the name of schizophrenia,

> It rests on their failure to provide evidence of having observed any pattern to justify their constructs and on the predictable failure, to find valid diagnostic criteria or reliable support for predictions from these constructs. Those who wish to continue using the concept of schizophrenia or any of it's variants as independent variables should first address themselves to this question: if neither Kraeplin or Bleuler nor Schneider discovered or described schizophrenia, then who did?

1.3   AETIOLOGICAL THEORIES

Despite the continuing issues of reliability and validity, a vast number of studies aim to determine the causes of schizophrenia. The aetiological studies directly relevant to this research are biogenetic, psychosocial, philosophical and spiritual explanations.

1.3.1   Biological and genetic explanations

Biological and genetic explanations of schizophrenia are varied and include genetic, biochemical, brain structure and neurodevelopmental theories.

1.3.1.1   Genetic theories

Joseph (2004) provides a summary of twin studies conducted up until 2001 that advocate for a genetic basis to schizophrenia. He separated classical studies (1928-1961) and contemporary studies (1975-1998) and found concordance rates for schizophrenia of monozygotic twins to be 40.4 and 22.4% respectively. While these rates are low, they are higher than family or dizygotic twin rates and therefore appear to support a genetic predisposition. However, these studies have been criticised by highlighting a number of methodological limitations, for example, monozygotic twins may be exposed to environments that are more similar than other family members (Joseph, 2004; R. Marshall, 1990).

1.3.1.2   Biochemical explanations

The "dopamine hypothesis" is most widely accepted biochemical explanation for schizophrenia (Carpenter & Buchanan, 1995). This hypothesis results from research that has found schizophrenics to suffer from an excess of the neurotransmitter dopamine or over activity of dopamine receptors in the brain. Jackson (1990) stated that despite extensive research, no consistent differences in dopamine levels have been found in the brains of drug-free schizophrenics and control groups. Further to this, the research cannot rule out the possibility that chemical differences are a result of the condition as opposed to the cause (The British Psychological Society, 2000).

1.3.1.3   Structural abnormalities in the brain

Enlarged ventricles have also been purported to contribute to the development of schizophrenia. A number of criticisms exist regarding the consistency of this finding and the over generalised conclusions made (Dean, 2000). For example, research has found that differences in brain structure between those diagnosed with schizophrenia and the general population have also been found in other non-schizophrenic hospitalised patients. These findings indicate that a combination of incarceration, the drugs that are used to sedate patients, diets or even excessive coffee drinking could have also contributed to these post mortem structural differences (Lewentin, Rose, & Kamin, 1984).

1.3.1.4   Drug use and abuse

Illicit drug use and abuse is another explanation for the development of schizophrenia and other psychoses. Most of this research has been directed towards investigating the relationship between cannabis and psychosis with inconsistent findings regarding a causal association (Geekie, 2006). It is generally recognised that rates of drug use (and subsequent abuse) are higher in people diagnosed with schizophrenia and that this can affect the onset, course and outcome of psychosis (RANZP, 2005).

1.3.1.5   Biogenetic beliefs in psychiatry

A number of psychiatric institutions subscribe to a biogenetic construction of schizophrenia. The Royal Australian and New Zealand College of Psychiatrists (RANZP) refer to schizophrenia on their website as a 'disorder of the brain'. Another World Health Organisation (WHO) publication entitled *'Schizophrenia: Youth's greatest disabler'*, written by the Director of the Schizophrenia Research Foundation and other psychiatrists stated, "while schizophrenia is best described as a bio-psycho-social disorder, it is anticipated that a clear biological model with soon emerge," (Thara, Sucharitakul, & Mendis, 2001, p. 11).

I entered the term 'schizophrenia' into an international Google search engine to assess it's popular portrayal (on 30/03/07). It is my clinical experience that clients will also tend to use the

Google site to research a diagnosis once it is received. Out of the first 10 results, eight of the sites assumed a biological basis to schizophrenia. For example:

- The website for the Surgeon General in the USA stated, "evidence indicates more and more strongly that schizophrenia is a severe disturbance of brain functioning".

- The site for the National Institute of Mental Health in the USA added, "Schizophrenia is a disease of the brain".

- Schizophrenia.com recognised that genetic predispositions can be 'triggered' by environmental factors. Referring to another recommendation at schizophrenia.com the preferred treatment seemed to be, "life long treatment with antipsychotic medication."

- The Schizophrenia Society Canada website provided some level of hope by stating, "Although a serious brain disorder, schizophrenia is treatable."

While biomedical constructions of illness are widely accepted amongst the psychiatric profession and popular websites, they have been found to have negative social implications. Research has indicated that biomedical constructions can lead to increased levels of social distance, increased rates of discrimination and negative attitudes towards those with mental illness (Lauber, Nordt, Falcato, & Rossler, 2004; Read & Harre, 2001; I. Walker & Read, 2002). One such study sampled a representative population of 594 people in Switzerland regarding the way in which participants reacted to a case vignette of schizophrenia. Medical attitudes and more knowledge about schizophrenia as a medical construct increased the social distance towards individuals with a diagnosis of schizophrenia (Lauber et al., 2004).

On a more local level, Walker and Read (2002) asked 126 undergraduate students in New Zealand to fill out a questionnaire measuring attitudes towards 'mental patients' before and after a video that presented either a medical, psychological or combined understanding of mental illness. Those exposed to the medical model had increased perceptions of unpredictability and dangerousness towards mental illness.

On a cultural level, research has found that biomedical constructions can have a deleterious effect on cultural constructions of schizophrenia (Das, Saravanan, Karunakaran, & et al, 2001). While this is considered to be a positive outcome by the researchers, the ethics of imposing a different cultural belief system on another is questionable (Taitimu & Read, 2006). This issue is discussed further in Chapter Two.

1.3.1.6 The role of the drug industry

The search for a biochemical cause of schizophrenia and it's concomitant treatments are argued to be intimately linked with a burgeoning drug industry (Mosher, Gosden, & Beder, 2004). For example, it is estimated that 50 million people were prescribed chlorpromazine within 10 years after the introduction of the drug to control patients diagnosed with schizophrenia (Lewentin et al., 1984). In their review of biochemical research into schizophrenia, Lewentin and colleagues (1984, p. 205) further commented that,

> Almost every biochemical substance known to be present in the brain has, within two or three years of it's introduction into the biochemical dictionary, been studied for possible involvement in schizophrenia by clinical scientists with the hope of a breakthrough in their years and with grant money (often from drug companies) burning holes in their pockets.

The presidents of two of the largest psychiatric associations have also raised concerns regarding the role of the drug industry in the conduct of their profession. In 2005, the president of the Royal College of Psychiatrists, Professor Mike Shooter (2005, p. 81) wrote:

> I cannot be the only person sickened by the sight of parties of psychiatrists standing at the airport desk with so many perks about them that they might as well have the name of the company tattooed across their foreheads. It simply will not do.

The president of the American Psychiatric Association, Dr Steven Sharfstein (2005, p.3) expressed his concern when she stated:

> As we address these Big Pharma issues, we must examine the fact that as a profession, we have allowed the bio-psycho-social model to become the bio-bio-bio model...If we are seen as mere pill pushers and employees of the pharmaceutical industry, our credibility as a profession is compromised.

1.3.1.7   Antipsychotic Medication

Antipsychotic medication as a treatment for schizophrenia has been firmly established for about 50 years (World Health Organisation, 1996). The Royal Australian and New Zealand College of Psychiatrists (RANZP) suggest that medication forms the cornerstone of therapy for schizophrenia. Indeed this is apparent in a study that surveyed 6558 outpatients in the Auckland area (RANZP, 2005). Overall, 3254 of the surveyed outpatients were prescribed antipsychotics and 2300 (72.5%) had a diagnosis of schizophrenia.

Recent research in Auckland has also found that antipsychotics are prescribed differentially depending on region (Humberstone, Wheeler, & Lambert, 2004). Various regions were more likely to use polypharmacy (multiple medications), conventional antipsychotics (see below) and depot antipsychotics (injection of medication).   South Auckland, a region that constitutes an overall lower SES and larger population of Māori and Pacific people, was found to prescribe higher doses of antipsychotics overall.   The pattern continues where certain groups (often ethnic minorities, women and the poor) are more likely to receive certain types of treatments. The issue of differential treatments according the ethnicity is discussed further in Chapter Three.

Antipsychotics can be distinguished as 'conventional' and 'atypical'. Both serve to reduce the dopimanergic activity of the brain. Conventional antipsychotics were the first to be introduced and are associated with a number of severe side effects (Ross & Read, 2004). These include tardive diskenesia, tremors, acute dystonias, akathisia, stiffness and shuffling gait, dry mouth, blurred vision, constipation, tachycardia, weight gain, skin irritations and some fatal syndromes. Many of these side effects occur in up to 70% of patients and are associated with significant subjective distress (Van Putten & Marder, 1987; World Health Organisation, 1996). Atypical antipsychotics were developed more recently to reduce the side effects of conventional antipsychotics and to target negative symptomology (World Health Organisation, 1996). However, research has found atypical antipsychotics to be only "moderately" effective and in some cases less effective than conventional antipsychotics (Ross & Read, 2004). Further to this, negative side effects such as weight gain, diabetes, seizures, hypotension, tachycardia and sedation are apparent in up to 10% of patients (World Health Organisation, 1996). Some of these side

effects actually mirror the negative symptoms they were developed to treat. It is evident that some of these side effects actually mirror the symptoms they were developed to treat, in particular the negative symptoms of schizophrenia. In reference to the constellation of these effects the WHO commented:

> The negative subjective experience of medication may go some way towards explaining the low levels of compliance. It is estimated that 50% of outpatients do not take prescriptions (World Health Organisation, 1996).

Several criticisms have been directed at research purporting the effectiveness of antipsychotic medications. One limitation is the fact that many patients are taken off antipsychotics and placed on a placebo for control groups. Sudden and complete withdrawal of antipsychotic medication can lead to withdrawal symptoms and inevitably leads to a flooding of the dopamine system. This may lead to behaviours that resemble a continuation of the symptoms of schizophrenia (Read, Mosher & Bentall, 2004). In addition, the level of blindness of participants and researchers in drug trials has been criticised. For example, if a study does not use active placebos the control group is easily identifiable due to an absence of side effects (Antonuccio, 1995). Another limitation is the fact that clinician rated measures of outcome are predominantly used in drug trials. Observations of a positive outcome may not correspond to subjective experiences when patient rated measures are used (Angermeyer, Loffler, Muller, Schulze, & Priebe, 2001).

Subjective accounts of the use of medications reveal mixed experiences. Some argue that medication helped during acute states and enabled their engagement with other forms of therapy. One person with a diagnosis of schizophrenia stated, "The drug blocks out most of the damaging voices and delusions and keeps my mood stable, " (The British Psychological Society, 2000). Alternatively, one New Zealand study recorded recovery narratives of individuals with a diagnosis of schizophrenia and found experiences of drug therapies were very negative. The most frequent themes were lack of choice, high doses and negative side effects (Lapsley, Nikora, & Black, 2002). The discourse found in the narratives referred to being "drugged up", "doped up" and "zonked out" (p.34).

1.3.2 Psychosocial constructions

Some psychosocial theorists reject an understanding of schizophrenia as a syndrome. One way in which schizophrenia has been deconstructed is to focus on specific symptoms or symptom clusters separately (Liddle, 1987). In addition, a dimensional approach has been adopted. For example, Strauss (1969) demonstrated that both hallucinations and delusions occur on a continuum with normal experiences where symptoms of schizophrenia are characterised by increased conviction and preoccupation. Bannister and colleagues also investigated thought disorder and found individuals with a label of schizophrenia engaged in a normal constructive process but experience continual invalidation of predictions (Bannister, 1960).

1.3.2.1 Negative Life Events

Some argue that psychotic symptoms are an understandable consequence of a traumatic history. Research has found that childhood sexual abuse increases the risk of positive psychotic symptoms. One study, conducted in the Netherlands, interviewed a general population sample of 4045 people and found that childhood abuse predicted positive psychotic symptoms in adulthood in a dose-response fashion (Janssen et al., 2004). This pattern has also been found in New Zealand where hallucinations were significantly more common in patients who have experienced childhood sexual abuse (Read, Agar, Argyle, & Aderhold, 2003).

Other negative life events such as poverty, discrimination, racism and marginalisation have also been implicated in the development of psychotic symptoms. For example, in the UK, racism is purported to increase the likelihood of developing psychotic experiences within African-Caribbean community (Fernando, 1995). In addition, the experience of negative events such as discrimination has been associated with the content of positive psychotic symptoms (Bentall, 2003; Sadowsky, 2004). These issues will be discussed within an international context more extensively in Chapter Two.

1.3.2.2 Psychosocial Treatment Methods

If symptoms of schizophrenia can be caused by negative life experiences, one may expect talking about these experiences would facilitate recovery. Psychosocial treatments have experienced a

resurgence in the last 10 -15 years, especially in the domain of Cognitive Behavioural Therapy (CBT) (National Institute for Clinical Excellence, 2002). CBT recognises that the process of psychosis exists at the maladaptive end on a dimension with normal cognitive processes. CBT predominantly targets maladaptive appraisals of experiences (that may have been developed through exposure to negative events or invalidating environments during development) in order to reduce symptom severity and distress (Morrison et al., 2004). This form of treatment has been found to be effective in reducing both positive and negative symptoms (Dickerson, 2000), at short term follow-up with 'chronic schizophrenics' (Gould, Mueser, Boulton, & al., 2001), in community settings under randomised control conditions (Turkington & Kingdon, 2000) and in preventing psychosis in people considered to be at high risk (McGorry, Yung, Phillips, & al., 2002).

Other forms of psychosocial interventions are also available. A recent review of New Zealand policy and service delivery emphasised the importance of support for successful living in the community via education, skills training, vocational opportunities and help with accommodation and finances (Noseworthy, 1997). Noseworthy (1997) also advocated for the needs of families such as assisting with the burden of care, facilitating relationships with mental health professionals, including the whole family in programs, providing psycho-education and increasing familial coping mechanisms. Wider community education and understanding was also recommended to address stigma and promote prevention and early intervention. Early interventions are discussed further in section 1.4.1.

1.3.3   Psychodynamic theories

During the 1940's psychodynamic therapy increased in popularity. Fromm-Reichmann (1948) explained schizophrenia via an "interpersonal and object relations" lens. They proposed schizophrenia emerged from an early disturbed mother-child relationship. The Fromm-Reichmann theory outlined that the child became confused by the alternative rejection and overprotection they experienced from a "schizophrenogenic mother".

Other psychodynamic theorists referred to changes in the experience of the self as part of the process of schizophrenia. Melanie Klein (1930) described "splitting off parts of the self and

projecting them onto another person" as part of the development of paranoid symptoms. Other psychodynamic theorists referred to schizophrenia as an adaptive strategy in the face of trauma to protect oneself against fragmentation and maintain an integrated sense of self (Shapiro, 1991). Indeed, subjective accounts of the experience of mental illness refer to significant changes in their experience of self (Roe, 1997). Geekie (2006) found participants with a diagnosis of schizophrenia felt disintegrated and 'not together' and believed this contributed to the development of their psychotic symptoms. One participant commented, "everyone's got a place, but I haven't got a personality or anything. I'm not in sync with my personality and my self or anything," (p.219).

1.3.4 Family Pathogenesis Models

Other theories suggest that communication within the family can lead to the development of schizophrenia. Laing's book 'Sanity Madness and the Family' (Laing & Esteron, 1970) aimed to portray this by first presenting a profile of the psychotic person to the reader. At first, the client seemed to behave in a way that is clearly psychotic, holding beliefs that appear to be delusional and communicating in a disorganised manner. The reader is then presented with the client within the context of their family. From this perspective, the same 'schizophrenic' symptoms are interpreted as an understandable reaction to dysfunctional relational and communication patterns within the family. Similarly, the experience of a 'double bind' has been cited as a style of communication that can lead to schizophrenia (Bateson, Jackson, Haley, & Weakland, 1956). Another family pathogenesis theory concerns the level of Expressed Emotion (EE) within families. EE refers to negative communication patterns within families such as hostility, criticism and over-involvement and has been shown to be a causative factor in the development of schizophrenia as well increase the risk of relapse (Bateson, 1973; Lefley, 1994; Read, Mosher et al., 2004). These theories have generally been criticised for blaming the family (Read, Seymour, & Mosher, 2004).

1.3.5 Bio-psycho-social constructions

It is clear that schizophrenia is variously defined depending on one's orientation to the experience. The bio-psycho-social models attempts to incorporate a number of perspectives and explanations by proposing that a complex interaction of biological, psychological and social

events contribute to the development of psychotic symptoms. This model assumes that symptoms of schizophrenia have genetic and or biological substrates that are triggered by personal and environment factors. For example, the traumagenic neurodevelopmental model proposed that exposure to early traumatic events can lead to changes in brain development and render the individual more susceptible to experiences found in schizophrenia (Read, Perry, Moskwitz, & Connolly, 2001). Another model outlines that personal stressors (physiological factors) and environmental potentiators (living within a high EE family) combine to increase the risk of relapse in schizophrenia while personal protectors (coping skills, a sense of self efficacy) and environmental protectors (social inclusion, psychosocial interventions) protect against relapse (Gottesman, 1991). In general it is increasingly accepted that a combination of nature and nurture contributes to the development of experiences labelled schizophrenic.

1.3.5.1 Bio-psycho-social treatment

Based on an integrated aetiological theory, bio-psycho-social treatments are often targeted towards combining medical, psychological and social interventions. Treatments can include medication, individual and group psychotherapy, family education, case management and occupational therapy (Wong, 2006). A number of community services available today utilise this model for assessment and treatment of psychosis and schizophrenia (see section 1.4). It is difficult with this form of treatment to delineate the differential effect of the various interventions. Research has found that combined treatments (medication , social skills training and family psycho education) are more effective in preventing relapse in patients with schizophrenia than each treatment delivered alone (Hogarty et al., 1991). Therefore, the efficacy of combined treatments may reside within the interaction of treatments rather than simply being a result of each treatments' individual effect. A major limitation of this model is the omission of spirituality. Research indicates this dimension of one's self plays an integral role in understanding and recovering from mental illnesses such as schizophrenia.

1.3.6 Spiritual constructions

While spiritual constructions of psychotic experiences have been evident throughout the ages, more recent Western theories find their origins in writings of Jung (1936) and James (1902).

Both understood psychotic experiences to be a result of disintegration in the spiritual realms of experience. James described the 'divided soul' or 'sick soul' as a state of spiritual illness characterised by depression and seeing evil in all things. He proposed that the divided soul needed a powerful mystical experience or religious conversion to heal. Furthermore, those who had healed, considered 'twice-born' souls, were referred to as the most healthy as they had experienced life from both perspectives (James, 1902). This is synonymous with the journeys of recovery described by mental health service users (see section 1.3.7).

Since the writing of James, a number of terms have been developed to describe the range of phenomena related to spiritual experiences that may be considered psychotic. A sample of which are, 'numinous experience', 'mystical experience', 'altered states of consciousness', 'spiritual emergency' and 'peak experiences' (Lukoff, 1985). Many of the contributors to this body of literature have personally encountered these experiences themselves. Most of these authors draw parallels between what is labelled psychotic and their own experience that is interpreted to be spiritual in nature.

The constructions of the individual encountering the experience (as well as those around them) have been deemed integral in determining if an experience is either spiritual or psychotic (Brett, 2002; Castillo, 2003; Claridge, 2001; M. Jackson, 2001). According to some theorists, the major boundary is determined by whether the individual and others they encounter believe the experience has an explanation within a spiritual context or whether it is inherently abnormal and therefore considered pathological and psychotic.

Further research has suggested that reliance on the phenomenology of experiences alone (as is the case with the DSM) is problematic when trying to distinguish between spiritual and psychotic experiences. Jackson and Fulford (1997) administered spirituality and schizotypy measures to those with spiritual and psychotic experiences. Descriptions of spiritual experiences included psychotic phenomena and vice versa. An interesting finding was the numinous experience scale (a measure of spiritual experiences) predicted clinical group membership more than the DSM-III based scale (Jackson, 1997). Further research has found that both psychotic and spiritual experiences have resulted in a loss of subject/object boundaries and loss of the relative

dimensional structure of perception (Brett, 2002). In a case study comparison, Jackson (2001) also highlighted similarities in the content, form and process of psychotic and spiritual experiences.

1.3.6.1 Spiritual emergencies and religious problems

There is evidence of increased recognition of spirituality within psychiatry with the inclusion of "Religious or Spiritual Problem" in the section of the DSM-IV entitled "Other Conditions that May be a Focus of Clinical Attention"(Lukoff & Turner, 1998). This category delineates religious problems from those that are spiritual. Religious problems involve distress regarding beliefs and practices of an organised church or institution (loss of or questioning of faith, changes in church membership or conversion to a new religion, intensification of one's beliefs, values and practices) while spiritual problems are characterised by distress that involves a persons relationship with a transcendent being or force (near death experiences, spiritual emergency, terminal illness, mystical experiences, meditation). Conditions within this category can be diagnosed concurrent with a mental disorder and determined to be related or unrelated to the disorder. The inclusion of experiences such as spiritual problems in a clearly medical publication could be criticised for legitimising a diagnostic ideology that is inherently contradictory to notions of spirituality. However, some consider this a positive step towards psychiatry's recognition of alternative constructs (Lukoff & Turner, 1998).

The inclusion of this category in the DSM grew out of the work of the Spiritual Emergence Network (C. Grof & Grof, 1990; Lukoff & Turner, 1998). Grof and Grof (1990) use the terms spiritual emergence and spiritual emergency to reconstruct psychotic experiences. Spiritual emergencies are described as a natural part of spiritual development. Grof and Grof (1990) argued that trauma, intense spiritual practices, mind-altering substances or strong emotions (as a result of events such as bereavement), can trigger crises. Spiritual emergencies align to other distressing spiritual experiences such as mystical experiences with psychotic features, kundali awakening (a transformative process in the Yogic tradition), the shamanistic initiation crisis (discussed further in section 2.5.3.4), possession states and psychic openings (spontaneous paranormal experiences) (Lukoff & Turner, 1998). Grof and Grof (1989, back cover) further describe spiritual emergencies as,

Crises when the process of growth and change becomes chaotic and overwhelming. Individuals experiencing such episodes may feel that their sense of identity is breaking down, that their old values no longer hold true, and that the very ground beneath their personal realities is radically shifting. In many cases, new realms of mystical and spiritual experience enter their lives suddenly and dramatically, resulting in fear and confusion. They may feel tremendous anxiety, have difficulty coping with their daily lives, jobs and relationships, and may even fear for their own sanity.

There is currently a significant growth in research regarding the role of spirituality in mental illness. This is especially important in the area of schizophrenia if one considers the phenomenological similarities between spiritual and psychotic experiences. In addition, research has repeatedly found that spiritual practices and beliefs are helpful in coping with and recovering from mental illness (Geekie, 2006; Lapsley et al., 2002; O'Hagan, 2006; Omeasoo, 2000).

1.3.7 The Experiencer's perspective

While I have discussed how psychiatrists, psychologists and other theorists construe experiences labelled as schizophrenic, it is important to recognise the subjective meanings given to these experiences by those who have been ascribed with the label. Research reveals that the majority of individuals using mental health services hold their own understandings of their experience that draw from multiple explanatory models (Geekie, 2006).

A common finding is that consumers favour psychosocial over biological explanations (Angermeyer & Klusmann, 1988). For example, Angermeyer and Klusmann (1988) assessed explanatory models of 198 inpatients (diagnosed with a psychotic disorder) and their family members. They found an overall propensity for explanations such as loneliness and stressful life events. A preference for psychosocial explanations is also mirrored within the general population (Read & Harre, 2001). This has been found in 16 countries and stands in stark contrast to the views of biological psychiatry (Read, Haslam, Sayce, & Davies, 2006).

To understand more about psychosis from within, a recent grounded theoretical study within New Zealand asked services users about their subjective experience of psychosis (Geekie, 2006). Geekie recorded psychotherapy sessions with service users in a first episode psychosis service. These sessions were part of the normal course of therapy in which participants were trying to

make sense of their experience. Approximately four sessions were recorded for each of the 15 participants.

Geekie found that participants made sense of their experience in a variety of ways. Primarily, having the ability to author one's experience and then tell one's story were of central importance to participants. Understanding the cause of their experience was commonly the first issue participants wanted to discuss in therapy. Geekie also noted participant's tendency to discuss their experiences in terms of individual symptoms rather than a diagnostic syndrome. Furthermore, the same participant held various explanations for various symptoms. For example, a spiritual explanation was provided for one symptom, a biological explanation for another and a psychological explanation for yet another. In general, Geekie found explanatory models fell under psychological (emotions, the self, information processing), developmental and experiential (general experience and history, isolation, abuse, interpersonal relationships, becoming independent) biological (drugs, brain, heredity, subvocalisation), spiritual (other beings, general spiritual matters) and functional frameworks (expressing painful emotions, giving voice to suppressed thoughts, making sense of things). This represents a vast range of explanatory models that includes *but is not limited to* that which is on offer from biological psychiatry.

Geekie then developed three theoretical construct from the qualitative themes to describe the subjective experience of psychosis: fragmentation-integration, invalidation-validation and spirituality. Fragmentation-invalidation encompassed participants' experience of a loosening of connections and associations between aspects of their experience both intra and interpersonally. According to Geekie, validation-invalidation represented participants' ability to understand others or be understood by others. And finally, spirituality referred to participants' understanding of their psychotic experience as being a meaningful relationship with the universe.

A limitation of Geekie's research is that participants were recruited from a clinical population. The effect of the dominant medical model and the label of schizophrenia on their constructions cannot be ignored. Beavan (2006) addressed this limitation by replicating international research (Romme & Escher, 1989), within New Zealand, aimed at investigating the various ways in which people from the general population experience and understand auditory hallucinations. Overall,

153 members of the public filled out a questionnaire regarding their understanding and experience of hearing voices as well as their coping strategies. From this pool, Beavan interviewed 50 respondents in depth. Approximately half of her sample had previously made contact with mental health services (although 40.7% of this group stated their contact was not related to their voices). The other half lived with their voices or accessed support from alternative avenues. Of those who had contact with mental health services, about 20% had received a diagnosis of a psychotic disorder.

Beavan also found participants held various explanatory models. Those participants who held spiritual explanatory models tended to value their voice experiences, have a more positive emotional reaction to the experience and have less contact with mental health services. Alternatively, participants who held medical and/or psychological constructions of their experience did not want to hear voices, had more of a negative emotional reaction and increased contact with mental health services. A significant finding was that the content of the voices predicted the emotional response for 93.3% of participants. This finding provides evidence for the argument that the constructs we place upon experiences can affect the course, content and outcome of one's experience.

Beavan (2006) used a phenomenological approach to further understand the subjective experience of hearing voices. Five aspects were proposed to make up the essential structure of the experience:

- The content of the voices is personally meaningful to the voice hearer
- The voices have a characterised identity
- The person has a relationship with their voices
- The experience has a significant impact on their life
- And the experience has a compelling sense of reality

While the above research recognises participant's constructions of their experiences they are still written by clinicians. There now exists a growing body of literature written by the subjects of psychotic and spiritual experiences. First hand accounts of psychosis provide further insight into the experience of this range of phenomena. Mary O'Hagan recalled from her journal in 1979,

> I am locked in here- all alone in this black box. Before this I used to hide the blackness with colourful decorations. On the walls of this black box I painted windows with pleasing views on them and I called these views reality. Now I have been stripped right back to the bare black boards of my psyche. My world has been emptied out. (O'Hagan, 1986, p.32).

Another first hand account described being cut off from the rest of the world,

> Things do not feel real. There is something between me and the things and persons around me; something like a wall of glass between me and everything else, (Spitzer, 1990)

Others discuss their experience in terms of a heightened sense of awareness,

> I was aware of a supernatural presence...It was like a throbbing living being all around me. It pressurised me. Cited in (Jackson, 1997)

In general, the subjective experience of psychosis provides a very different insight into the characteristics and phenomenology of the experience.

1.3.7.1 Recovery from the consumers perspective

Stripped or bound

Knocked around

Drugged or shocked

The doors all locked

The windows grated

But we are hated

They ridicule our meditation

Rather give us medication

Confine us in those fishbowl rooms

Train us early for our tombs

Blinding lights, stare in the glass

While they inject us in the arse

Surly, angry male attendants

Dignity a tattered remnant

Hold us down and bruise our arms

They call it help but we are harmed.

(cited in Estroff, 2004, p.293)

Psychiatric treatments are often experienced as negative and at times, traumatic, by those they are used on.   A growing body of literature exists that represents consumers' perceptions of what helps, and does not help, on the pathway to recovery. A recovery framework is part of a world wide consumer movement that has been forged against the myth that schizophrenia and other mental illness are a life long sentence (Curtis, 1997; Lapsley et al., 2002). This movement involves consumers participating in the development, delivery and assessment of services. The consumer movement aims to centralise consumer constructions of what constitutes a positive outcome and address the harm that treatments have caused in the past. The literature suggests that positive outcomes incorporate more than standard measures of symptom reduction and include a sense of hope, making meaning of one's experiences and social participation (Lapsley et al., 2002).

In a recent study in New Zealand, Lapsley and colleagues (2002) interviewed 40 individuals, Māori and non-Māori.   All had been previously diagnosed with a severe mental illness (schizophrenia was a common diagnosis) and considered themselves at the time of interviewing to be fully recovered (they had not used services for two years and were not taking anti-psychotic medication). The recovery narratives shared by participants outlined a journey that began with "getting a glimpse of recovery." This theme included one or two good things happening and feeling a sense of hope. Many then reached a "turning point" representing dramatic moments in their recovery. This theme included participants' stories of 'taking charge', having a 'spiritual experience', 'deciding to live' and 'changing identity' by rejecting one's diagnosis. Subsequently, participants described a 'long road to recovery' that was littered with many setbacks. These setbacks were endured with the use of coping strategies, resources, social supports and the development of their identity independent of the illness. Many participants assumed a philosophical stance towards their mental illness, viewing their experience as a journey that has helped them grow. Participants referred to their experience as a 'gift' and 'blessing' that taught them about life.

Mary O'Hagan (1999), who proudly attests to being a psychiatric survivor, is also now a Mental Health Commissioner in New Zealand.   She related hers and other psychiatric survivors'

journeys recovery to climbing the peaks of one's 'self' (exploring the far reaches of the inner self). She used the analogy of climbing Mount Everest to represent her journey of recovery (2004). She felt that her journey, (akin to other mountaineers) had a purpose, had taught her many things along the way and presented her with one of the biggest challenges that any human being might face. However, she added that the pioneers of the frontiers of mental illness do not receive the same acclaim as those who have conquered Mt Everest. Instead they are often faced with stigma and isolation. O'Hagan (1999, p.9) reiterated that recovery is part of human experience in general rather than a term specific to service users,

> Recovery is not exclusive to people with more serious forms of mental illness. Recovery is part of the fabric of life, everyone's life. For we all have to deal with adversity, injustice, loss or fluctuations in our health at some point in our lives.

Consumer perspectives have ultimately facilitated a much deeper understanding of experiences commonly labelled psychotic and what helps in recovery. When deconstructed from the experiencer's lens, it is difficult to argue that schizophrenia and it's symptoms are merely meaningless experiences of a mad person (psychotic symptoms are defined by the DSM-IV as incomprehensible and irrational in nature). Rather, the writings that are gifted from consumers about the experience of "madness" and their recovery provide insight into journeys that are full of meaning and legitimate in their own right (Porter, 1987). Indeed, just as some of the stories that have been shared above indicate, madness may be one of the most meaningful experiences an individual encounters throughout their life.

1.4 SCHIZOPHRENIA: NEW ZEALAND MAINSTREAM TREATMENT

Mental health services in New Zealand are an extension of the international history outlined above. A review of these services also provides insight into the changes, both positive and negative, that have taken place over the last few decades of mental health reform. Recent developments are in no small way the result of increased participation of consumers in the development and delivery of mental health services. This movement has advocated for the development of alternatives to acute inpatient units and increased access to a variety of treatments and therapies within the community.

The current system in New Zealand uses a combination of community residential and hospital care on a compulsory or voluntary basis (O'Hagan, 2006). This system is similar to that which exists within the UK, Australia and the USA. Individuals are placed under the Mental Health (Compulsory Assessment and Treatment) Act if they present an imminent risk of harm to themselves or others as a result of mental illness and once placed, have no legal choice regarding hospitalisation or the form of treatment (commonly medication) they receive. Current acute inpatient units generally have 15-60 beds that are not always in separate rooms, communal eating and living spaces, nurses stations, that are separated and strategically placed to view ward behaviour, and intensive care units with seclusion rooms. With limited space, only the most disturbed and distressed are admitted and, at times, discharged early to free up beds.

The Mental Health Commission in New Zealand developed a report entitled 'No Force Advocacy by Users and Survivors of Psychiatry' (O'Hagan, 2006). This document advocated for a reduction in the use of compulsory treatment, the consideration of human rights within the process of compulsory treatment and recognition of discrimination in legal processes. This report reiterated the basic premise of mental health services to 'first do no harm'. The Mental Health Commision argued, "compulsory treatment in New Zealand, whether in the community or an in-patient unit, is used too frequently, for too long and too often it is used for the wrong reasons – not those specified in the Mental Health Act," (p.2).

Within New Zealand it has been proposed that hospital based acute services require improvement on a number of levels. A current research project that interviewed young adult service users found they experienced a restrictive institutional environment, overcrowding, physical, verbal or sexual violence, traumatic experiences in seclusion, a lack of empathy from staff, an over-reliance on medication and lack of psychological assistance and boredom (as yet unpublished, cited in O'Hagan, 2006). These findings reflect those found elsewhere in the UK and USA (MIND, 2000).

1.4.1 Alternatives to hospitalisation

A number of alternatives to hospitalisation exist within community based acute services. Home based acute services require members of a multi-disciplinary team to visit people and families in

their own home, any time of the day or night and provide medication, brief counselling, practical assistance, information and support (O'Hagan, 2006). Home based acute services are used in the UK and are currently provided by one area in New Zealand (O'Hagan, 2006). Research indicates this alternative is related to greater service user and family satisfaction when compared to inpatient care (Reet, 2004).

Another alternative to hospitalisation is Soteria House. This model is world renowned and provides acute care for those diagnosed with schizophrenia within a non-medical, psychosocial oriented environment that uses minimal antipsychotics (Mosher & Menn, 1978). Soteria houses are staffed by non-professionals, service users and mental health professionals and are located within a home in the community (Mosher, 1999). When compared over two years to a control group using inpatient services, clients accessing Soteria house used significantly less medications, less outpatient care, experienced better occupational outcomes and were more able to live independently (Mosher & Menn, 1978). This model of service delivery is not yet available in New Zealand even though it's implementation has been supported by a number of community and governmental groups including the Mental Health Commission (Agar, 2006).

Recent research within New Zealand asked service users what they need when in crisis (Agar, 2006). Upon discharge from an inpatient unit, service users were asked about their experience of hospitalisation, what they found helpful or unhelpful and their recommendations for alternatives. Seventy-eight participants filled out a questionnaire and ten attended a qualitative interview. Ninety-three percent supported the idea of Soteria style residential crisis services as an alternative to hospitalisation. Themes from the data indicated that service users found the atmosphere of acute services to be important. They preferred peace, comfort, privacy and being near nature when in crisis. These characteristics may be difficult to integrate into current city bound, hospital inpatient settings. The services users surveyed also valued 'being with' staff and other service users where the communication is non-judgemental, they were taken seriously and provided with care a compassion. Service users also wanted to be informed about what is being done with, or to, them. In general they wanted more freedom and autonomy. Reactions to medication were varied although 71 percent found this form of treatment helpful. What was not helpful were the side effects of medications including sedation. Māori participants wanted more

access to cultural and spiritual input. In general, participants in Agar's research wanted more of a holistic approach than that provided within the hospital setting.

Another innovation in community treatment is the development of Early Intervention Services (EIS). These services were developed based on research that indicates long term outcomes can be improved if treatment is provided early during the first episode of psychosis (Mental Health Commision, 1999). EISs are predominantly based on a combined psychological and medical model and have been available in a number of countries including New Zealand since the mid 1990's. EISs in New Zealand are unique in their bicultural orientation, which will be discussed more extensively in Chapter Three. New Zealand guidelines indicate that EISs should help the client to develop meaningful understandings of their experience using a variety of interventions (Turner, 2002). Examples of innovative interventions with EIS are the philosophy and storytelling groups offered at an EIS in Auckland. The philosophy group encourages clients to ponder questions such as, 'what is the nature of the mind?' and, 'does medication change my personality?' The storytelling group aims to promote individuals to author their own experience, share this story with the group and then reflect on their own and others stories. Both are reportedly well received (Burdett & Geekie, 2003).

1.5   SUMMARY

> In the New Testament, the words *name* and *power* are synonymous. The power to name things, to classify acts and actors, is the greatest power in the world...language thus not only reveals and conceals acts and actors; it also creates what and who they are, (Szasz, 1979, p.183).

In line with Szasz's (1979) assertion above, over the millennia, those in power (priests, physicians, politicians) have differentially defined acts and actors in terms of who and what is considered to be mad. Various eras have defined the same experiences and people differently. To hear voices and see things others cannot could have lead an individual to be considered a prophet, heretic or schizophrenic depending on which century they were born. In general, symptoms of schizophrenia have been defined as either a problem of the spirit or a problem of the body. For only the last 100-150 years, the discipline of psychiatry has held the power to name acts and actors, and has determined schizophrenia as a problem of the body. Within this chapter, the construction of schizophrenia as a medical label has been criticised from both a scientific

(reliability and validity) and critical (recognising power displacements, such as the drug industry's role in developing treatments) perspective. Medication as the predominant form of treatment is also viewed as producing limited positive, sometimes negative and other times dangerous outcomes. As opposed to the medical profession, consumers and the general public seem to hold various explanatory models for understanding, and healing from, psychotic experiences. It is argued here that listening to the subjective experience of psychosis and it's treatment can lead to a deeper understanding of the phenomena. Finally, a major finding is the role spirituality seems to play in understanding one's experience.

1.5.1   The current research

This chapter is relevant to the current research in a number of ways. By turning the research lens back on 'schizophrenia' and it's development throughout history, one is able to view this term as a cultural construct that was forged within a specific historical, social and political context. This is necessary if we are to recognise the validity of cultural constructs that are shared by participants in this research as opposed to viewing them as misunderstandings of objective, scientific phenomena. Rather than providing any definitive answers, this chapter recognises the problem of trying to label diverse behaviours and people with a nosologic category. Multiple and diverse realities exist, with 'schizophrenia' being only one of many ways available to understand experiences such as hearing voices that others can't hear (hallucinations) or holding unusual beliefs that seem very odd to other people (delusions). Wider indigenous and Māori constructs will be addressed in the following two chapters to further critique the nosology of schizophrenia.

2 CULTURE AND PSYCHIATRY: THE INTERSECTIONS, THE SIGNPOSTS AND THE DIRECTIONS

It is argued that *all* indigenous groups have been under the lens of psychiatric and medical research at some point (Bhurga & Littlewood, 2001; Fernando, 1988). Within this chapter, it is argued that certain definitions of indigeneity are used depending on whether the aims of the research are to find universal syndromes across cultures; establish anthropological accounts of cultural syndromes (where a Western lens is used to interpret cultural phenomena) or understand unique cultural constructions from within the culture regarding mental health and illness. This chapter will use the diagnosis of schizophrenia to provide a short history of encounters between psychiatry and culture. Finally, the emerging discipline of indigenous psychology is acknowledged as a site of resistance against traditional approaches to psychiatric research by understanding cultural experiences and phenomena from within the cultural group for the benefit of the group.

2.1 DEFINITIONS OF CULTURE AND INDIGENEITY

The research that is outlined within this chapter incorporates research on two distinct minority groups. Ethnic minorities are considered those people who are a minority as a result of forced or chosen migration. For example, African-Caribbeans in the UK or African-Americans, Asians and Latin Americans in the United States of America are considered ethnic minorities. Ethnic minorities are distinct from indigenous peoples who are a minority *in their own land* as a result of invasion of a dominant group through the process of colonisation. Sometimes, indigenous peoples are dislocated from their lands and subsequently migrate, thus being an ethnic minority within another land.

Research regarding culture and mental illness has used various constructs to represent those who do not belong to the dominant group. 'Aboriginals', 'ethnic minorities', 'blacks', 'first nation people', 'natives', 'people from developing nations' and 'immigrants' are only some of the terms utilised around the world to represent 'the other' (Fernando, 1988; L. Smith, 2003). The terms 'indigenous' and 'aboriginality' are considered here as an example of the complexity of constructs relating to research into culture and mental illness. WHO proposed the terms related to

indigeneity can either *include* (by broadening the definition) or *exclude* individuals (by narrowing the definition) (World Health Organisation, 1999). For example, inclusivity of the term would ensure that both native speaking Māori, living on their ancestral land and urban, English speaking Māori are considered indigenous to New Zealand. Any research with indigenous populations needs to take into consideration the complexity of these issues. The International Labour Organisation's Convention, along with the World Bank, aimed to incorporate a broad definition of indigeneity by including factors such as descent from populations inhabiting the country, having common customs, traditions and institutions, having a common language of origin, self perception and geographical concentration (Psarcharopoulous & Patrinos, 1994; Van de Fliert, 1994).

Other theorists refer to the experience of marginality as a key component of being indigenous (Brass, 1999; Maybury-Lewis, 1997). Kirmayer, Brass and Tait (2001) refer to the dual effect terms of indigeneity can have on those groups for which the term has been ascribed (by the dominant group) or assumed (within the group). On one hand, terms of indigeneity can serve a positive function of uniting individual and collective indigenous groups under a common experience of struggle and survival. Alternatively, the same term can serve a function of separation, "the very notion of aboriginality is a social construction that serves as a dividing practice that both marginalises and unites" (p. 13).

A Kaupapa Māori researcher, Linda Smith (2003), indicated these constructs often serve to separate indigenous populations from the majority as the 'other'. In some ways, colonisation made differentiation between 'us' and 'them' necessary. Those already inhabiting a region suddenly needed to differentiate between those from 'here' and those from 'there'. The dominant group also sought to differentiate 'us' (civilised) from 'them' (savages). One example of the terms that arose out of colonisation is apparent for Māori within New Zealand. Prior to European contact, there was no universal term for the indigenous people of New Zealand. Each individual identified themselves according to their iwi (tribe) and hapu (sub-tribe). The language and customs of each iwi and hapu shared similar characteristics, however were distinct and unique in their own right. When the Europeans came, there was another group that looked, talked and behaved in ways that were clearly different. For the first time there was a need to

differentiate between us (living in New Zealand before colonisation) and them (the colonisers). The term 'Māori' was developed to denote the in-group or us. 'Māori' translates to that which is normal, usual or ordinary (Williams, 1992). While 'Pākehā' was developed to represented the 'other' (those of European origin), a term that translates to strange, other or abnormal (Sharp, 1997). Within the context of this thesis the development and meaning of these two terms seems, to say the least, ironic. Sharp further explained the emergence of the terms 'Māori' and 'Pākehā',

> Māori invented- as the word suggests- Pākehā. They also invented themselves and are continuing to do so. To speak of the 'Māori' as one people…is to speak a recently-invented tongue expressing a modern identity and modern customs. The members of the aboriginal tribes thought of themselves as tribesman. 'Māori' when the Pākehā arrived, meant 'normal, ordinary and of the usual kind'- as the Pākehā were decidedly not when they arrived. The 'ordinary bloke' was not in the beginning a Pākehā but a Māori, and the Pākehā, in what now looks like an irony, called the Māori, 'New Zealanders', (p.50).

A definitive understanding of the term indigenous is elusive. The construct 'culture' is also just as difficult to delineate. Culture has been popularly defined as the values, beliefs and practices of an ethno cultural group (Lopez & Guarnaccia, 2000). This definition however is limited in it's view of culture as a static product as opposed to an organic process. It is argued that cultural systems are a 'dynamic creative process' that adapt to change by incorporating and/or actively resisting various social, economic and political events (Greenfield, 1987). Furthermore, notions of culture can mask individual variability in values, beliefs and practices.

The arguments outlined within this section do not attempt to reject the use of terms related to culture and indigeneity. In fact, they are used throughout this text depending upon the literature being cited. The intention of this section is to highlight the variability and complexity in the use of terms within research. The following will outline how various forms of research into culture and psychiatry tend to adopt particular definitions to meet their own research agendas.

2.2 CROSS-CULTURAL PSYCHOLOGY, TRANSCULTURAL PSYCHOLOGY AND INDIGENOUS PSYCHOLOGY

There exists three main research paradigms at the intersection between culture and psychiatry: Cross–cultural psychiatry, transcultural psychology or psychopathology and indigenous psychology (Matsumoto, 2001). Cross-cultural psychiatry aims to enhance the validity of already

established Western psychiatric constructs. This is achieved by investigating commonalties and comparisons in the phenomenological expressions of psychopathology across cultures using Western measures and diagnostic criteria. The WHO International Pilot Study of Schizophrenia is a primary example of cross cultural research (World Health Organisation, 1973;, 1975;, 1979) (discussed in more detail in section 2.4). This body of research assumes cultural interpretations are misconstructions of already established medical and psychiatric conditions. Transcultural psychology takes a step towards recognising the role of cultural beliefs and practices in the onset, course and outcome of experiences. However, members of the dominant group do much of this research *upon* ethnic minority and indigenous cultures. In this sense culture is objectified. Finally, indigenous psychologies (plural, as there are many local psychologies emerging) aim to research culture from an insider's perspective as opposed to the anthropological position of transcultural psychology. Indigenous research aims to primarily benefit people within that context. These very distinct ways of researching culture will be outlined in section 2.4, 2.5 and 2.6 respectively. Prior to this, the role that colonisation has played within all of these disciplines requires recognition.

2.3 COLONISATION: THE COLLISION OF CULTURE AND PSYCHIATRY

Culture and psychiatry intersected through the process of colonisation. Fernando (1988), an African-Caribbean psychiatrist, recognised the context of slavery and colonisation that psychiatry was forged within. At this time, the writings of theorists were littered with racist constructions regarding the colour of one's skin (being 'black' meant being 'evil'), the size of one's brain (black people had smaller brains, supporting an ideology of the primitive race) and the primitive nature of collective cultures as explanations for mental illness (Fernando, 1988). Fanon, another black psychiatrist, described the racism inherent in Western society that laid the foundation for the racism in psychiatry,

> In Europe the black man is the symbol of Evil...In the remotest depths of the European unconsciousness an inordinately black hollow has been made in which the most immoral impulses, the most shameful desires remain dormant...With those savage peoples, everyone agreed: Those Negroes were the principal of evil...In the collective unconscious of *homo occidentalis* the Negro - or if one prefers, the colour black - symbolises evil, sin, wretchedness, death, war, famine, (cited in Fernando, 1988, p. 16).

In Africa, India, Australia, New Zealand and the Americas, colonisers attempted to theorise about and label people who were considered as naturally inferior. For example, the concept 'national minds' indicated that Nordics have a propensity for scientific work while African Americans had an 'instinct for submission' (McDougall, 1908). This supposedly provided evidence for African Americans' natural instinct to become slaves. Around the same time in America, 'Drapetomania' was a mental illness category developed to explain the characteristic symptom of Negroes running away from slavery. The 'therapy' recommended was whipping and the effectiveness was measured by submission to the slave owner (Szasz, 1971).

While all indigenous and minority cultures inhabit a unique time and space, many have experienced commonalities when faced with colonisation. The World Health Organisation, WHO (1999), refers to these common experiences as depopulation, violence, dislocation, poverty and challenges to and repression of culture. Smith (2003) compared the experiences of the colonisers and the colonised. She referred to the process from a coloniser's perspective as (1) initial discovery and contact (2) population decline (3) acculturation (4) assimilation, and (5) reinvention as a 'hybrid ethnic culture'. The indigenous experience, however, is markedly different and follows a process of (1) contact and invasion, (2) genocide and destruction, (3) resistance and survival, and (4) recovery as indigenous people. The racial/cultural identity development model (S. Sue & Sue, 1990) also outlines five stages of acculturation experienced by minority and/or colonised peoples. These being: conformity, dissonance, resistance and immersion, introspection and integrative awareness. According to Sue and Sue, progression and/or regression through these stages is dependant upon subjective experiences of oppression and how individuals attempt to understand their place within their own and the dominant culture.

2.3.1 Historical trauma

Many individuals and cultures are at various stages of acculturation. Acculturation was, and still is, a specific weapon of colonisation. The cultural wounds wrought upon indigenous populations are still raw. It is now widely recognised that cultural health is intimately related to the physical, mental and spiritual health of indigenous peoples. A number of indigenous researchers have

described the sequale of the trauma related to acculturation. The commonly cited symptoms and effects being increased suicide rates, depression, self-destructive behaviours, substance abuse, identification with pain endured by ancestors, fixation on one's own or their ancestor's trauma and somatic symptoms that do not have a "medical" explanation (Brave Heart, 2001).

Maria Yellow Horse Brave Heart (1999), a Native American professor, coined the term 'historical trauma response' to describe the violation of selfhood experienced as a result of self, or ascribed, identification with groups that have historically been marginalised by colonial powers. 'Soul wounds' (E Duran, 2006; E. Duran, Duran, Yellow Horse Brave Heart, & Yellow Horse-Davis, 1998) is another term used by a native American psychotherapist, Eduardo Duran, to describe the intergenerational trauma of colonisation and the psychology of 'internalised oppression'. Duran and Duran (1995) refer to soul wounds as the unresolved grief and mourning that is passed on intergenerationally through dysfunctional coping strategies in the family. To access these wounds within therapy, Duran simply asks a client who they learnt their way of coping from (for example aggression or substance abuse). He often receives the answer, "from my family or parents". He then asks, "where did they learn it from?" or "why do you think they did that?" and so on. In contrast to current assessment processes that predominantly focus on the client's and their parent's history, this form of assessment often spans several generations.

'Cultural wounding' and 'Cultural Trauma Syndrome' (CTS) were coined by an indigenous Hawaiian researcher, Bud Pomaika'i Cook, to describe the relationship between cultural trauma, Hawaiian spirituality and current health status (Cook, 2005; Cook, Withy, & Tarallo-Jensen, 2003). CTS is referred to as the process of cultural genocide towards the cosmology, epistemology, pedagogy and social structure of indigenous Hawaiians. According to Cook, historical events may not be experienced as injurious by one generation (due to the hegemonic structures of the time) but may be experienced as traumatic by successive generations as they recall the stories of their ancestors. Injuries can remain dormant and recent traumas can trigger the re-experiencing of historical traumas.

Karina Walters is a Native American researcher (Choctaw Nation) who, along with colleagues, has mounted several studies into the effect of historical trauma and current physical, verbal and

sexual abuse on Native American stress-coping. By reviewing the relevant literature and conducting preliminary research, she proposed that trauma (stress) for indigenous groups incorporates historical trauma and discrimination as well as individual traumatic life events (Walters, 2002; Walters, Johnston-Goodstar, & Palmanteer Holder, 2005). Walters also proposed microagressions (discriminatory events that can lead to soul wounds) are encountered by indigenous peoples on a daily basis, such as being asked, "what percentage Indian are you?" These stressors can lead to poor physical and mental health and increased substance abuse. This can be mediated by cultural resilience factors such as identity attitudes (internalisation or externalisation of attitudes towards oneself and one's groups), enculturation (learning about and identifying with one's culture), spiritual coping (using spiritual methods to cope) and access to traditional health practices.

Within this framework colonisation is not considered a historical event but a current trauma that occurs on a daily basis. Historical trauma is a result of remembering and re-experiencing the traumatic events of ancestors (sometimes multiple generations past) or directly experiencing the legacy of colonisation (poverty, acculturation, marginalisation, microaggressions, media representations of indigenous cultures and encountering stereotypical constructions the general community hold about what it means to be indigenous).

These cultural wounds are evident in statistics throughout the world (Kirmayer, Macdonald, & Brass, 2001). As early as 1837 the effects of colonisation were recorded in the *Official report of the select committee on Aborigines,*

> It is not too much to say, that the intercourse of Europeans in general, without any exception in favour of the subjects of Great Britain has been...a course of many calamities to uncivilised nations. Too often their territory has been usurped; their property seized; their numbers diminished; their character debased...European vices and diseases have been introduced among them. (House of Commons Select Committee, 1837, p.65)

In North America almost 90% of the seven million indigenous population had died as a direct or indirect result of colonisation (Kirmayer, Brass et al., 2001). In New Zealand, by 1896, it was predicted that Māori were a 'dying race' where the population had fallen by two thirds to it's lowest level of 42 113 (Durie, 2001; Kingi, 2005). In Australia, population decline was also a

major issue. In 1824, settlers were authorised to shoot Aboriginals. A number of massacres of aboriginals have been recorded in which many woman and children were killed and, according to Aboriginal accounts, whole tribes were wiped out (Human Rights and Equal Opportunities Commission, 1997).

The historical traumas faced by Aboriginal and Torres Straight Islanders are numerous. In addition to physical genocide, the Australian government tried to eradicate Aboriginals culturally and genetically. The 'stolen generation' was a result of a legally sanctioned assimilationist policy aimed at removing aboriginal children from their family and relocating them within mission schools or non-aboriginal families. In effect, the Australian government was made legal guardian of all aboriginal and 'half caste' children. One in three half caste children were removed from their families and placed in dormitories or white families over a 30 year period (1940's to 1970's). Full blooded children were of no interest as it was believed at the time that "aboriginality" could be bred out genetically in half-caste children. The government of the time commented that full blooded aboriginal children 'should be left alone to pass in peaceful ease' (McKendrick, 2001). One commentator observed,

> It is the story of the attempt to 'breed out' the Aboriginal race. It is the story of attempted genocide. Genocide does not simply mean the extermination of people by violence, but may include any means at all. At the height of the policy of separating Aboriginal people from their parents the Aborigines Welfare Board meant to do just that. The 1921 report of the board stated that the 'continuation of this policy of dissociating the children from camp life must eventually solve the aboriginal problem...when children were placed in a 'first class private home,' the superior standard of life would 'pave the way for the absorption of these people into the general population, (Rowley, 1973, p.2).

A poem written by a victim of the stolen generation recalls the process from an insider's perspective,

> This story's right, this story's true
> I would not tell lies to you.
> Like the promises they did not keep and how they fenced us up like sheep.
> Said to us 'come take our hand', sent us off to mission land.
> Taught us to write, to read, to pray.
> Then they took the children away,

took to children away, the children away.

Snatched them from their mothers breast, said it was for the best.

Took them away.

"Took the children away", (Archie Roach, cited in McKendrick, 2001, p. 72).

The traumatic effect of the stolen generation on successive aboriginal generations is evident in a growing number of studies (McKendrick, 2001; NSW Department of Health, 1997). In general, Aboriginals and Torres Straight Islanders experience greater levels of socio-economic disadvantage and are overrepresented in negative physical and mental health statistics.   In one study (McKendrick, 2001), a random sample of 116 aboriginal adults attending a general practitioner were interviewed at first contact and again three years later. Twenty-nine percent were separated from their aboriginal families under assimilationist policies (many were removed as babies). They were compared to those participants brought up within their extended family networks. The major differences found for those of the stolen generation were lower employment rates, increased instability in housing, less knowledge about their culture, more feelings of loneliness, less social supports, greater levels of substance use and abuse and higher rates of suicide attempts. All of the children of the stolen generation also met criteria for chronic depression.

It is now widely recognised that increased rates of psychiatric disorders, unemployment, suicide and low socio-economic status are experienced by many indigenous populations, at least in part as a result of colonisation (Bhurga & Littlewood, 2001; Durie, 2001; Kirmayer, Brass et al., 2001; Kirmayer, Macdonald et al., 2001; World Health Organisation, 1999). The following will outline past and current research that has attempted to investigate the manifestations of mental illness (more specifically schizophrenia) within indigenous populations and the various reasons proposed to explain these disparities.

2.4   CROSS CULTURAL PSYCHIATRY: INVESTIGATING SCHIZOPHRENIA ACROSS CULTURES

The aim of cross cultural psychiatry is to "uncover" Western syndromes in indigenous populations. This approach tends to ignore local constructions of illness. Kraeplin (1919), was among the pioneers of this discipline when he observed patients in Malaysia (Littlewood &

Bhurga, 2001). He compared the condition of *Amok* (constituting behaviours symptomatic of schizophrenia and now included in the DSM-IV as a cultural syndrome) to 'dementia praecox' in Germany. Kraeplin believed if commonalities were found, a biological and universal explanation for dementia praecox would be substantiated. However, where differences were apparent he also indicated this was as a result of biological, rather than cultural, differences between Malays and Europeans. An excerpt from his observations reveals his assumption of the universality of Western psychiatric disorders,

> A visit to the institution in Singapore at once showed me that in the most different constituent parts of the mingling of notions there, among Chinese, Tamils, Malays, there were clinical pictures to record which wholly resemble the forms of dementia praecox known to us, (Kraepelin, 1919, p.232).

The famous WHO studies (World Health Organisation, 1973;, 1979) have made similar assumptions about the universality of psychiatric disorders. From 1967 to date, the WHO has initiated a number of studies to investigate the manifestation, consequences and course of schizophrenia across regions and cultures. Three major findings have been derived from these studies: 1) the phenomenological symptoms of schizophrenia occur in various cultures around the world, 2) differences in symptomology exist between cultures and 3) developing (non-Western) countries experience more positive outcomes than developed (Western) countries. Nearly thirty research sites, spanning 19 countries have participated in the research. Significant commonalities have been found in the symptoms and symptom clusters across all sites. These commonalities were lack of insight, pre-delusional signs, flatness of affect, auditory hallucinations and experiences of control. However, it has been highlighted that when pairs of centres were compared, differences were apparent in the frequency of symptoms present (Cherrington, 1994). In developed centres, the frequency of affective symptoms, thought insertion and broadcast delusions was higher while auditory and visual hallucinations occurred with a greater frequency in developing centres (Jablensky et al., 1992). Participants within the Agra region were found to experience particularly bizarre and florid symptoms when compared to other sites. These results are consistent with those of Chandrasena's (1987) study that found a lower prevalence of Schneiderian First Rank Symptoms among psychotic inpatients who migrated to the West from

developing countries when compared to those born in Canada and the United Kingdom. Possibly the most often cited finding of the WHO studies is the differential outcome between developing and developed centres where more positive outcomes were experienced by developing centres. Up to half of the participants in developing countries displayed complete remission while only 17% did so in developed countries (Satorious et al., 1987; World Health Organisation, 1979).

A major limitation of the WHO studies is the validity of using a Western construct on other cultures. By assuming the 'universality' of the construct of "schizophrenia", indigenous constructions and pathways of seeking help were either ignored or criticised. For example, descriptions of help seeking in Agra criticise cultural constructions by referring to patients' "ignorance about the nature of mental illness" and "misconceptions and superstitious beliefs about mental illness" that drove them to resort to "faith-healers" (World Health Organisation, 1979, p. 104). In reference to this limitation Fernando (1988) stated,

> The IPSS [International Pilot Study of Schizophrenia] is a demonstration of how to impose Western concepts of illness on other countries...All through the series of WHO studies...there is an assumption that, if a system that is developed in Europe and seemingly suitable for Western cultures can be reliably applied, it is good enough for other cultures. This is a position of cultural arrogance, bordering on racism (p.134).

Recent evidence that takes into account the cultural constructions suggests this factor may help to explain the better outcomes in developing countries. Lin and Kleinman (1988) argue that the better prognosis for schizophrenia in developing countries is explained by the sociocentric nature (interested in the collective as opposed to egocentric which is interested solely in the individual) of non-Western cultures. Castillo (2003) reviewed the available literature that has documented the differences in outcomes for non-Western cultures. He argued positive outcomes are a function of the lesser demands placed on those in underdeveloped countries, the increased integration they may experience with their family and society during the course of their illness and the spiritual constructs they may hold regarding psychosis that externalise the locus of origin of the illness. He concluded,

> Traditional cultures are more likely to eliminate stress and trauma which may be evoking spontaneous trances by providing social support and acceptance, altering family dynamics, expecting brief duration and full recovery and using traditional practices which place blame neither on the patient nor the family, (p.20).

Alternatively, indigenous and migrant populations, who have moved to urban Westernised centres, do not experience the same level of positive outcomes. Indeed, African-Caribbean's in the UK have been found to experience significantly higher rates of schizophrenia and poorer outcomes than Caribbean's living in the Caribbean (Bhurga et al., 1997). Higher readmission rates have also been found in New Zealand for the Māori population (Te Puni Kokiri, 1993a) indicating a poorer outcome at least within the clinical population. The prevalence data across a range of urban centres will be discussed in the following.

2.4.1 Higher rates of schizophrenia for ethnic minority populations

A common theme found throughout the literature is the increased risk of receiving a diagnosis of schizophrenia among ethnic minority and indigenous peoples when compared to majority groups. This pattern has been established in the USA (Feinstein & Holloway, 2002), Canada (Kirmayer, Macdonald et al., 2001), New Zealand (Te Puni Kokiri, 1993a), Australia (Bruxner, Biurvill, Fazio, & Febbo, 1997), Germany (Hassen, Lambert, Mass, & Krausz, 1998), Sweden (Johansson, Sundquist, Johansson, & Bergman, 1998), Denmark (Mortensen, Cantor-Graae, & McNeil, 1997), The Netherlands (Selten & Sijben, 1994), Micronesia (Waldo, 1999) and Japan (Noda, 1998). In many regions, higher rates of diagnosis for ethnic minorities were also associated with higher levels of involuntary admissions, longer hospital stays, increased rates of readmission and forensic sections (Coid, Kahtan, Gault, & Jarman, 2000; Te Puni Kokiri, 1993a). The largest body of literature available is on admission rates for African-Caribbeans in the UK (Bhurga et al., 1997; Harrison, 1990). In reference to this literature, Harrison et al., (1990) commented, "[an increased incidence] has been replicated in sufficiently diverse geographical and treatment settings and in studies employing a range of methodologies to allow the conclusion that it's validity is beyond a reasonable doubt."

A number of limitations have been cited in regards to the finding of an increased prevalence in ethnic minority populations (Snowden & Cheung, 1990). Many studies do not consider

longitudinal perspectives; only some consider the possibility of over diagnosis or misdiagnosis of minorities; many do not take into consideration the patient's understanding of their experiences and treatment; and only a limited amount of studies are in outpatient settings or the general population (Snowden & Cheung, 1990). Despite these limitations, the finding has been consistently replicated in a number of countries. Therefore, a search for the cause of these disparities has been mounted.

2.4.1.1   Why are there higher rates of schizophrenia in ethnic minority populations?

Genetic explanations propose ethnic minorities are predisposed to higher rates of schizophrenia. Nimgaonkar et al. (1992) found a relationship between a particular gene and schizophrenia among African Americans that was not detected among their white counterparts. This form of research represents a continuation of the themes in psychiatry evident in the early 20th century where ethnic minorities were believed to more susceptible to mental illness. Indeed, within New Zealand, Johnstone and Read (2000) found that 11.3% of psychiatrists believed Māori were genetically predisposed to madness.

In order to test the genetic hypothesis, migrant populations present a unique opportunity to compare prevalence rates in the country of migration to the country of origin. If genetics alone explains higher rates in ethnic minority populations, similarities in prevalence should be found between the two sites. However, decreased rates have been found in the country of origin when compared to migrant populations (Bhurga et al., 1996; Hickling & Rodgers-Johnson, 1995). This has lead theorists to hypothesise that there must be something else, or at the very least, something *more* associated with such disparities.

Migrational theories espouse various hypotheses (Bhurga & Jones, 2001). The social drift theory asserts that those more prone to schizophrenia move and therefore contribute to current disparities. However, evidence suggests that selection for migration is positive (those more resilient move) rather than negative (Cochrane and bal, 1989). Another explanation for the difference between migrant and indigenous populations is the proposition is that the move drives ethnic minorities mad. However, it has been repeatedly found that second generation African–

Caribbean's experience higher rates of schizophrenia than first generation individuals (who experience similar rates to the White British population) (Hutchinson et al., 1996). If the process of moving caused higher rates of schizophrenia, the expressions of illness should be present in the first generation cohort. One may argue that that the generational differences are a result of second generation African-Caribbeans being more likely to access mainstream services for treatment. However, it is unlikely that this fully explains why children of migrants experience much higher rates than their parents.

If ethnic minorities were not mad before they left their country of origin and the move did not make them mad, then what is causing the current disparities? Some have argued that second generation migrants experience greater levels of discrimination as they are alienated from both their indigenous and the dominant culture. Several environmental factors related to acculturation, poverty, isolation and discrimination have been used to explain the disparities. Research has found that minority status in itself can contribute to higher rates of schizophrenia. In essence, an individual is at a higher risk of being diagnosed with schizophrenia if they are black in a predominantly white neighbourhood when compared to being black in a predominantly black neighbourhood (Boydell et al., 2001). One large prospective study (with a sample of 4076 participants) found that the degree of discrimination experienced predicted the rate of delusional ideation for those with no history of psychotic illness as well as for those with a prior diagnosis of schizophrenia (Janssen et al., 2003). The rate of delusional ideation increased in those who reported discrimination in more than one domain (the factors assessed for discrimination were age, sex, disability, appearance, skin colour, sexual orientation and ethnicity).

There is mounting evidence to suggest that experiences related to being marginalised contribute to the development and manifestations of symptoms of schizophrenia. Based on this evidence, some have criticised psychiatry for medicalising social and political issues. Whaley (2001) drew a distinction between the paranoid subtype of schizophrenia and 'cultural mistrust', a normative, healthy and adaptive response to racism. Similarly, Hutchinson and colleagues (1996, p.780) indicated that psychosis may be an explainable and even adaptive reaction to being a minority in urban UK, "Perhaps for the Caribbean population in Britain, the excess rates of psychosis may well be the consequence of an adaptive strategy to the social unease they experience in urban

Britain." Fernando (1988, p. 37) referred to the relationship between marginalisation and mental illness by stating, "the diagnosis may cover up and legitimise the social extrusion of black people from society by psychiatrising their problems- just as the legal system does so by criminalising them."

Another explanation for these disparities is the bias of the diagnoser towards ascribing ethnic minority groups with a label of schizophrenia. One study provided 139 British psychiatrists with a case vignette that varied on sex and race to examine bias. African-Caribbean's were considered to be more violent and require criminal proceedings when compared to white vignettes (Lewis, Croft-Jeffreys, & David, 1990). In Germany, significant disagreement in diagnosis was found between German and Turkish psychiatrists when assessing Turkish migrants with psychotic symptomology (Hassen, Yagdiran, Mass, & Krausz, 2000). German psychiatrists were more likely to diagnose patients with schizophrenia. Further research conducted in the United States indicated African-Americans required fewer symptoms to receive a diagnosis of schizophrenia (Trieweiler, Neighbours, Thompson, Munday, & Comex, 2000). One implication of these findings is that psychiatrists hold racist biases towards diagnosing ethnic minorities with psychotic illnesses. Alternatively, clinicians may be misdiagnosing patients as a result of a lack of education and understanding of cultural expressions of illness.

In summary, cross cultural research aims to investigate prevalence, manifestation, course and outcome of schizophrenia in ethnic minority populations. Experiences of marginalisation are receiving greater recognition as a possible aetiological factor in cross cultural psychiatry however the affect of local constructions on the course, content and outcome of experiences commonly labelled psychotic are largely ignored. In summary, a major limitation in cross cultural research is the *direction* of the research. From a scientific perspective, Western constructions are considered the 'control group' by which all other 'variables' (cultures) are compared. Fanon referred to this process as 'lactification' where indigenous knowledges are "whitened" for the information to be digested by the academy (Fanon, 1963). Duran and Duran (1995, p.5), both Native American health practitioners, highlight the problematic nature of cross cultural research,

> As long as the language implies that the discourse is cross cultural, we are perpetuating the notion that other cultures do not have their own valid and legitimate epistemological forms. "Cross-cultural" implies that there is a relative platform from which all observations are to be made, and the platform which remains in place in our neo-colonial discipline is that of Western subjectivity.

The following will summarise research that has attempted to address these limitations.

2.5 TRANSCULTURAL PSYCHOLOGY: RECOGNISING CONTEXT

> Where a culture differs markedly from our own Western European society both ethnologically and ethologically...it appears difficult, if not impossible, to characterise aberrant behaviour in that society in terms of psychiatric concepts derived from aberrant behaviour in our own society. It may of course be possible to force such concepts on other materials, professing indifference as to whether the concept in the process is squashed out of shape or whether tags and tatters of behaviour are left over after the squashing is completed. But valid scientific concepts are not elaborated in this cavalier fashion, (Beaglehole, 1939, p.145).

Transcultural psychological research represents a movement towards describing behaviour by using the constructs found to be meaningful within a given culture. Section 2.5.1 will first build upon arguments presented in Chapter One that suggest schizophrenia is a cultural construct in and of itself. A summary of the research that recognises the social context and cultural constructions of individual who are already labelled schizophrenic will then be presented. Finally, cultural syndromes and experiences that share a similar symptom profile to schizophrenia will be discussed.

2.5.1 The DSM-IV as a cultural construct

The Culture and Diagnosis Group (CDG) was established to advocate for the recognition of cultural context during the development of the DSM-IV (Mezzich et al., 1999). A summary of the research and recommendations made by the workgroup is provided in the cultural issues section of the DSM-IV source book (Mezzich et al., 1997). The recommendations included in the DSM-IV were a glossary of culture bound syndromes, cultural considerations within diagnostic criteria and the outline for a cultural formulation. However, proposals that challenged the universal categories within the DSM-IV and contextualised illness were largely omitted or placed in the margins. For example the cultural formulation and culture bound syndromes sections were relegated to the appendix. Despite these barriers, the CDG viewed the inclusion of cultural

considerations in the DSM, where there had previously been none, as a step in the right direction. The CDG argued that culture is involved in psychiatric assessment in at least five ways,

> First, culture shapes the phenomenology of symptoms themselves, their content, meaning and configuration. Second, culture is manifested through ethno-psychiatric diagnostic rationales and practices of grouping symptoms together into patterns that include but are not limited to the familiar culture-bound syndromes found in various societies including our Western culture. Third, culture provides the matrix for the interpersonal situation of the diagnostic interview. Fourth, because the clinical encounter is often intercultural, the dynamics of cross cultural work are crucial for understanding and refining diagnostic categories and practices. Finally, culture informs the overall conceptualisation of diagnostic systems, which are children of their time and circumstances, (Mezzich et al., 1999, p.458)

Some argue that the inclusion of culture within a text such as the DSM is akin to putting a round peg in a square hole. A number of theorists have questioned the relevance of the DSM-IV and it's diagnostic categories, such as schizophrenia, when applied cross-culturally (Fernando, 1988; Gaines, 1982; Kleinman, 1973; Littlewood & Bhurga, 2001). A closer investigation of the DSM-IV criteria for schizophrenia reveals a number of constructions that are culturally loaded. For example, 'bizarreness' is judged based on an experience or belief being 'clearly implausible', 'not understandable' and not deriving from 'ordinary life experiences' (American Psychiatric Association, 1994). Ordinary life experiences of whom? In present day settings, the assessing psychiatrist's beliefs are commonly used as the benchmark for comparison. An example provided by the DSM-IV of a bizarre delusion is a person who believes their body or actions are being influenced by some outside force. Disregarding the fact that treatment and incarceration on inpatient units could be considered to fuel such beliefs, some cultures may find this particular belief totally plausible. What is of more concern is the fact that only one symptom is required to meet criteria, as opposed to two, if a delusion is considered to be bizarre. One study (Mojtabi & Nicholson, 1995), asked 50 senior psychiatrists to differentiate between delusions that were 'bizarre' and 'plausible' in 30 case vignettes. The researchers found "bizarre delusions" to hold inadequate validity and advocated for the removal of the term in the DSM.

2.5.2 Recognising socio-cultural context

The content of symptoms can also be influenced by socio-cultural context. For example, (Sadowsky, 2004) found that the content of delusions in African patients in Southwest Nigeria

were related to their experiences of war and colonisation. Further to this, Lenz (1964, cited in Dragnus, 1980) found the content of delusions to change with the technology throughout history. Delusions regarding electric currents surfaced first, then robots, followed by radio waves. Research within New Zealand (Beaglehole & Beaglehole, 1946) found Māori patients experienced delusions related a context of colonisation. For example, some participants were considered "paranoid" about the political and racial views and behaviours of their Pākehā neighbours. Beaglehole and Beaglehole surmised that patients' beliefs may be closer to the truth rather than delusional. This project and others within the New Zealand context will be presented in Chapter Three.

Research has also found cultural differences in the role of the family during the experience of psychosis. Lopez and Guarnaccia (2000) compared the effect of various forms of communication in the family on relapse in Mexican–American and Anglo-American clients. A lack of warmth from Mexican American parents was the strongest predictor of relapse for their children diagnosed schizophrenic. In contrast, criticism was the strongest predictor for relapse in Anglo-American clients. In reference to cultural differences, Fabrega (1989a) proposed that schizophrenia is experienced differently, and understood by others differently, depending on whether they conceive of the self as being autonomous and separate or connected and bound to others. He commented, "culture plays a role in the manner in which families respond to relatives with schizophrenia, which in turn relates to the course of illness," (p.586).

2.5.3   Recognising cultural explanatory models

Individuals and families in non-Western cultures have been found to hold multiple and seemingly incompatible explanations for experiences labelled schizophrenic (Allen, 2002). Jenkins' (1988) research with Mexican American patients (labelled schizophrenic) and their families found they prefer to use the construct of "nervois". Jenkins understood the use of this construct to minimise stigma and increase integration of the patient within their families. The label nervois indicated to families they are 'just like me, only more so'. Jenkins further hypothesised that this construct protected the individual against the negative impact of the diagnosis of schizophrenia and subsequently influenced the course and outcome of their experience in a positive manner.

Mental health workers from indigenous populations have also been found to hold multiple Explanatory Models (EMs) when working with patient's labelled schizophrenic. Joel and colleagues (2003) interviewed 80 indigenous community mental health workers in India and found various and seemingly contradictory EMs. While biological explanations were apparent for a small group of participants, they were always held within a wider spiritual and/or psychological framework. The most frequently cited EMs related to poverty, black magic or evil spirits. Many believed doctors cannot help with these factors. Despite evidence of a strong belief in indigenous constructs within India, leaders in the profession of psychiatry do not seem to ascribe to such explanations. The director of the Schizophrenia Research Foundation in India co-authored the following material:

> Myth:
>
> Schizophrenia must be treated by sorcerers and faith-healers.
>
> Fact:
>
> Schizophrenia must be treated by qualified medical professionals with allopathic medications. Rituals performed by sorcerers and faith healers have no role in the treatment of schizophrenia. Many of these rituals can be harmful and can even be a risk to the life of a patient, (Thara et al., 2001, p.13)

The fear and mistrust of traditional psychiatry towards indigenous beliefs will be discussed further in section 3.2.1.

Recent research in India has attempted to investigate the effect of biomedical education on indigenous patients with a diagnosis of schizophrenia and their families (Das et al., 2001). One study found biomedical education reduced the range and number of indigenous EMs held by participants (measured before and after the training). The authors referred to the indigenous constructions that were still held by participants after "education" as 'resistant' and 'persistent'. This indicated that the authors perceived indigenous beliefs to be problematic. Indeed, they commented that indigenous EM's lead to negative outcomes that are narrowly defined as not recognising a biomedical explanation of schizophrenia and not adhering to medication. This is circular logic. It has already been cited that indigenous beliefs may contribute to better outcomes

in non-western cultures. "How does exporting the beliefs of Western experts to low-and middle income countries fit with this consistent finding?" (Taitimu & Read, 2006, p.284)

The above research points to the importance of accessing indigenous constructions before Western medical psychoeducation starts to eliminate these beliefs. Kleinman (1980) has proposed a sample of questions to access cultural and individual ways of understanding experiences related to illness. These questions ask the individual about their cultural constructions (cultural diagnostic labels), their beliefs about aetiology, help seeking behaviours and their expectations of recovery.

2.5.4   Culture bound syndromes

Kleinman, and other medical anthropologists, transcultural psychologists and psychiatrists, have attempted to investigate non-clinical populations to understand the indigenous constructions of psychotic phenomena held within various cultures. These experiences have been broadly classified as culture bound syndromes. In total, approximately 186 conditions have been recorded (Jilek, 1998) and some are now listed in the appendix of the DSM-IV (Mezzich et al., 1999). Four cultural syndromes will be discussed in the following to provide an example of the influence that cultural constructions have on the content, course and outcome of experiences that may be considered schizophrenic within a Western context.

2.5.4.1   The Malay Amok

The Malay *amok* syndrome is considered to parallel schizophrenic symptoms in phenomenology. Common symptoms are violent, aggressive or homicidal behaviour accompanied by persecutory ideas (Carr, 1985). The course can be brief or chronic and similar patterns have been found in other Asian, Pacific, Native American and South American populations (American Psychiatric Association, 1994). *Amok* is understood to be caused by external factors either natural (Germs, trauma) or supernatural in origin (Spirit possession, punishment for unethical behaviour by witchcraft or divine intervention). Internal causation is attributed to a loss of the 'vital force' that makes them more vulnerable to illness.

Some theorists have interpreted *amok* to be part of a culturally sanctioned emotional release of frustration by Malays. This is a result of the difficulty in conforming to expectations of appropriate behaviour such as speaking softly, respecting the status of other individuals, formal processes of conducting oneself with refinement and being openly sensitive in interpersonal relationships (Carr, 1985). Carr commented on the relationship between social status, social values and the experience of Amok,

> Despite the propensity for stringent proprietary rules, the Malay has available a wide range of behavioural options, there is always a loophole somewhere for his escape…in the case of societal sanctions against aggression and confrontation, the behavioural alternatives include a loophole option in the form of traditional sanctions for the phenomenon of Amok – that under prescribed behavioural conditions (e.g. insult of self-esteem) there are both expectance and reinforcement for the consequent act of running amok.

2.5.4.2 The Eskimo Pibloktoq

Pibloktoq is a cultural syndrome occurring mostly in women in the arctic. This condition is understood to be a result of social and spiritual events (Gussow, 1985). Symptoms include the individual being oblivious to their surroundings, strongly agitated, tearing off clothing, fleeing current surroundings, eating faeces, tiredness, depressive silences, confusion, weeping, body tremors, performing bizarre acts (attempting to walk on ceilings) and talking very fast and unintelligibly. The duration can be from a few minutes to about 12 hours with extended periods of withdrawal leading up to it. Gussow (1985) concluded from his own research (and a summary of the available literature) that Pibloktoq is related to situations of intense culturally determined stress.

Foulks (1985), highlighted several life events that were common across 10 cases. These events include being: adopted or abandoned by parents; influenced by elders; shamed by peers; influenced by shamanistic associations; influenced by religious or supernatural experiences; affected by sexual or spousal jealousy; affected by a loss of significant supports; and being ostracised within one's village. Gussow (1985) indicated that significant similarities exist between the positive and negative symptoms of schizophrenia and Pibloktoq. However, it was concluded that misdiagnosis would be unlikely due to the brevity of symptoms and complete remission.

One may wonder whether the cultural constructions used to understand the experience contribute to it's short duration.

2.5.4.3 The Samoan ma i fasia

Samoan constructions of mental illness are considered to be intimately linked to their understanding of the self as a relational being. The self is defined by identity and belonging, genealogy, roles responsibilities and heritage. The Samoan illness experience of *ma i fasia* involves hallucinations and out of character behaviour for the individual (Tamasese, Peteru, & Waldergrave, 1997).

Ma i fasia is understood to be a result of being 'struck' or 'hit' by a spirit. The spirit may be offended by the actions of an individual or their family members where the tapu (sacredness, explained further in section 3.1.1.2) of spirits or gods had been breached. Treatments include finding the malevolent spirit, knowing the grievance, and making apologies or amends. Cluny and La'vasa Macpherson (1990, p.99) shared a narrative of *ma i fasia* they encountered during their research,

> A young woman became ill after working in the plantation. Her family became concerned with her condition and took her to a *fofō* [Samoan healer] for treatment. The healer concluded that the girl had become ill after she was struck, *fasia*, by a ghost on her way back from the plantation. The healer persuaded the ghost, who turned out to be the girl's grandfather, to reveal his reasons for striking the girl...The ghosts complaint was that the descendants of those buried in the old graveyard had forgotten them and that this was obvious from the overgrown state of the grave yard and it's general neglect

In terms of treatment, a village meeting was held and it was decided that the bones in the old grave yard should be exhumed and transferred to the newly built and decorated tombs closer to the village. The researchers further commented on this healing process,

> Thus while the healers' primary role may be identifying and treating specific illnesses in individuals around them, this must be seen in it's broader context. This activity is an attempt to restore balance in and between the natural, social and supernatural elements of individuals' lives, (p.100)

Gluckman (1977) reflected upon his clinical experience with Samoans in New Zealand in the 1970's. He referred to the history of Samoan migration to New Zealand to understand the

presentation of his clients. Prior to the 1970's many Samoans migrated to New Zealand in response to a demand for labour. During an economic downturn in the 70's, Samoans were no longer a needed commodity. The "dawn raids" began where houses were raided and illegal immigrants removed (sometimes separating parents and children). The dawn raids represent a significant historical trauma for Samoans. "Overstayers", the common term to describe Samoans staying illegally, and their families were subject to social and emotional instability and stress when faced with the possibility of dawn raids and random checks by authorities. These events, coupled with the loss of extended family networks when moving from Samoa, were proposed by Gluckman to explain the cause of mental unwellness for many of his Samoan clients.

Gluckman shared a number of cultural syndromes he encountered during his practice. *Musu*, often experienced by Samoan adolescents, was characterised by looking at floor, closing the eyes tightly, refusing to answer questions and sometimes being aggressive. He added this was often misinterpreted by the psychiatrist as an indication of negativism, defiance, dissociation, depression, catatonia or schizophrenia. However to the Samoan, *musu* is a reaction to being placed in a situation that is overwhelming. They may fear authority, lack comprehension of the situation and experience shame. Gluckman also referred to *musu* as a reaction to racially determined injustice. He surmised *musu* was a form of protection in a threatening situation. This aligns to the Māori experience of *whakamā* discussed is Chapter Three.

Gluckman also encountered *ma i fasia* in his clinical practice. He described one woman who visited an area in Samoa that was looked after by a *fasia (*ghost). In this place the woman laughed loudly and instantly began hallucinating, which lasted for a long period. The voices told her in the Samoan language she would die or be killed in the near future. The woman came to New Zealand to escape this fate however the symptoms continued. Despite Gluckman's documentation of Samoan perspectives, he valued his own constructions as superior to his clients',

> It is not helpful to have one classification for the self and a different one for the patient. If one accepts the patient's conceptualisations one must think with the patient. He cannot ascend to the level of Western thought. It is a good deal easier to descend to the patient's level. (p.107).

While spiritual constructions are central to Samoan EMs, Clement (1984) found many would not share their beliefs with palangi (white settlers) or the church due to fear of judgment or being misunderstood. Tamasese and colleagues (1997) also reported that elders, service providers and consumers found Western mental health services in New Zealand limited in their ability to treat Samoan illnesses. This was understood to be a result of the medical model's individualistic construction of the self as separate from family and the spiritual realm. One participant stated,

> It is not that the hospital is of no use...there is a need for holistic treatment and this is not undertaken...this is true of the treatment for mental unwellness where doctors have separated the whole into three parts, treating only the physical. You cannot divide a Samoan person because if my mind is unwell, everything else becomes unwell, (p.70).

Another participant within Macpherson and Macpherson's research (1990, p.88) added,

> Some illnesses are understood in the same way by Samoans and Europeans. Everybody can fall out of a tree, or cut a hand or get sick from food...that sort of thing happens to people everywhere. But there are other illnesses which are caused by things that Samoans understand well, like illnesses caused by supernatural agencies (*ma i aitu)*. Samoans understand these well because they have been around a long time before missionaries came. We recognise these sorts of illnesses and have ways of treating these. *Pālagi* [Europeans] understand other sorts of illness...I don't know but I suppose each people understands their illness best.

Tamasese and colleagues (2005) also asked Samoans about culturally appropriate mental health services in New Zealand.   Participants considered that services needed to respect the Samoan view of the self as relational where spiritual, mental and physical aspect are considered as a whole. The critical role of the family and elders was also highlighted. Participants wanted services that were community based, employed elders and other Samoan staff and delivered both clinical and cultural treatments. The service should also be conducted according to *aganu'u* (Samoan customs and traditions). The needs and aspirations of Samoans in New Zealand strongly align to those stated by Māori (see section 3.4).

2.5.4.4   Shamanistic crises and healing

Some studies have drawn parallels between shamanistic states and psychosis (Allen, 2002). This is commonly associated with the shamanistic initiation crisis, when the shaman first experiences

altered states of consciousness (ASC). The shamanistic crisis will be discussed using the example of the shamans of Okinawa, yuta.

Okinawan healers are identified by first being *saadaka unmari* (of high spirit birth). Identification is based upon their ability to have visions and /or hear voices. As part of their initiation, *saadaka unmari* often first endure *kami dari* which entails, loss of appetite, vomiting, anxiety, withdrawal, distress, delusions, discussions with gods and spirits, premonitions, blurting out incomprehensible words and a tendency for long monologues (Allen, 2002). If an individual enduring *kami dari* subsequently receives a label of being *saadaka unmari*, their behaviours are sanctioned, which then serves to ensure their future emotional and mental stability and prevent a condition more similar to schizophrenia. Once identified as *saadaka unmari* the individual will often receive guidance (from another yuta) on how to develop and use their skills. If they do not accept their role they may remain ill.

While yuta can determine difference between *kami dari* and schizophrenia the lay population in Japan finds it more difficult to differentiate between the two conditions (Allen, 2002). Psychiatrists have been found to also experience difficulty in differentiating these experiences. Randall (1990) interviewed 485 patients and found 28% were judged *saadaka unmari* by a yuta. More than 70% of those considered to be *saadaki unmari* had a diagnosis of schizophrenia. Within this context, shamans are also 'experiencers' of illness through either *kami dari* or having been misdiagnosed as schizophrenic. Ultimately, the shamanistic initiation crisis provides indigenous healers in Okinawa with a significantly different insight into the illnesses of their patients when compared to the majority of psychiatrists.

To characterise the differences between traditional healers such as shamans and Western treatments, Kleinman aimed to delineate the practitioner- patient relationship. In order to work cross culturally between Western and indigenous treatment methods, he developed a number of categories to use for comparison such as the institutional setting, time, space, the

quality of relationships (e.g. between practitioner and patient), the idiom of communication and means of sharing explanatory models (Kleinman, 1980, p.207).

Using these categories to compare cultures, Kleinman (1980) found numerous similarities within non-western cultures. For example, being a traditional healer is often determined by genealogy. He proposed this functions as a mechanism to protect and transmit knowledge, practices and instruments to the next generation. Kleinman also found a number of other patterns to shamanism. Many shamans are trained by other healers on how to control their 'trance behaviours' (delusions and hallucinations according to Western constructions) and use herbal medicines and spiritual rituals to heal. In this sense, the experts on trance behaviours are also the experiencers. In addition, shamans do not believe it is they who heal, rather, they act as a medium for the appropriate spirit or god. .

Access to shamans varies across cultures. Within Asian cultures, shamans are extremely common and carry their healing out within both rural and urban environments (Allen, 2002; Kleinman, 1980). This has also been established within Saskatoon and San Francisco. In San Francisco, difficulties in accessing mainstream heath services were cited as a reason for visiting a healer. In Canada, it was found that those who speak an aboriginal language were more likely to access traditional healing or shamans (Waldram, 1997). The access Māori have to tohunga, traditional healers, will be discussed in Chapter Three.

2.5.5   Transculutral counselling and treatment

Sue and Sue (1990) argue that all psychotherapeutic encounters are in some way cross cultural, based on factors such as race, ethnicity, class, religion, sex, age, indigenous status, country of birth and so on. They emphasise the importance of recognising the significance of cultural concerns related to ethnicity where experiences of racism, discrimination and marginalisation can affect one's health. Sue and Sue also express the importance of learning, understanding and incorporating cultural constructions of illness into assessment and treatment practices. The rationale and need for increased competency within helping professions is evident in the

increasing cultural diversity within the general population (D. Sue, Arrendondo, & McDavis, 1992).

In order to increase one's cultural competency Sue and colleagues (1992) have proposed a three dimensional model. The first dimension is *awareness* of beliefs and attitudes, first of the self and then of one's client. At this point the therapist is liberated from the "status quo" and recognises their own assumptions and biases derived from their cultural heritage. The therapist also recognises how they have benefited or been privileged by inequalities between dominant and minority groups. They recognise the limits of their expertise when working cross culturally and the stereotypes they may hold about other cultural groups. The second dimension is *knowledge*. The therapist recognises the interaction between their own and their client's knowledge base. They recognise and understand how oppression, marginalisation and discrimination can affect the access minority groups have to their own knowledges. The therapist also has specific knowledge of the cultural history of their client. They respect knowledges from the minority group as legitimate and useful for therapy. The final dimension relates to *skills*. Therapists seek out education, consultation, partnerships and participation within culturally different populations. This should take place not only on a professional level but also within their communities.

2.6   INDIGENOUS PSYCHOLOGIES

To address some of the negative effects of cross cultural and transcultural research, indigenous psychologies attempt to conduct research from *within* as opposed to *upon* cultural groups. This paradigm accepts knowledges from different cultures as legitimate in their own right without having to adhere to a specific body of knowledge for it's validation. Four female indigenous researchers within New Zealand commented,

> While some indigenous psychologists are in search of psychological universals, some are interested in cross-national studies, and some in teasing out minute similarities and differences between cultures, others have bent to the task of solving local challenges within their own contexts with compatible approaches, (Nikora, Levy, Masters, & Waitoki, 2004, p.2)

Indigenous psychologies attempt to bring to the centre previously marginalised indigenous and local constructions of health and illness. This school of thought represents a movement of

resistance against the dominant hegemony of American psychiatry. Within this context, indigenous populations are afforded the right to define mental health and illness for themselves and access treatments that are in line with their needs and aspirations. Healers are viewed as practitioners and cultural constructs are recognised as legitimate knowledges that are meaningful in their own right.

Indigenous psychologies have been compared to Western psychology and psychiatry in a number of ways (Little Bear, 2005; Schwendler, 1984). Leroy Little Bear, a Native American Professor in Education, compared Western physics and Indian science, noting that recent advances in quantum physics are finally beginning to recognise knowledges that have been part of Native American information systems for aeons. Schwendler (1984) also argued that Western psychological knowledge is often limited to individual processes as opposed to recognising wider social, structural and cultural influences on mental health. The notion of knowledge "transfer", that implies a flow of information in one direction (as is the case with the process of colonisation) and places the position of power in the hands of the "transferer" was criticised. Instead, Schwendler preferred a relationship akin to knowledge "exchange" where both forms of knowledge (that which is derived from indigenous and Western knowledge systems) are empowered and a dialogue between two world views can begin. Knowledge exchange needs to occur to protect and nurture the multiple psychologies that exist world wide against "wholesale" importation of dominant knowledges. To illustrate this process, the movement towards developing a local indigenous psychology in New Zealand, Kaupapa Māori Psychology, will be discussed in the following chapter.

As an example of an indigenous psychology, Duran and Duran (1995) described various aspects of a Native American world view. While the authors recognise they cannot paint all Native Americans with one brush, they commented on some general patterns of thought inherent in their experience as members of the community and indigenous clinicians. Native Americans tend to conceptualise history in a spatial rather than temporal fashion. The authors stated that Native Americans want to know *where* an event took place rather than *when*. Further to this, Little Bear (2005) commented on Native American conceptions of time. He stated that within his language there are only words for yesterday, today and tomorrow. Stop for a second and think of how

differently a person may approach life with this construction of time. Professor Little Bear provided the example of his ancestors being only two days gone, just before yesterday and his descendants two days away, just beyond tomorrow to illuminate the psychology of his tribe. Surely an assessing psychologist or psychiatrist would be interested in events two days ago.

Duran and Duran (1995) also indicate that indigenous psychology must acknowledge the "internalised oppression" and "soul wounds" carried by the group (outlined in section 2.4.1). They "fantasised" that one day the DSM will have the diagnostic criteria of "acute or chronic reaction to genocide and colonialism" (p.53). However, they indicated that rather than waiting for Western psychology and psychiatry to recognise indigenous ways of understanding health and illness, many communities have already developed ways of helping themselves from within.

Treatments that are based on indigenous psychological models are increasing around the world. Across a number of sites such as Hawaii, Australia, the USA, Canada and New Zealand, organisations, workgroups and services have been developed and run by indigenous mental health workers and healers (Durie, 2001; Kirmayer, Brass & Tait, 2001). These services attest to the resilience of indigenous healing practices in the face of colonisation. The Six Nations Mental Health Service in Canada is based in a rural community on a reserve, is staffed by indigenous mental health workers, including nurses and psychiatrists, and works collaboratively with traditional healers within the community. In 2000, this service was reportedly the first of it's kind in Canada (Wieman, 2001). They provide mental health crisis services, psychiatric consultation, traditional healing and community education. All staff sought traditional teachings to ensure their competency in both medical and cultural healing practices. In general, indigenous treatments are broad based and incorporate both traditional and clinical ways of healing from mental illness (Kirmayer, Brass et al., 2001).

2.7   SUMMARY

> Now brood no more
> On the years behind you
> The hope assigned you
> Shall the past replace

When a juster justice

Grown wise and stronger

Points the bone no longer

At a darker race.

("Song of hope" Oodgeroo of the tribe Noonuccal, cited in Hunter, 2001, p.28)

The above quotation represents the gradual shift that has occurred at the intersection between culture and psychiatry since colonisation. This shift is towards the increased recognition of factors such as cultural constructions, social context, political history, and marginalisation as legitimate when making sense of mental illness and health. Indigenous peoples have been placed under the lens of psychiatry in various ways since the advent of colonisation. Often culture has been viewed differently depending upon psychiatric and psychological research agendas. Within this context, many indigenous peoples have been over-diagnosed and / or misdiagnosed with schizophrenia. The emergence of indigenous psychologies signposts a step towards 'undiagnosing' indigenous peoples and recognising what in fact are social, political and spiritual ills. This is made possible with the use of meanings provided by practitioners, researchers and experiencers from *within* a cultural group. Indigenous psychologies recognise the common experience of indigenous populations the world over as victims of colonisation while at the same time respecting unique and local ways in which these issues have been endured, understood and addressed. To illuminate the indigenous journey from devastation to resistance and finally resilience, the following chapter will attempt to represent Māori ways of interacting with, and reacting to, Western constructions of mental health and illness.

2.7.1 The current research

This research is considered to fall within the realm of indigenous psychology. First and foremost I am a Māori researcher conducting research from within, rather than upon, my culture. Within the next chapter, I also attempt to present the history of interactions between Māori and psychiatry from a Māori perspective by recognising the historical trauma of colonisation. Further, I have tried to bring to the centre Māori ways of understanding experiences commonly labelled schizophrenic (chapters 6 and 7). More specifically, the results of this research represent local constructions and local issues alongside local solutions. It is hoped this research will also

contribute to the wider movement of indigenous psychology by drawing parallels to experiences of other indigenous and minority groups. For example, mate Māori is understood and treated in a very similar way to *ma i fasia.*

3 MĀORI CONSTRUCTIONS OF ILLNESS AND WELLNESS

Pre-colonial Māori social, economic and political structures for Māori were based on spiritual foundations. All human pursuits were governed by spiritual lore (tapu). Should an individual not acknowledge these laws, they would be susceptible to "attack" or relinquish their spiritual protection and thereby open themselves to negative influences in the spiritual world. This often manifested in illness and at times death. The first section of this chapter will present Māori values, beliefs and social structures relevant to the understanding of health and illness. The integral role a particular class of tohunga played in maintaining knowledge regarding Māori constructions of health and healing will also be presented. The effect of colonisation on Māori mental health will also be discussed. Within this context disparities in the rates of schizophrenia and other psychotic disorders are emphasised. Current Māori models of wellness will also be illuminated with examples of how these models have been incorporated into mental health services today to address current disparities.

It is acknowledged that there is a risk involved in referring to Māori society in an idealised manner. Caution has been expressed within this chapter not to consider pre-colonial Māori history as a "perfect paradise" that was suddenly desecrated by the arrival of Europeans. At first, Māori society flourished during early contact with the acquisition of new tools for trade. While it is evident that colonisation affected Māori health in a very sudden and traumatic manner, it is also recognised that Māori society was previously neither static nor egalitarian. Many divisions of power were already apparent within Māori communities. For example, slavery and war are part of the history of Māori society, indicating that discrimination and marginalisation, between and within groups, was apparent before European arrival (albeit in a different manner). Illness was also present within Māori communities in pre-colonial times although the manifestation and treatment of illness was governed by beliefs in spiritual concepts such as tapu and mana. It is generally accepted that Māori understandings of wellness and illness were intimately related to a spiritual world view that perceived tangata (people), whenua (the land) and tupuna (ancestors) as integral parts of a larger whole.

3.1   RESEARCHING MĀORI SPIRITUALITY

A comprehensive outline of Māori spirituality is impossible to capture within the constraints of a thesis. Much of the earliest available literature on Māori spirituality was conducted *upon,* as opposed to *with,* Māori. Fortunately, since the Māori renaissance, during the mid 20th century, Māori scholars have begun to translate and document early manuscripts written by Māori as well as record their own knowledges passed to them via their ancestors. This section will draw from these various sources, however it does not attest to be a 'pure' representation of pre-colonial Māori constructs.

It should be noted that an in depth understanding of Māori spirituality cannot be gained via literature reviews, definitions and theorising. Some argue Māori spirituality can only be understood by experiencing it through participation within the Māori community. The limitations of writing about Māori constructions in English are also apparent. At times, there exists no English equivalent for terms such as *mana* and *tapu* described shortly (Sachdev, 1989a). The difficulty in defining Māori spirituality is evident in a comment made by Māori Marsden's son, Taki Marsden, when asked how his father would define mātauranga Māori (Māori knowledge systems). He replied, "to ask my father what mātauranga Māori is would be like asking a fish what water is. It remains invisible to them," (Royal, 1998). Henare (2003, p. 63) commented upon the experiential nature of Māori spirituality,

> Māori religion [does not] have a founder prophet like Jesus Christ or Mohammed or Buddha. Rather, it is a religion that can be recognised only in experiencing and living life as a Māori within the culture, and according to tikanga Māori, namely ethics, morals and values. In this sense, the culture is the religion.

In a similar vein, Linda Smith (2003) referred to the teachings and interactions with her grandmother as the foundation from which she understood her spirituality. She contrasted the practical and mystical aspects of spiritual realities for Māori,

> Although she developed in me the spiritual relationships to the land, to our tribal mountain and river, she also developed a sense of quite physical groundedness, a sense of reality, and a sense of humour about ourselves. It may be those qualities that make me sceptical or cautious about the mystical, misty-eyed discourse that is sometimes employed by indigenous people to describe our relationship with the land and the universe. I believe that our survival as peoples has come from our knowledge of our contexts, our environment...we had to know to survive. We had to work out our ways of knowing, we had to predict, to learn and reflect, we had to preserve and protect, we had to defend and attack, we had to be mobile, we had to have social systems that enabled us to do these things. We still have to do these things (p.12).

Smith recognised that Māori spirituality is intertwined with the practical reality of survival in the face of a competing world view. Māori constructions were threatened via the domination of Western constructions. Our current definitions and experiences inevitably reflect this history.

3.1.1 Continuity between the physical and spiritual realms

The natural world of Māori was in constant contact with spiritual world (Marsden, 2003a). Through *whakapapa* Māori are bound to all life forms, such as forests, the wind and the sea, as they directly descend from the *atua* (gods) of each domain. These atua have been referred to as departmental gods who descend from one Supreme Being, Io (Marsden, 1992). Māori cosmology represents the universe as emanating from an original source '*i te kore, ki te pō, ki te ao marama,*' from nothingness, into darkness and then into the world of light.

The departmental atua are believed to either be appeased or offended by an individual's actions within their domain. Rituals such as *karakia* (prayer) guide encounters and help to protect the individual against the negative consequences of causing offence. Early anthropological records allude to the relationship between Māori and atua of the natural world,

> The Māori had dealings with his gods for two purposes, on two occasions-when he wanted something, and when he feared something; in the one case he craved the desired object or quality, in the second case he craved protection, (Best, 1976 [1924], p. 39).

The connection between Māori and the spiritual and natural world is found within various constructions of the Māori self. Some of these being *mauri*, *wairua*, *tapu*, *mana*.

3.1.1.1 Mauri

Mauri is variously defined as a unique power, a life-essence, a life force and vital principle. It is "the bonding element that holds the fabric of the universe together" (Marsden, 2003a, p.44). Mauri derives directly from Io and connects *tangata* (people) to *atua* (gods) via a shared life force. Mauri is described by Barlow (1991, p.43) as a special power that allows "everything to move and live in accordance with the conditions and limits of it's existence." Mauri is inherent in all living things and can be established in material objects so that the object can be protected by the atua and fulfil the purpose for which it will be used (Ihimaera, 2004).

When mauri is diminished, illness can manifest. Best commented, "should the mauri of man become noa, or defiled, then his physical, intellectual and spiritual welfare is seriously endangered and he is exposed to many perils," (Best, 1954, p. 22). Henare (2003) indicated that mauri can be abused and diminished through neglect or direct attack. Within the natural world, this can lead to significant depletion of resources. Restrictions or *rāhui* can be placed on land or sea to restore mauri (for example when fish are scarce or forests are depleted, a rāhui restricts materials from being taken from the area). Breaching rāhui has been reported to lead to various forms of physical, spiritual and mental illness (Lyndon, 1983).

3.1.1.2 Tapu/noa and mana

Tapu plays an integral role in understanding health and illness from a Māori perspective. Tapu begins with a being's birth and refers to the potential for what it can become (Barlow, 1991). Mana is the fulfilment of that potential. In this vein, Barlow and Shirres (1979) refer to tapu as "being with potentiality for power." The "being" element of this definition refers to the essence that is tapu that was passed down from the original source, Io. "Potentiality for power" indicates each being has the potential to relate to another being in a powerful way and the laws of tapu govern this. In terms of these laws of interaction, tapu has been referred to as a Māori legal system consisting of rules around prohibition and protection to ensure society flourished (Ministry of Justice, 2001).

Tapu could be applied to people, places, animals, food, plants, events and relationships. Sometimes tapu is a permanent state, at others, it is temporarily applied to guide encounters and

restore or maintain equilibrium. There are practical aspect to tapu in terms of managing resources and protecting the health of the community (Durie, 1999). For example, waste from latrines was tapu to prevent dysentery and infestations and woman were tapu shortly after giving birth to enable them to attend to their child and recover after birth.

Breaches can occur when the proper respect and discipline is not afforded to tapu (Mihinui, 2002). Examples of breaches of tapu are abundant in the early literature such as mixing cooked food or water with tapu beings or objects (food renders tapu, noa changing the state from sacred to profane); and touching or removing tapu items (Shortland, 1856). Research conducted later in the mid twentieth century found examples of breaches of tapu in psychiatric patients that parallel early anthropological accounts (Gluckman, 1962). Some of these being, a breach of tapu by trespassing or taking something from wahi tapu (a site that is restricted due to contact with a being or item of high tapu); taking food into a cemetery; eating or drinking while in a tapu state or place; wearing, stealing, giving without permission, finding or keeping taonga (items of importance) of unknown ancestry; speaking irreverently of the dead; touching another's head; and swimming during menstruation (this research is discussed further in section 3.1.4.5). A breach of tapu often manifested in illness, possession or death (Best, 1924).

Noa represents the duality of tapu and can have both positive and negative connotations. Tapu and noa relate to Durkheim's (1912) notions of the sacred and profane found within many cultures around the world. Durkheim proposed that the profane represents the secular everyday world while the sacred is characterised by: beliefs in a power or force; non-empirical experiences that cannot be predicted or measured by the senses; and the ambiguity of experiences (can be both positive and negative or helpful and dangerous). In this sense, while tapu forms the connection between the spiritual and physical realm, noa helps the individual to return to the here and now, in this realm (Ihimaera, 2004). Dennehy (2005, p.54) posits that noa, "is generally seen as a positive state resulting from intense tapu being reduced to a safe level, balance being restored and freedom being regained when restrictions are overcome."

If there has been a violation of tapu or someone has 'trampled' on another's tapu (by putting them down) people can also be affected by negative noa. In pre-colonial times slaves or prisoners

were in a state of negative noa. Pa Tate (1990, p.9), a well respected Māori elder and Roman Catholic Priest, indicated that whole families and communities can also be affected by negative states of noa, "left to themselves, they do not have the mana to free themselves from that state of noa. This negative noa can disempower and hold in a diminished state whole families down generations."

Mana is intricately linked to tapu. Shires (1979) defined mana as the expression or fulfilment of the potential power inherent in tapu. A person of mana is one of spiritual authority and power. A story relayed to me of Māori Marsden's (a well respected Māori tohunga) indicated that authority and power are distinct attributes with both being required to truly express one's mana. He provided the example of sitting at a traffic light. When the traffic light is red, one has the power to proceed but not the authority. If the light turns green but the car stalls, one then has the authority but not the power. If the light is green and the car is running, the person then has both the power and authority to proceed. Mana is further defined as "lawful permission delegated by the gods to their human agents and accompanied by the endowment of spiritual power to act on their behalf and in accordance with their revealed will," (Marsden, 1992, p.4).

Pa Henare Tate (1990) related the relationship between mana and tapu to an Artesian well. This understanding indicates that without the proper respect for tapu, there can be no mana or at least it is seriously diminished, "the water source deep underground is like tapu: the gushing of water up through the bore and on to a thirsty land is like mana. Failure to address tapu drives the water back down the bore and the land dries up," (p.3).

Mana can be conceived, acquired and maintained in a number of ways including mana atua, mana tupuna, mana whenua, mana tangata and mana Māori (Love, 2004). Mana atua represents the mana all beings have the potential to connect with, some people and events having stronger connections than others. Mana tupuna (ancestors) refers to the mana one is born with based on their whakapapa. The actions of any member can diminish or bolster the mana of the *whanau, hapu* and *iwi* (family, sub-tribe and tribe). Mana whenua (land) relates to the power and authority to care for and use the land. Mana tangata (person) relates to the individual's own achievements and qualities, while Mana Māori is a more contemporary term that relates to the maintenance of

Māoridom and Māori wellbeing. The various manifestations of mana can be diminished by violating tapu or failing to fulfil obligations of guardianship over family or land. Diminished mana on any one of these levels can render the individual susceptible to Māori illnesses (mate Māori) (Tate, 1990).

3.1.1.3   Wairua

Wairua refers to the spiritual dimension or the soul of a person. Pere (1991) refers to wairua as the flow of two waters (*wai*-water, *rua*- two). The two waters represent the duality of all things, for example, the spiritual and physical worlds, man and woman, tapu and noa. Mauri is the element that binds the wairua of a person to the physical being. Upon death, the mauri is believed to leave the physical body and the wairua travels back to Te Pō from where it came (Barlow, 1991; Ihimaera, 2004). Best (1954) recorded that wairua are visible to some men and women known as *matakite* (literally translated as 'seer of faces', see section 3.1.5.1). Early accounts indicate that the wairua could travel while an individual slept (Best, 1954; Henare, 2003). In it's travels the wairua could detect any impeding danger or visit others. However, the wairua must reconnect to the *tinana* (physical dimension or body) in time otherwise illness could prevail (Best, 1954; Johansen, 1958). For example, some Māori are cautious not to wake their family members suddenly as their wairua may be wandering in their dreams and will not have time to reconnect before the individual awakens.

3.1.1.4   Tikanga Māori

In relation to health, tikanga Māori governs the balance between people, the natural and physical worlds. Tikanga involves practices such as *karakia* (prayer), *powhiri* (welcome ceremony) and *karanga* (welcoming call) designed to safeguard the elements of tapu, mana, mauri and wairua. Through tikanga, encounters and relationships are respected and protected. For example, during the first stage of a powhiri, the processes and people involved are considered tapu. According to tikanga, the sharing of food should follow to facilitate to progression to a positive state of noa. When tikanga is not followed, relationships can become strained and illness may ensue. Healing from these illnesses often entails balancing the states of tapu and noa (Durie, 1999).

3.1.2 Māori society

The nucleus of Māori society is the *whanau* (family). This constitutes not only one's immediate family but also extended networks such as cousins, aunties and uncles. A number of whanau belong to hapu (sub tribes), while a number of hapu belong to an iwi (tribe). Each whanau, hapu and iwi are intimately connected to their *whenua* (land). The concept of whenua is central to Māori identity as it links them to their ancestral mountains, rivers, seas, *turangawaewae* (a place to stand) and economic base (R. Walker, 1996). The connection between Māori, their family and the land is evident in the multiple forms in which the language is used. Iwi also means bones, hapu can also refer to being pregnant, whanau denotes the process of giving birth while whenua is the placenta. Therefore, the tribe represents the supporting structures that house the sub-tribe (bones, iwi). The family is born (whanau) from the sub-tribe (hapu) and reconnects directly back to the land through the placenta (whenua). Turangawaewae refers to belonging to the land and being part of it. In many circumstances this is in a literal sense as the place in which one's placenta is buried becomes their turangawaewae (Durie, 2001). These connections have connotations for health in that imbalance, disconnection and illness within one's whanau, hapu, iwi, whenua or turangawaewae can affect personal health status.

The *Marae* is also an integral part of pre-colonial and contemporary Māori society. This space represents a nucleus for Māori community activities, a forum for welcoming guests, negotiating issues and directing tribal business (Durie, 2001). In reference to these functions, Walker (1975) believed the marae was essential to the cultural survival of Māori in the face of colonisation. The marae also represents 'the most viable political institution left to the Māori (R. Taylor, 1974, p. 99). After urbanisation, many marae were erected in urban areas such as schools and more recently, in some mental health services. These 'urban marae' are a vital link for *hunga haere* (urban Māori) to their culture.

3.1.3 Māori constructions of wellness

It has already been mentioned that balance (between various aspects of the Māori self), connectedness (to one's wider community and land), integration (between physical, natural and spiritual realms) and respect (following tikanga) are all aspects of wellness for Māori. A number

of models of Māori health have been developed that incorporate both traditional and contemporary Māori constructions of wellness.

3.1.3.1   Te Whare Tapa Wha

Te whare tapa wha model (literally translated as 'the house of four walls) incorporates four dimensions considered to be essential to wellbeing. Originally proposed by Mason Durie (1999), a Māori researcher and psychiatrist, this model posits that all four walls must be strong for the house to stand. If one is weak, the whole house falls down. The four dimensions are *wairua* (spiritual), *hinengaro* (mental and emotional), *whanau* (family) and *tinana* (physical) indicating that the mental, physical, spiritual and social aspects are inseparable. Te whare tapa wha is used extensively in mental health services for both Māori and non Māori today.

3.1.3.2   Te Wheke

Te wheke (the Octopus), was a model developed by Rose Rangimarie Pere (1991), another Kaupapa Māori researcher, that extends upon te whare tapa wha. This model is characterised by an octopus with all of it's tentacles intertwined and connected at the core. This represents the interconnectedness of the individual and whanau unit. Each tentacle represents *wairuatanga* (spiritual practices and wellbeing), *mana ake* (the absolute uniqueness of being an individual), *mauri* (the life principle), *Hā ā koro mā a kuia mā* (the breath of life from one's ancestors), *whanaungatanga* (both genders from each generation working together), *whatumanawa* (emotional development), *hinengaro* (the mind, source of thoughts and emotions) and *waiora* (total wellbeing). The suckers on each tentacle represent the many facets to each dimension of health.

3.1.3.3   Ngā pou mana

The Ngā Pou mana model places more emphasis on the environment and the continuity of oral traditions as essential aspects of wellbeing (Durie, 1999). In line with the holistic nature of the prior models, four cornerstones represent an individual's overall wellbeing. *Whanaungatanga* represents the family, *taonga tuku iho* refers to the cultural heritage upon which intellectual and

metaphysical traditions are based, *te ao tūroa* represents the physical environment while *tūrangawaewae* indicates the possession of an indisputable land base.

3.1.4   Māori constructions of illness

3.1.4.1   Mate Māori

Māori illnesses were commonly believed to be *Mate atua* (sickness of the gods) and a result of a breach of tapu or *mate tangata* (known physical cause) and the result of an accident or injury (Buck, 1949; Gluckman, 1962). With the arrival of the Europeans, Mate atua became popularly known as mate Māori, to distinguish Māori forms of illness from Pākehā (European settlers). Explanations of mate Māori revolved around the dual nature of the atua as either being protective or punitive. An individual would warrant protection if he/she appeased the atua by following correct tikanga and punishment if there was any transgression of these rules of conduct.

Mate Māori often manifested in the form of illnesses such as becoming 'tangata pōrangi' or a mad man, getting physically ill or dying (Lyndon, 1983). Descriptions of mate Māori include fit like behaviour, talking in an incomprehensible manner, getting physically ill suddenly with no obvious cause, hearing things, seeing things, withdrawal socially, eyes looking different or black and sensing an ill presence within the room (Best, 1898; Gluckman, 1962; Lyndon, 1983). It was not uncommon for members of a transgressor's family to also be affected. One participant within this research suggested that it is often the weakest member of a family that is "hit" with mate Māori as a result of transgressions. A transgression often occurs when tapu relating to another individual, land or item had been affected. Once breached, attempts need to be made to appease the atua, whanau or tupuna who had been offended (see healing in next section).   Tamasese, Peteru and Waldergrave (1997) found similar beliefs regarding the effects of tapu on Samoan health:

> The implications of breaching tapu and sa often resulted in maledictory invocations upon the offenders. These maledictions were stated to cause the offenders to enter into various states and manifestations of mental unwellness...and even death, (p. 40).

3.1.4.2   Mākutu

While mate Māori is a direct result of the *ngau* (bite) of the offended atua, the powers of atua could also be employed by humans in the form of *mākutu* (curse). Mākutu could remain with a family for generations until it is removed.   Only an individual with sufficient mana and knowledge to utilise the atua in order to attack another individual could carry out a mākutu (Gluckman, 1962). An individual had to be careful when using this form of spiritual power due to the risk of repercussions within one's own whanau. Even though the tohunga who practiced mākutu were powerful, they were also loathed and feared (Gluckman, 1962).

Through careful questioning, only suitably trained tohunga could decifer if mākutu was causing mate Māori as well as what was required to treat it (Lyndon, 1983). A tohunga of greater mana was required to overcome the mākutu of another tohunga. In observing mākutu a lieutenant of Early European settlement commented,

> I have asserted that a man could be destroyed in a few days by means of witchcraft, but I ought to have made this reservation: provided no greater tohunga intervened to save him. In such cases the curse, like the chickens, might come home to roost, and destroy the man who had evoked the evil thing. This mākutu was indeed the dangerous part of the tohungas profession, (Gudeon, 1921, p. 67).

Beaglehole and Beaglehole (1946, p. 249) also observed mākutu within a community they researched, "as is to be expected from the theory of the silent bullet the sickness is invariably sudden, always acute, and often takes the form of insanity of some kind, or of immediate death". Percy Smith (1921) observed mākutu as a result of an insult, "if a man should be inclined towards some fine woman, and she will not reciprocate his feeling, that man will feel aggrieved and go to the sorcerer and get him to bewitch the woman; she will become insane, tear her garments and go about naked, til she dies."

Hopa (1998), Lyndon (1983) and Gluckman (1962) referred to several constructions and observations of mākutu. The term *whaiwhaia* is used to describe the process where an *ohonga* or *hau* (article belonging to the victim e.g. clothing, hair, fingernails) is used to destroy the vital essence or *mauri* of the victim through mākutu (Gudeon, 1921). Matakai referred to cursing

someone while eating. Hopa also commented that mākutu could be directed against an entire family, *whare ngaro* (a family doomed to extinction).

Discussion of mākutu is very tapu as is the cure of this condition. Within this research I faced the dilemma of whether to include any reference to mākutu at all. Via numerous conversations with advisors to the research, it was considered essential that this experience was discussed as it is encountered by some Māori using mental health services today. As a result, I consulted with tohunga and kaumatua about the depth of knowledge that should be shared regarding mākutu. I received advice regarding the process around how to discuss mākutu within interviews and how to include information within the thesis. This was to ensure the participants and I were protected. This is in contrast to earlier accounts of mākutu that have shared karakia used to induce and cure mākutu, knowledge that should not be published lest it be used by people without the suitable qualifications (Smith, 1921). Publishing such tapu material is dangerous for the author and reader alike. While I have included comments and stories regarding mākutu, there are a number of narratives that I have omitted as I could not ensure the protection of the information. Where mākutu is mentioned, I have also discussed the appropriate process and people (namely tohunga) required to address these issues.

3.1.4.3   Pōrangi

Another term related to mate Māori is pōrangi. Various definitions of pōrangi abound including: being headstrong, having the mind full or occupied, being beside oneself, out of one's mind or mad   (Reed & Karetu, 1948). Early Māori newspapers have used this term to indicate an individual is silly or foolish (Rewiti, 1856; Te Pipi Wharauroa: He Kupu Whakamārama, 1909). These terms foolish, silly, an idiot, mad are all akin to stigmatising mental health constructs found within Western cultures. Indeed, in my experience, pōrangi can be used to label people displaying socially unacceptable behaviours. However, there are those who understand pōrangi in a more spiritual manner. Naida Glavish (2000), the Tikanga Advisor to Auckland District Health Board, elaborated that the 'pō' in pōrangi (meaning dark or night) is akin to feeling lost, a feeling of total despair with nowhere to turn. While 'rangi' refers to the sky where the individual

is trying to reach upwards to the atua for healing however it is out of reach. In essence, the person is unable to rise above where they are.

3.1.4.4 Wairangi

Wairangi is also referred to as a form of mate Māori. Again, this term has been described in a variety of ways from being excited or infatuated (Reed & Karetu, 1948) to more spiritual interpretations (Glavish, 2000; Gluckman, 1962). Wairangi as a spiritual condition could not be found in the early anthropological literature gleaned for this research. A consultant for this research, Rau Kapa, (*personal communication.,* 2006), proposed that wairangi meant more of a spiritual illness or sickness due to the use of the term 'wai'. He believed wai, meaning water, is the essence of life, therefore indicating the condition was associated with the wairua. Glavish (2000) delineated the term by interpreting wai (water) to mean one is sinking in the sea of despair while help (rangi, the sky, the atua) is out of reach.

3.1.5 Resilience of Māori constructions and healing practices

Research conducted in 1946, 1962, 1983 and 1994 all signify the resilience of these beliefs in the face of colonisation (see next section). These papers have been selected as they are amongst the few available that specifically include participants labelled as psychotic or schizophrenic.

In 1946, two anthropologists, Beaglehole and Beaglehole set out to study the everyday lives of Māori living within a rural community. In their study, the couple took up residence in a Māori community and participated in everyday life hoping to be accepted by Māori they observed and lived with. In the authors words they aimed to,

> Show the way these people live, how they make a living, how they make a home, how they bring up children, how they amuse themselves, how they act when they are being religious or being sick, how they react to members of other races, (Beaglehole & Beaglehole, 1946, p. ix).

Significant limitations of this study require recognition. Throughout the text it is evident that the researchers were comparing Māori lives to European ideals. For example, they offer an explanation for Māori spending money on their family, rather than saving it for their own wealth, as being a result of trying to 'buy back' the love of their family. Another representation

of their Eurocentric judgement is apparent in their comments on the *tangi* (Māori funeral), "the least the sympathetic Pākehā can do is to help the Māori retain the positive values of the tangi while at the same time help him to purge it of some of it's present-day less desirable elements," (p.269).

Despite these limitations, their records provide significant insight into the prevalence of traditional beliefs within a Māori community. In terms of beliefs in tapu, the authors indicate that, "there are few serious scoffers at these beliefs in spirits, ghosts and tapu and probably no absolute disbelievers," (p 228). Beaglehole and Beaglehole also observed beliefs in death from mākutu. They observed that many Māori sicknesses (mate Māori) began or ended with delusions and included a number of sensory hallucinations. They recorded one woman, considered to suffer from mate Māori, who believed she had insects crawling or buzzing in and on her head. The couple also went to the local mental health institution and interviewed 20 Māori (males and females), half of them diagnosed with schizophrenia. They found the content of their 'symptoms' were related to Māori religious and spiritual issues such as 'wicked Māori spirits drop on him like flies, say horrible things to him, trying to destroy him,' and 'he sees purple Māori spirits singing in a tangi at night and they worry him with crimes and misdeeds he has committed,' (p.242). The researchers also observed traditional healing practices such as karakia and cleansing rituals with water to heal from mate Māori.

Further research conducted by a Pākehā psychiatrist, (Gluckman, 1962), investigated the nature of mākutu from a number of sources. These sources were: anthropological literature, his own clinical cases and other hospital records, a survey of teachers in Māori schools and a survey of the experiences of theological workers. Gluckman found various manifestations of mākutu in the early writings of Shortland (1882), Goldie (1904), Buck (1949) and Best (1898) indicating that mākutu was a deeply entrenched belief during early contact. He also found beliefs in mākutu to be seriously diminished through colonisation in recorded literature although still present in case records, surveys and his own medical experience. He related mākutu to a number of Pākehā illnesses such as epilepsy, psychoses, psycho-neuroses and psychosomatic illnesses. He also referred to his personal experience where many patients and families believed their mental illness to be due to mākutu or mate Māori. He found mākutu was especially related to chronic illnesses

and 'failure of the patient' to respond to therapy (note the wording in terms of the 'patient failing' instead of the clinician). Overall, he shared a number of cases, one being,

> The stresses and strains of pregnancy and parturition, associated with the fact that she was to be deprived of her child by her mother in law, produced first anxiety, depression hysteria and suicide attempts...and disturbing visual and auditory hallucinations and thought disorder. Prior to her first suicide attempt her symptoms intensified as she thought back to the fact that her mother had been mākutu'd many years before. The mother had the means of counteracting mākutu, the patient did not, (p.523).

He also commented upon the effect of Christian beliefs on traditional Māori understandings of illness. Conflict was evident in his patients where they "realised their concepts were wrong [according to their Christian beliefs], but something inside of them made it impossible for them to reject these concepts [Māori constructions of illness]," (p.29). He asked a patient about the effect of his Christian faith on his beliefs in mākutu, tapu and other concepts. The patient replied, "the presence of the Christian god has silenced the Māori gods, but the gods of the Māori still hold us in their power and if I break their laws they will punish me with death," (p.29).

Later in 1983, Christina Lyndon conducted one of the first research projects from a Māori perspective regarding beliefs in tapu, mākutu, mate atua and mate Māori. She interviewed 60 members of her own rural community (Ngati Hine) including her family, elders, those who had experienced mate Māori or been committed to mental hospitals and a group of children. She found Māori spiritual beliefs regarding illness were still prevalent and being transmitted to the next generation. Several narratives revealed the continuation of beliefs in mākutu, tapu and mate Māori. One woman dreamt of pulling string out of her mouth which was a sign of mākutu. Participants talked of looking for *tohu (*signs) that a given venture was going to succeed or fail. They described illnesses as a result of breaching tapu within cemeteries or going to wahi tapu. Lyndon's participants discussed tapu as "fact" as opposed to a superstition. All of her participants believed mental illness could be caused by mate Māori. Many also believed urbanisations negatively affected Māori society and helped to explain the higher levels of admissions to psychiatric inpatient units. Further to this, Lyndon found a strong reluctance towards discussing cultural beliefs with Pākehā lest they be labelled crazy. Participants believed their beliefs were pathologised and marginalised within the dominant Pākehā culture, "if a Māori wants to get

ahead in this world they have to forget about Māori things and Māori ideas," (p.79). Despite the silencing of Māori views and decades of oppression Lyndon concluded,

> Despite nearly two hundred years of contact with Pākehā and one hundred and forty three years of sustained contact with them, the Māori still retain many of the beliefs of their ancestors, including the belief that spirits can and do punish transgressions of tapu or that they can be used as an instrument in mākutu to punish or avenge, (p.113).

Just over a decade later, Lisa Cherrington (1994), a Māori clinical psychologist, conducted research that investigated symptoms in Māori and Pākehā diagnosed with schizophrenia. The aim of her study was to investigate the effect of paranormal beliefs and cultural knowledge on the frequency and content of symptoms. Before conducting the study, Cherrington hypothesised that Māori and Pākehā would differ in respect to levels of Māori knowledge and the strength of their paranormal beliefs. She also predicted that Māori would have a higher frequency of hallucinations, delusions of control and sub-cultural delusions and hallucinations. She interviewed 14 Māori and 16 Pākehā with a diagnosis of schizophrenia using mental health services. The Present Status Examination (PSE), a Test of Māori Knowledge (TMK), a Provisional Māori Cultural Identity Questionnaire (PMCIQ) and the Revised Paranormal Beliefs Scale (PBS-R) were administered to test her hypotheses.

Cherrington reported that Māori experienced higher frequencies of hallucinations and delusions. The patient's level of Māori knowledge was also found to influence the content and frequency of sub-cultural delusions and hallucination (regarding Māori spirits or gods). She also asked participants about their beliefs in tapu, mate Māori and mākutu. In total, 93% knew about tapu, mate Māori and mākutu and could explain what these concepts meant. Another 78% believed mental illness could be caused by mate Māori and mākutu, 28% knew of others who had been affected by these conditions and 21% believed they had been affected by mate Māori or mākutu. This demonstrated a high level of belief and understanding of Māori constructions of illness within a clinical population.

A limitation of this research was the questionable validity of measures, standardised on Western cultures, for Māori. For example, the PBS-R uses terms such as 'witchcraft' and 'superstitions' which may be foreign to Māori. This may be why Cherrington did not find any differences

between the level of superstitions held by Māori and Pākehā when using the PBS-R. Further to this, the TMK included questions that could be viewed as a stereotypical construction of what it means to be Māori. For example, some questions asked how many times participants visit their marae or whether they know the translation of Māori words. This questionnaire does not recognise the diverse ways in which people identify as being Māori (Durie, 1996). Despite these limitations, Cherrington's study demonstrated the continuation of Māori beliefs in the expression and understanding of symptoms of schizophrenia.

3.1.6   Tohunga: Māori healing

Tohunga are defined by Marsden as, "a person chosen or appointed by the atua to be their representative and the agent by which they manifest their operations in the natural world by signs of power," (cited in King, 1992, p. 128). The treatment of mate Māori was generally in the domain of the tohunga. *Tohu* meaning sign or omen and *ngā* being the plural. Therefore tohunga were people who understood the signs. As part of assessment and treatment of mate Māori, tohunga would attempt to identify the cause of the illness as either being a breach of tapu or a result of mākutu (Sachdev, 1989b). The focus was more on social infringements rather than physiological or psychological malfunction (Durie, 1999). The diagnostic processes involved asking the client about their recent movements to determine how the breach of tapu or mākutu occurred. For example, the client may have been to a tangi recently, been somewhere they should not, such as wahi tapu, or taken and item of importance. In the assessment process, tohunga asked about whakapapa to understand any forms of illness or mākutu within the family. They also paid keen attention to *moemoeā* (dreams) and *tohu* (signs for example, seeing a lizard indicated mākutu). Best (1898) outlined various forms of tohu that can arise in dreams or within an awake state (e.g. seeing lizards indicated a bad omen while certain birds were a positive omen). To ignore these signs would lead to failure of your endeavour or illness.

Tohunga were often selected from a young age either by right of birth or by displaying special abilities in learning and oratory skills. Those selected were taught in houses of learning named *whare wānanga* about such things as Māori cosmology, metaphysics, whakapapa and karakia. Due to the rigorous nature of the training, only a few completed their training within the whare

wānanga (Gudeon, 1921). There were various levels of whare wānanga that would be responsible for particular domains of the natural world or particular human endeavours. For example, tohunga could be trained in carving, to guide men to war or in the relevant karakia for cultivating crops (Best, 1898). Gluckman (1962) described the whare wānanga as conducting teaching from sunrise to sunset. The more important karakia were conducted while facing the rising sun in the morning. Alternatively, the whare marie operated only at night. This house of learning was dedicated to the "black arts" and training tohunga in mākutu. In general, tohunga were an integral part of Māori society as they not only treated Māori health, but they also acted as our medical libraries ensuring the protection and transmission of a predominantly oral knowledge base. (For a more detailed account of whare wānanga see Marsden, 2003b; Robinson, 2005; Smith, 1913).

Tohunga used a variety of methods for healing. Treatment often involved restoring the balance between tapu and noa (Durie, 1999). The most commonly cited tools being rongoa (medicinal plants) for healing physical ailments (mate tangata), and karakia and cleansing rituals (referred to by Robinson, 2005, as 'karma cleansing') with water or food, for spiritual illnesses such as mate Māori (Beaglehole & Beaglehole, 1946; Beattie & Tikao, 1939; Robinson, 2005). Karakia and cleansing rituals were also often performed at sunrise (Marsden, 2003b). Durie outlined various methods of healing such as *karakia* (to restore spiritual equilibrium), *rongoa* (for physical relief), *mirimiri* (Massage for muscular and joint development), *wai* (water for the removal of physical and spiritual contamination) and surgical interventions (for the alleviation of painful swelling).

Durie (1999) developed a table to highlight the similarities and differences between Māori and Western healing systems (see Table 1 below). He delineated the actors and scripts used during the healing process. Differences are apparent in terms of the healers, classifications, diagnostic processes, aetiological theories, treatments and attitudes to illness. However, similarities are also apparent across all of these factors in that they are derived from well established and in depth knowledge systems that require a level of faith for their efficacy.

Table 1: Differences between Māori and Western Healing Systems

	Differences	Similarities

	Māori	Western	
Healers	Tohunga-spiritual and religious leaders	Doctors, nurses and spiritual leaders	Graduates from recognised training institutions
Classification of illness	Mate atua; mate tangata (spiritual; temporal)	Physical; psychological; Medicinal; surgical	Largely based on theories of causation
Diagnostic process	Intuitive; assumptions of cause and effect based on tapu and noa	Physical examination and special investigations; assumptions based on scientific evidence	Extensive history taking followed by diagnosis, prescribed treatment, and rehabilitation; family involvement
Causes of illness	Breach of tapu	Viral or microbial infection; degeneration	Unseen forced can lead to illness; disease process can be reversed
Remedies	Karakia; rongoa	Pharmacological; surgical	Specific treatments for particular complaints; concurrent therapies
Attitudes to knowledge	Information protected in order to guard healers powers	Information shared within the profession; publication enhances reputation	Knowledge is key to understanding; specialised knowledge necessary to manage illness
Rituals	Karakia; ritenga, symbolic activities	Professional mystique; placebo response	Esteem of healer enhanced; faith necessary for healing

(Sourced from: Durie 1999, p. 22)

3.1.7 Matakite

Matakite literally translates to seer of faces (Robinson, 2005). My own family has told me that matakite are believed to be able to see the faces of ancestors and other spiritual beings residing on the earth. There exists a limited amount of literature referring to matakite. Beattie (1939) interviewed a well respected tohunga, Teone Tāre Tikao, who described matakite as seers who were not usually tohunga but possessed powers that could surpass that of a tohunga. While tohunga could carry out supernatural healing, matakite could 'see' beyond normal human vision. Teone provided the examples of a matakite being able to find lost items with their sight or see the future and tell members of their family what was going to happen in a given situation. Teone Tāre Tikao, used the terms *matatitiro* and matakite interchangeably. This was likely a function of the dialect from his iwi, Kai Tahu, in the south island. He referred to the ability of matakite in the comment below,

A seer of visions is called *matatitiro* (mata: a medium, *titiro*, to look) and could be either male or female. Although sometimes referred to as *tohungas* they were not really so. If you had lost anything you valued you could go to a *matatitiro,* who would dream about it and tell you where to find it. If a relative was ill you could ask the seer what was the best to do and he, or she, would dream over it and tell you what to do. The *matakite* far excelled the *tohungas* at finding lost things and could discover anything, (p.92).

3.2   COLONISATION AND MĀORI HEALTH

First, it should be acknowledged that the picture for Māori was not all bleak in the face of colonisation. During early contact, the Māori economy flourished as we learnt the tools, trades (whaling, sugar mills) and language of the Pākehā. One observer commented in 1821, Māori "showed remarkable quickness and sagacity in learning everything mechanical that came under his observation," (Cited in Sutherland, 1929). Indeed early accounts of Māori reflect these opinions. An early missionary, Samuel Marsden, commented,

> I do not believe that there is in any part of the world, or ever was, a nation in a state of nature superior to the inhabitants of New Zealand in mental endowment and bodily strength, nor any who would in a shorter period render themselves worthy of being numbered with civilised nations (cited in Sutherland, 1929)

In terms of the Māori ability to politically strategise with the Pākehā it was commented,

> In all outward signs of civilisation the Māoris proved to be extremely backward...but in reasoning, especially on political topics, in making provisions for their own government and for the education of their children, they exhibited cleverness and good sense, (Gorst, cited in Sutherland, 1929 p. 132).

Walker (1990) provided a revisionist Māori history that presented Māori society during early European contact as flourishing. However, this success posed a threat to Pākehā dominance both politically and economically and lead to a number of legal and political events that served to reverse this trend. There exist a number of texts that analyse these events in detail (Binney, Bassett, & Olssen, 1990; Sharp, 1997; Walker, 1990). Only three events have been outlined here in regards to their impact on Māori mental health. These events are the Tohunga Suppression Act, assimilationist agendas of schools and churches and the diaspora of Māori with the advent of urbanisation. Primarily, our practitioners and protectors of knowledge were removed (via the tohunga Suppression Act) then, our language was suppressed through schools and educational

practices. Finally, our socio-political and economic structures were unwoven with the Māori migration to urban centres from the 1950's. These events effectively severed our means of protecting, practicing and communicating health practices.

3.2.1   Taking our voices: The Tohunga Suppression Act

The Tohunga Suppression Act, passed in 1908 has been referred as the greatest blow to the organisation and protection of Māori knowledges (Durie, 2001). The Act outlawed the conduct of traditional Māori spiritual leaders and healers as indicated by the following excerpt:

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

Some argue that the Act was specifically put in place to silence and neutralise powerful Māori leaders of the time such as Rua Kenana (Ihimaera, 2004). At the time, there were also pseudo tohunga who used a combination of Pākehā and Māori medicine for profit. Māori and Pākehā alike wanted these practices to be stopped. Further to this, the practices of legitimate tohunga were not as affective with the Pākehā illnesses as they were with mate Māori. At the turn of the 20th Century Pākehā diseases were threatening to wipe out the Māori population. Many Māori began to lose faith in the capability of their tohunga to heal these new illnesses and turned to the medicines of the Pākehā for treating introduced diseases. In this manner, the Act was cited as a means to 'protect' the health of Māori (Ihimaera, 2004). For this reason, the Act also received the backing of Māori health professionals such as Maui Pomare and Peter Buck (Durie, 2001). The following quote from Peter Buck, refers to the clash between Christian belief systems and the practices of tohunga that were intertwined with beliefs in the power of Māori atua and mate Māori. Buck (1949, p.412) proposed that Christian faith should preclude any beliefs in mate Māori,

The Māori Gods and malignant spirits had mana in ancient times when the people believed in them. However, our elders had discarded them when they accepted Christianity. How then could a discarded god have any mana? To believe in mate Māori now meant resurrecting gods and spirits which had long ago been deprived of power. It also meant a denial of the new faith which our elders had substituted for the old. I then asked my interrogators how they could believe in one thing and profess another.

No tohunga were ever convicted under the Act. This is possibly a result of many tohunga stopping their practices (not only to protect themselves but also the tapu nature of their knowledge) or going underground to evade legal and social ramifications. Palmer's (1951) article on Tohunga represents the perception of Western health professions at the time where tohunga treatments were considered "dangerous", "debased", "untenable", and "naïve",

> Tohungaism of today is seemingly eclectic and essentially debased. When firmly established in a district it often hinders the more suggestible Māori from taking advantage of freely available services of the New Zealand hospital system. To some extent it serves to perpetuate vague fears and hostilities to present day European medicine in much the same way that certain ill-informed groups in the European community prefer to foster old prejudices, fears and hostility towards modern methods when practiced in State institutions for the treatment of the mentally ill, (p.149).
>
> These [tohunga] methods are *not* in any way similar to the methods of a *competent* psychiatrist, despite the assertion to the contrary by a Māori Welfare Officer, (p.150).

In effect, this Act signalled to Māori that health care was to be based on Western constructions and treatments (Durie, 1999). By the time the Tohunga Suppression Act was repealed in 1963, a significant amount of damage had been done. In the absence of formal institutions and acceptance within the community, tohunga (the protectors and carriers of all know ledges, sciences and skills) had only haltingly passed what they knew to the next generation. Durie (1998) referred to the significant impact the Act had on Māori health practices,

> The Act forced Māori healers underground, although their skills were not entirely lost, the transmission of the methodologies faltered. For succeeding generations the significance of rongoā (traditional healing treatments) and karakia (rituals such as prayer) were not only scarcely appreciated, but often with scorn, even after the Act's repeal in 1963, (p.45).

3.2.2   Taking our words: Assimilation

The Tohunga Suppression Act in effect colonised the bodies and spirit of Māori in terms of health. The main tool utilised to colonise the minds of Māori was education. The following

excerpt was taken from a resource book given to all teachers of Māori children in reference to how Māori health could be enhanced (Pope, 1884):

> What we want to do now is to show the Māori how he, too, may get rid of the bad things that are hurting him, and to give the natives such a share of the knowledge we have gained as shall make them able to prolong their lives as the Pākehā does, and also to make them better and happier.

In 1867 a report by Rolleston (cited in Gardner, 2006) outlined that Mission schools were not succeeding in assimilating Māori. The Native Schools Act of 1867 established a national system of village day schools for Māori funded by the government. Funding for schools was provided on the condition that the English language was the language of instruction (Parsonage, 1957). Concurrently the Māori language, te reo Māori, was suppressed. The use of the indigenous language of New Zealand was punished, sometimes corporally, "for many years teachers have been instructed to discourage the use of Māori (language) in the school environment. In certain schools, fortunately a minority, this resulted in a firmly enforced ban," (Powell, 1955).

This inevitably contributed to Māori identity being portrayed as negative. Many Māori themselves began to suppress the language in their own homes as a result of the internalisation of colonial beliefs (Parsonage, 1957). Indeed, this happened within my own family where my grandmother and grandfather would speak Māori between each other and only English to their children. They believed the "Pākehā way" and language would lead to future success for their children. The detrimental effect of punishment for speaking Māori in school was commented upon by Walker (1990, p.147) when he stated, "the damaging aspect of this practice lay not in corporal punishment, but in the psychological effect on an individual's sense of identity and personal worth."

3.2.3 Taking our homes: Dispossession of lands and urbanisation

Alongside the bodies, spirits and minds of Māori, the whenua was also colonised. Referring back to the Māori models of health shared earlier, it clear that almost every dimension of the Māori self that determined wellbeing was affected by colonisation. Via confiscation or legislation, by 1896, only 11 000 acres of land remained in Māori ownership out of 66.5 million acres (Durie, 1999). The land left to Māori was often that which was difficult to cultivate or farm. In the

absence of an economic land base many moved to the urban centres for employment, excitement and opportunities (Kingi, 2005). In the 1950's, Māori moved from small rural communities to larger urban centres in great numbers and by 1999, 83.2% of the Māori population lived in urban centres (Te Puni Kokiri, 1999). Urbanisation essentially severed Māori ties to their culture and social support systems. The mana of whanau, hapu, iwi and the whenua had been diminished as there were no systems in place for it to be protected and maintained. As has already been stated, diminished mana can lead to individual and collective forms of illness.

3.2.4 Loss of identity

Considering the far-reaching effects of only three events outlined above, it is not surprising that colonisation had a significant impact on Māori mental health. In the words of a participant in this research, these events effectively 'cut Māori off from their anchors of identity'. This is a concern if one considers a recent finding that a secure and positive cultural identity is protective against mental illness (Durie, 1998).

Durie and colleagues conducted a longitudinal study over 20 years with 700 Māori households (Te Hoe Nuku Roa, 1997; 1998). Data analysis revealed cultural identity was dimensional, based on factors such as self-identification and access to cultural resources (See Table 2). Four cultural identity profiles were constructed from the data. Participants held either: a secure identity (self identification and considerable access to resources); a positive identity (self identification with limited access to resources); a notional identity (self identification and no access to resources); or a compromised identity (non-identification despite considerable access to resources). Over half of the respondents in the study were found to hold a positive identity, however less than a third held a secure identity. This indicated that even there was a significant lack of access to cultural resources to strengthen Māori identity. Considering a secure identity is protective for good health, even in the face of adverse socio-economic circumstances, this is an important issue (Durie, 2001).

Table 2: Māori identity determinants and Markers

Identity Determinants	*Identity Markers*
Self-identification	Ethnic affiliation Tribal affiliation
Access to cultural resources	Māori language knowledge and skills Tikanga Māori knowledge and skills Marae participation
Access to Māori physical resources	Māori land Fisheries Wahi tapu Tribal estates
Access to Māori social resources	Whanau Friends and associates Māori educational institutions Māori services Tribal services

(Sourced from Durie, 2001, p.55)

Durie contends that access to a cultural identity is a fundamental right, not an option, and that the development of a secure cultural identity is essential for wellbeing. This is reflected in the Draft Declaration of the Rights of Indigenous Peoples, which states, "Indigenous peoples have the right to have dignity and diversity of their cultures, traditions, histories and aspirations appropriately reflected in all forms of education and public information," (Durie, 1996, p.61).

Durie (1996) also cautioned that Māori identity can be stereotyped and generalised to the point of ignoring the diversity of Māori realities. He urged mental health services to move beyond static notions of "traditional beliefs and values" as the only legitimisation of identity. Mcfarlane-Nathan (1996) recognised diverse realities by incorporating the various levels of acculturation Māori experience as a result of colonisation into a CBT framework (see section 3.4.2). In terms of recognising diverse Māori realities Durie commented:

It is unethical to insist that all Māori in hospitals or attending clinics should be managed in the same way, but by the same token it is equally unacceptable that a Māori who has a health problem should be treated as if being Māori was of no consequence. It always is, though not in a way that can be presumed, (Durie, 2001, p.60).

3.2.5 The aftermath

Māori are over-represented in almost all negative social and health statistics within New Zealand. Māori experience higher rates in prison populations, for heart disease, diabetes, alcohol and drug disorders, psychotic disorders and mortality (Durie, 2001). Conversely, Māori are less visible in positive statistics such as health professionals, managers, decision makers in policy and students at the university level (Durie, 1988; Mental Health Commision, 1998; Sharples, 1993).

Before reporting on mental health statistics, it needs to be recognised that service users have only recently had the opportunity to self report regarding identity (Dyall, 1997). Even still, ethnicity is recorded upon admission to a service and does not take into consideration the changes in one's cultural identity during recovery (Dyall, 1997). Further to this, the available statistics are all based on inpatient, clinical populations. It is unknown whether these disparities hold within community populations. Dyall (1997) commented upon the flawed nature of statistical recording where, "the answer (to questions of identity) depends on who is asking, and why and how a person feels about him or herself at the time," (p.87).

Māori overrepresentation in mental health statistics has only been evident since the 1970's (Durie, 1994). While physical illness was rampant during early colonisation, mental illness, as it was understood by Western psychiatry, was not recorded. Kingi (2005) proposed three possible reasons for this. One hypothesis was that Māori were so busy trying to stay alive, they did not have "the luxury" of mental illness. Another proposition is that Māori may have experienced mental illness but did not access mainstream health services, and were treated within their communities. The third proposition is that Māori did not experience psychiatric illnesses in the way in which they are defined today due to their spiritual ways of understanding and treating health and illness. A definitive answer is impossible to glean retrospectively however it is likely that an interaction of all three factors contributed to the low rates of hospitalisation for Māori prior to the 1970's.

In the period 1929 to 1935 (Beaglehole, 1939) rates for Māori admissions to psychiatric inpatient units were around half that of Pākehā (31:58 per 100 000). Throughout the 1940's, 50's and 60's admission rates for Māori were about a third of Pākehā rates (Beaglehole, 1939; Sachdev, 1989b). A shift in Māori admission rates to mental health hospitals began in the 1970's. In 1974, Māori admission rates were recorded as being equal to Pākehā (222:222 per 100 000) (Sachdev, 1989b). By 1981, Māori rates of admission to psychiatric inpatient units had surpassed Pākehā rates (348:299 per 100 000). During the period from 1981 to 1990, the rates of Māori admitted to psychiatric hospitals has gone from around 400 per 100 000 to 600 per 100 000 while Pākehā rates of admission remained constant or slightly fell (Te Puni Kokiri, 1993a). By 1993, Māori admission rates were almost two times higher than Pākehā, with the majority of these admissions being for drug and alcohol disorders and psychosis (Te Puni Kokiri, 1996). This trend also held for readmission rates where Māori rates were about two to three times higher than that of Pākehā by 1993 (Te Puni Kokiri, 1996). Nearly half of all readmissions for Māori were for the diagnosis of schizophrenia. The most recent statistical data was recorded in the year 2000 for people admitted to three psychiatric units in Auckland (Wheeler, Robinson, & Robinson, 2005). Overall, Māori admissions were double the expected rate based on population statistics. Sixty-two percent of Māori admissions were for psychotic disorders as opposed to 38 percent for Pākehā. In addition, Māori were more likely to be admitted involuntary. When looking at length of stay, Te Puni Kokiri (1993) found Māori spend 40 percent less time in inpatient units. These statistics indicate that Māori have differential experiences in terms of access, treatment and outcomes when compared to Pākehā using mental health services (Dyall, 1999).

Before trying to understand these disparities, two major limitations of the statistics need to be recognised. First, the statistics assume that western constructions such as schizophrenia are a meaningful way to describe illness within the Māori community. There is danger in accepting Māori have a problem with high rates of schizophrenia as this legitimises the diagnosis itself. Therefore, one explanation for current disparities is that assessing psychiatrists are misdiagnosing Māori. It has already been mentioned that seeing or hearing things that others cannot could represent a gift, or a connection to one's ancestors. Delusions and hallucinations have also been recorded within Māori populations experiencing mate Māori as a result of a transgression of tapu.

In addition, tangential thinking may be ascribed to Māori patterns of thinking. Durie (2004) described Māori communication and thought as metaphorical which often moves outwards towards larger connections. This can appear incoherent to others not used to this style of communication.

To facilitate a greater understanding of Māori communication patterns, Metge and Kinlock (1978) investigated problems of cross cultural communication. They recorded a number of communication patterns for Māori that may be pathologised within a Western medical context. For example, *whakamā* (shame) was described as a culturally determined behaviour that involves varying degrees of withdrawal, limited eye contact, monosyllabic answers, unresponsiveness and running away and hiding. This is often in response to "feeling at a disadvantage, being in a lower position morally or socially, whether as a result of your own actions or another's" (p. 23). Metge and Kinloch argue that this behaviour is misinterpreted by Pākehā as a bad temper, symptoms of schizophrenia, guilt, moodiness, insolence or insubordination. It could be argued the environment of an inpatient unit may make Māori service users feel whakamā.

Recent research suggests that medical constructions of illness and treatment may diminish positive outcomes for Māori diagnosed with schizophrenia by negatively influencing their belief that they can recover. Sanders (2006) compared illness representations of 83 New Zealand Europeans (NZE) and 93 Māori who had been diagnosed with schizophrenia. While the research did not ask participants their constructions of their experience, Sanders found differences between Māori and European representations of their diagnosis. Māori believed their illness would last for significantly less time than NZE. This was found even when other factors such as level of disability, severity of symptoms and level of functioning were controlled for. In general Māori experienced fewer symptoms, less disability and better functioning when compared to NZE. When Māori did believe in a longer duration of their illness, they also held a stronger illness identity, experienced more symptoms, more negative consequences, had increased concern about their illness and a stronger belief in the efficacy of medical treatment. This mirrors research cited in chapter one and two where biomedical constructions were found to have a negative effect on the experience and outcome of psychosis while spiritual and/or cultural constructions can have a positive effect (Beavan, 2006; Jenkins, 1988)

Another explanation for the current disparities in statistics is the aforementioned social, cultural and spiritual effects of colonisation. Research overseas has already found racism and discrimination, as a result of being a minority, can lead to psychotic illnesses (see Chapter Two). Similarly, a recent study in New Zealand (Harris et al., 2006) interviewed a sample of 12500 members of the public and found a dose response relationship between the number and type of discrimination and health status. This cohort included those who self identified as Māori, Pacific, Asian and European. The experience of racism and discrimination was measured by experiences of ethnically motivated attacks (physical or verbal) and/or unfair treatment because of ethnicity. Māori reported the highest prevalence of all forms of racial discrimination and were 10 times more likely to experience multiple forms of discrimination. On a clinical level, a Māori psychologist, Rickard (cited in Houkamau & Rickard, 2001), also recognised the impact of discrimination and trauma on Māori presenting at the mental health services. She challenged the numbers of Māori being diagnosed with schizophrenia by drawing upon her own observations of PTSD (Post Traumatic Stress Disorder) symptoms in many of her clients with a label of schizophrenia. She referred to schizophrenia as an internalising disorder that does not recognise other socio-cultural issues such as individual (sexual, physical and verbal abuse) and collective (colonisation) trauma.

Further explanations for current disparities lie within the socio-economic history of Māori. Kingi (2005) referred to the economic downturn of the 1970's that may have been felt most within the Māori community due to the places in which they were employed. This aligns with the increased hospitalisation rates occurring around the same time. High unemployment is associated with increased poverty, poorer housing, reduced access to health services and lower educational achievement (Durie, 2001). All of these social and economic indicators have been proposed in the literature to be associated with higher rates of psychotic illnesses for Māori (Durie, 2001; Te Puni Kokiri, 1993a). However, this factor cannot solely explain current disparities. Pacific rates of admissions are actually lower than expected and this group is also over-represented in the more deprived deciles (Wheeler et al., 2005).

Another factor that has been used to explain current disparities is drug and alcohol abuse within Māori communities. Higher rates of alcohol and drug use are apparent within indigenous

populations the world over in the wake of colonisation (Durie, 2001). Substance abuse is understood as a negative coping strategy employed by indigenous peoples in response to a history of racism and discrimination and socio-economic deprivation (Walters et al., 2005). Successive generations of indigenous peoples then learn these negative coping strategies, with some family systems having multiple generations of substance abuse issues. Although definitive statistics are not available, Durie (2001) indicated that in some Māori communities solvent abuse and marijuana use is so high that it has been normalised. One study among my own iwi found that out of 125 members of the iwi, 31 had been regular users of marijuana in the past (Te Runanga o Te Rarawa, 1995). These patterns may be related to increased rates of hospital admissions for substance use disorders and drug related (predominantly marijuana) psychoses (Drug Advisory Committee, 1995).

A number of explanations have been proferred for higher readmission rates for Māori (Te Puni Kokiri, 1996; Durie, 2001). One explanation is that Māori first admissions are more acute. This leads to a more chronic course due to a lack of early intervention. Another explanation is that, upon discharge, Māori are returning to environments in the community that are not conducive to recovery. Yet another explanation is that current treatment methods are inappropriate for Māori.

3.3   MĀORI EXPERIENCES OF MAINSTREAM TREATMENT

There exists a limited base of research regarding Māori experiences of mainstream treatment for mental illness in general, let alone for the diagnosis of schizophrenia. This represents a significant gap that the current project aims to address.

Goldsbury (2004) interviewed 10 Māori service users regarding their experience with non-Māori psychologists. Overall, she found the therapeutic alliance was the most important feature. This was strengthened by services users experiences of acknowledgement of cultural factors, having needs addressed and receiving help with the development of one's cultural identity. In addition, respecting tikanga facilitated the building of trust. Goldsbury found that before entering mental health services, all participants were nervous about not being understood culturally. Many found the environment of mental health services alien and uncomfortable. Some participants were not

comfortable with the introduction process and withheld cultural understandings of their experience due to fear of judgement. Dyall (1999) also found that Māori *rangatahi* (youth) withheld cultural understandings of their mental health issues from psychiatrists in fear of judgment, mirroring findings from Lyndon's study. In this sense, silence needs to be considered as an active form of protection rather than a sign of passivity.

Tangata whaiora within research I have previously conducted (Taitimu, 2002) also commented upon their experiences of treatment. Hospitalisation was a confusing part of their illness that was difficult to remember (p.23), "I can't remember when I was unwell what they said; All I know is that I thought, I want to get out of here...that period is very blank to me." And, "at the time [of hospitalisation] my mind was like a washing machine, I wasn't listening to them and it didn't sink into my brain...I can see them clear as day talking to me, but I was turned off." Others stated that they had to fight to get help in they way they needed it (p.26), "I do have to push them a little bit, that's the problem, you can get help but you have to actually push them, because if you're quite happy not to do anything that can happen too. Others had to actively resist some forms of treatment "I had to fight to get off my medication."

Gibbs and colleagues (2004) investigated Māori experiences of community treatment orders (CTOs). They conducted 39 interviews with patients, psychiatrists, key workers and carers. The predominant diagnosis of participants was schizophrenia. Practitioners believed CTOs provided ways of managing patients' illnesses; helped them to face their illness; ensured adherence to medication and attendance at appointments and helped to provide supported accommodation. Some patients and family also believed CTOs were a "safety net" in terms of accommodation, managing treatment and preventing relapse. Other patients felt the CTO took away their rights and the control of their experience. Strong feelings of coercion and a loss of freedom were shared such as, "I always held it in the back of my mind that the control wasn't mine," (Gibbs et al., 2004, p.832). Additional barriers were the side effects of enforced medication; restrictions on their place of residence; and not getting better, merely existing. In many patients' minds, CTOs were directly linked to medication and the continuation of their illness. However, all participants preferred this form of treatment over hospitals in the absence of alternative options (such as voluntary treatment and supported whanau care).

Another project interviewed 21 Māori men and women and 19 non-Māori about their pathways to recovery using a narrative methodology (Lapsley et al., 2002). The second most common diagnosis was schizophrenia. They found every participant, both Māori and Pākehā, who had been ascribed this diagnostic label believed their diagnosis was incorrect. Participants associated the term with words such as 'doom', 'hopelessness' and 'nowhere to go'. Over half of the participants referred to hospitalisation as negative, 'incredibly devastating' and 'a real bad trip'. Again, a frequent theme was a loss of memory for the duration of their hospitalisation either due to the distressed state they were in or high doses of medication they received. In terms of receiving medication, participants predominantly experienced this form of treatment as negative using language such as 'drugged up', and 'doped up'. Some expressed the feeling of being a 'guinea pig' in reference to multiple medications. One Māori participant discussed his negative experience of medication, "I was on...eight or nine pills three times a day...there was a point where I couldn't stand up, you know, that's how they wanted me to be. Just floppy, couldn't talk," (p.83).

Māori participants within the same study believed their experiences had been misinterpreted by a discipline that does not understand their culture. One participant understood his "bipolar" symptoms to stem from an "illegal" transference of land out of his families ownership multiple generations back. Another participant with a diagnosis of schizophrenia derived meaning from her upbringing,

> I was a child that heard voices, that saw people that weren't there, that talked to the kehua, the dead people. And that was a real presence in my life as a child...I was always told by my mother and my kuia [elder] and those people who brought me up that [matakite] is something you just don't talk about. That it was a gift you hold close, (p.82).

The negative effects of medication have also been cited within other indigenous populations (Redko, 2000; World Health Organisation, 1999). Omeasoo (2000), a Native American indigenous healer commented that medication can actually sever the connection an individual has with their spirit and therefore create, rather than cure, illness.

These negative experiences of hospitalisation and medication are of concern if we consider Māori are being admitted to inpatient units at significantly higher rates than non-Māori and are being

prescribed antipsychotic medication in a differential manner. One study collected data from the Auckland outpatient antipsychotic audit (Humberstone et al., 2004). Significant variations were found in patterns of prescriptions where Māori were more likely to receive higher doses of typical (conventional, see section 1.3.1) antipsychotics and were more likely to receive depot medication (via injection). Individual depot doses were also significantly higher for Māori. Differential prescription of atypical antipsychotics based on factors such as service delivery and ethnicity have already been established abroad (Segal, Bola, & Watson, 1996).

While there exists a limited range of research asking Māori with psychotic experiences directly about their treatment, an extensive base of research has highlighted the limitations of mental health services in general. Encountering mental health professionals who do not understand Māori ways of constructing health and wellbeing is the first major barrier. While Māori participation in the mental health workforce is slowly increasing (see 3.4.1), due to lack of Māori staff and services, Māori often encounter Pākehā or foreign psychiatrists and psychologists in their treatment. Cultural competency training for non-Māori is rare and almost non-existent in many institutions (Brady, 1992).

Johnstone (1997), a Māori psychologist, gathered opinions regarding improvements for training and mental health services in New Zealand from 445 psychologists and 247 psychiatrists. She found 73.2% of psychologists and psychiatrists believed they were inadequately trained to work effectively with Māori. It is positive however that over 90% of both groups believed knowledge regarding Māori constructions of health was important. The limited world view of some psychiatrists was evident in that 11.3% believed that Māori were genetically predisposed to experience higher rates of mental health (Johnstone & Read, 2000). The following comments made by psychiatrists in this study indicate that the racism inherent in psychiatry prior to the 20th Century (discussed in section 2.3) is evident in some settings today,

> I am sick of questionnaires regarding Māori stuff, there is far more important issues than those regarding Māori mental health. I mean do you really think that psychiatrists need to have an understanding of such concepts like spirituality come on give me a break, (Johnstone, 1997, p.74).

> There is no need for Taha Māori in training programmes, as psychiatrists we are taught skills and we apply them in a cookbook manner. My effectiveness as a psychiatrist is not dependant on the colour of my skin, my culture, nor my understanding of bloody Māori culture, (Johnstone, 1997, p.74).

Another negative experience in mainstream settings is the limited recognition of tikanga. Manna (2002) provides the example of note taking which is both frightening and to some, offensive. She added, "as clinicians, we may unconsciously, or consciously impose or assume the correctness of our local moral order in interactions, possibly leading to unsafe outcomes for those involved," (p.38). Another project found indigenous Australians held a mistrust and fear of mental health services and their processes (Vicary & Westerman, 2004). Participants did not like therapy being conducted in an office setting; felt restricted by the time limit of sessions; did not like it when the process was not transparent; and were cautious about the intentions of the clinician. Indigenous participants preferred a professional *and* personal relationship with the therapist and wanted the time to 'yarn about my problem' rather than being interrupted with therapeutic interview techniques such as providing summaries and asking questions.

Durie (2001) summarised the barriers to effective use of mental health services for Māori. These barriers included medical gate keeping, committal for compulsory treatment, cultural alienation, inappropriate measures (assessment and outcomes), being sceptical of the Western paradigm and inadequate funding. At the same time, he proffered a number of solutions including the development of: a referral system with Māori health providers; advocacy and support services for Māori in mainstream Māori services alongside mainstream; early intervention for Māori in primary health care; a Māori mental health workforce; cultural assessment schedules; outcome measures that are relevant to Māori; Kaupapa Māori services; and new funding arrangements. A number of these solutions are addressed in the following sections and resonate with the major themes of the current project.

3.4   SOLUTIONS: FINDING A VOICE AND RETURNING HOME

The significant events that have contributed to positive gains in health are the development of a Māori mental health workforce, bicultural services, Kaupapa Māori services and the increased

recognition of tohunga as practitioners in health. Before commenting on these initiatives, the relevant policy requires mention.

The Treaty of Waitangi (Te Tiriti o Waitangi) affords Māori the right and responsibility to develop and access culturally appropriate services. The Treaty was signed in 1840 by a number of chiefs from various iwi and the crown. Some argue the Treaty was not recognised meaningfully in mental health service policy until more recently (Durie, 1999). The implications of the Treaty are viewed by some to be political rhetoric that is not felt or expressed meaningfully within everyday practice in mental health services. Alternatively, the following quote refers to the interpreter's intentions as to the relevance of the Treaty to mental health,

> Those who study the treaty will find whatever they seek. Those who look for the difficulties and obstacles which surround the Treaty will find difficulties and obstacles. But those who approach it in a positive frame of mind and are prepared to regard it as an obligation of honour will find the Treaty is well capable of implementation, (Sir Apirana Ngata, cited in Department of Social Welfare, 1989)

The Treaty now forms the basis of a number of mental health services. As the founding document of Aotearoa, Te Tiriti o Waitangi has been referred to as "part of the fabric of new Zealand society" (Te Puni Kokiri, 2002, p. 14). The four articles of the Treaty will be outlined below in reference to implications for service development and delivery for Māori.

Article One outlines the obligations of the crown as kawana of Aotearoa. Within this document, Māori agree to share governorship upon the condition that the crown supports and protects Māori and their endeavours. According to this article, health services that meet the needs of Māori and non-Māori are required. All individuals are afforded the right to decide the appropriate services for their needs. Te Puni Kokiri outlines the Government's responsibility to "make healthy choices easy choices," (Te Puni Kokiri, 1993a).

This begs the question, who has the right to decide what healthy choices are? The answer is evident in two key words within the second article of the Treaty, *tino rangatiratanga* and *taonga (*treasures*)*. Tino rangatiratanga pertains to the right and responsibility of Māori to posess and protect their taonga. Taonga encompass both material and non material treasures. The health of

Māori is a taonga, therefore Māori are afforded the right by the crown to be responsible for protecting it. In order to do so, it is essential that Māori define wellness and health, as well as how these are maintained, for themselves. A logical extension of this right is the development of services delivered by Māori, for Māori, in a Māori way as distinct from Mainstream services that merely include Māori in their staff and consumer groups. The Blue Print for Mental Health Services in New Zealand states:

> This Blueprint acknowledges tino rangatiratanga through specifications for more Kaupapa Māori services and directions and guidelines which will provide increased opportunities for Māori to create and implement strategies and services which will improve mental health services and mental health outcomes for Māori (Mental Health Commision, 1998).

The third article of the Treaty states that Māori should be afforded the same rights and privileges as non-Māori. Responsibility is placed on the crown to ensure that Māori not only have equal access to health services but also experience equal outcomes (Department of Social Welfare, 1989). Unfortunately this is not the case based on the statistics in the prior section.

There also exists a very important, and seldom cited, fourth article that was developed during verbal negotiations of the treaty and most likely contributed to the final consensus regarding it's signing (Naumann, 1990). This article has important implications for Māori health as it is not only an extension of the first three articles but also specifically outlines the rights of Māori to their customs surrounding spirituals beliefs and the responsibility of the Crown to protect this right. The implication this article has for mental health services is the acknowledgement, acceptance, incorporation and education of Māori spiritual practices into service development, implementation and evaluation.

The Treaty has been interpreted in various ways in multiple policy documents. Three general principles are often referred to in terms of the spirit of the Treaty (Ministry of Health, 2007). These are partnership (Māori and Pākehā working alongside each other), Protection (protection of Māori knowledges and taonga) and Participation (Māori rights to participation in endeavours that impact on them). .

3.4.1 The development of a Māori workforce

One solution proposed to address current disparities is the development of a Māori mental health workforce. However, Michelle Levy's (2002) barriers and incentives report indicated Māori are extremely underrepresented within mental health professions. She cited the 2000 New Zealand Health Information Service (NHIS) Health Workforce Survey where only 1.3% (n=9) of the 667 registered psychologists who completed the survey were Māori. Levy (2006) also reports survey information for 2002 (n=43), 2003 (n=42) and 2004 (n=40) showing an approximate 3% increase of Māori in the psychology workforce from 2000. In 2003, a New Zealand Psychologists' Board Survey found 42 respondents or 4.7 percent of active psychologists were Māori (Ministry of Health, 2003). This number dropped slightly in 2005 to 39 (Ministry of Health, 2005). This drop was likely a result of registered psychologists taking up educational or policy level positions. Disregarding the reasons, any drop in practicing Māori clinicians is of serious concern if we considered this is mirrored by increasing utilisation of services by Māori.

Te Rau Matatini (Tassell, 2004), an organisation established to work towards developing a Māori mental health workforce, conducted a survey of the workforce in 2002. Out of 586 Māori respondents working in both non governmental (NGO) and district health organisations (DHB) the greatest number were working as community support workers (42%), then nurses (22%) and other professions such as counsellors (11%) and social workers (6%). The lowest representation was for clinical psychologists and psychiatrists (figures were not provided in the report), representing a trend that has been long standing (Mental Health Commision, 1998). To my knowledge, there are only four practicing Māori psychiatrists in New Zealand today.

Brady (1992) outlined barriers in training programmes as an explanation for the low numbers of registered Māori clinicians. The first barrier was selection interviews where only one programme had a culturally relevant protocol for interviewing Māori. In addition, Māori were either not present, or severely underrepresented, in selection panels throughout training programmes in New Zealand.

Even if a Māori student gets over this first barrier, a number of hurdles are inherent in the process and content of clinical training programmes. Understanding human dysfunction from a Western

perspective may contradict Māori understandings and alienate students from the learning process (Milne, 2005). In addition, the scientist-practitioner model may preclude Māori from utilising their own models of healing due to a lack of an empirical base (Brady, 1992). Tereki Stewart (1992), a Māori clinical psychologist, interviewed Māori psychology students and found general dissatisfaction with content of psychology courses. One participant commented, "I expected more relevance and they were totally irrelevant, I think I thought it would give me skills, practical skills that I could apply, you know, if I want, if I was working in the community, that, you know would be of use," (p.11).

Overall Stewart found the experience of students were 'negative' and 'alienating'. Students described psychology as a 'war zone' as they had to fight for positive initiatives. Almost 15 years later, Milne (2005), a female Māori psychologist, found similar themes when she interviewed 69 Māori either working, or in contact, with the profession of psychology. Milne's participants indicated a Kaupapa Māori Psychology training programme is required as Māori actually think differently from their Pākehā counterparts. One participant commented, "they've got to realise that they're dealing with two different cultures in Aotearoa. And our minds, our whakaaro, our way of thinking is not the same," (p.12).

Being colonised in terms of constructions of health and wellbeing was proposed to be detrimental to Māori psychologists' ability to work within their communities. Some participants in Milne's research believed psychology was actually dangerous. This is because training can change Māori students' approached to health and render their practices inappropriate for working within the Māori community once they are qualified. As a solution, Paewai (1997) proposed cultural safety is achieved in training programmes through preparation, development of skills to work with Māori, learning cultural practices and constantly assessing outcomes from service users' perspectives.

A number of initiatives have targeted the development of the Māori mental health workforce on both larger and more local scales. On a macro scale, Te Rau Matatini (Ministry of Health, 2005), a government funded organisation, was specifically developed to increase the Māori mental health workforce. This organisation has been involved in implementing education and training in both

clinical and cultural aspects of Māori health. Raranga Tupuake is a development plan published by Te Rau Matatini that outlines three major objectives. The first objective was to increase numbers of Māori in mental health by attracting school leavers, mature Māori and Māori in diverse sectors. The second objective involves expanding the skill base of the current workforce both clinically and culturally. Finally, Te Rau Matatini aims to enable equitable access for Māori to training opportunities such as psychology and psychiatric courses. Within each area of Raranga Tupuake various action points are operationalised, some of which have already been implemented (Hirini & Maxwell-Crawford, 2002). These initiative need to be balanced with increasing the cultural relevance of training programmes for Māori. There is no use in getting more Māori to enrol if training programmes are not prepared to help Māori clinicians develop (Levy, 2002). Moana Waitoki (2006) aims to target this barrier by delivering cultural competency training witin clinical training programmes within New Zealand.

On a local level, support programmes, such as tuakana (literally translated as older sibling) and mentoring programmes, now play a major role in nurturing psychology students ascending the echelons of psychological training. The inclusion of the programme at the University of Auckland's Department of Psychology is designed to improve retention rates and academic achievement of Māori students (Cooper, Taitimu, & Wharewera-Mika, 2006). Helping students survive (social / peer support) and making the experience of learning in psychology relevant to Māori lives (academic support) are two core principles of the tuakana philosophy, "It's pretty simple, eh. One, I just wanna survive in this place and two, if I'm not surviving I want somebody I can go to, and three, part of my life has to touch the papers, you know," (Stewart, 1992). A student from the tuakana programme at the University of Auckland elaborated further on the tuakana philosophy.

> The benefits of the tuakana/teina programme can be interpreted through it's name … The tuakana is able to develop leadership, provide support and create an environment of awhi (support, trust) and manaakitanga (caring). While the teina (mentee, younger sibling) is able to feel supported socially and academically, and learn and develop in ways that are familiar to our cultural dynamics … To me, it's achievement through the basis of whanaungatanga (relationship-making) and the incorporation of the roles of a tuakana and a teina through whanaungatanga which contributes to it's success, (Cooper, Taitimu & Wharewera-Mika, 2006).

3.4.2 Bicultural models practices and services

The development of bicultural services is an obligation under Te Tiriti o Waitangi. These services aim to increase the cultural competency of the Pākehā workforce. Based on her personal experience, Huygens (1999) outlined a number of factors imperative for increasing accountability of Pākehā practitioners. First, the clinicians must recognise professional interactions that assume as the 'norm' certain ways of understanding and communicating. Huygens advocated for protecting against 'cultural blindness' where monocultural beliefs and practices proceed without checks and balances. She further criticised the fact that 'checks' on practitioners are predominantly conducted by other members of the dominant group. Accountability can only be increased by including Māori in the development, implementation and monitoring of cultural safety in services. This places the non-dominant group in the position of the expert while Pākehā professionals become students or learners. Hyugens commented these processes require a commitment to learning and change.

The development of a number of bicultural models and practices represents a positive step towards increasing the cultural competency of mental health professionals. Mcfarlane-Nathan (1996) developed a bicultural therapy model that combined aspects of acculturation with Cognitive Behavioural Therapy (CBT). This model was eventually implemented with correctional services. He argued that while CBT is a clinical tool, the culturally competent clinician is able to use this tool to understand various levels of acculturation and how this factor contributes to current behaviours. In a pilot study, training was delivered in stages by Pākehā and Māori experienced in working with Māori. The first stage aimed to generate awareness of clinicians' cultural biases and limitations of their knowledge base when working with Māori. The second stage aimed to provide clinicians with experiential training in marae and other Māori spaces. The third stage involved skills training outlining assessment and therapeutic procedures. This process supports research outlined by Sue and colleagues in the USA (Sue et al., 1992). Mcfarlane-Nathan summarised the bicultural therapy model as a process that, "acknowledges the Māori perspective of psychological dysfunction by identifying the extent to which issues of deculturation and acculturation have supported the manifestation of psychological deficits," (p.24).

Another model used within an early intervention service in New Zealand aims to incorporate both Māori and Pākehā assessment practices. This model was developed by Peta Ruha and was introduced into a Māori mental health service, Te Whare Marie, in 1999 (Manna, 2002). The Pounamu model stresses the importance of beginning clinical sessions with karakia (prayer) and mihimihi (introducing familial background). This model incorporates a cultural and clinical assessment process based on the four walls of the whare tapa wha model. In the first meeting, tangata whaiora and whanau (family) are presented with a visual representation to fill out collaboratively with a clinician and a cultural advisor (see Figure 1). The Pounamu model has been incorporated into the Wellington EIS for both Māori and non-Māori clients.

Figure 1: Te pōunamu model

TE POUNAMU MODEL

COPING STRATEGIES
ALCOHOL & DRUG USE
VIOLENCE
CRIME
INAPPROPRIATE BEHAVIOUR

PRESENTING ISSUES
DSM IV
SAFETY
SOCIAL STRESSORS

WHANAU DYNAMICS
RELATIONSHIPS
PARENTING
ISOLATION

UNDERLYING ISSUES
GRIEF
ABUSE
IDENTITY
SPIRITUAL
ENCOUNTERS

RELATIONSHIP ISSUES
HISTORY OF DISHARMONY
HISTORY OF ABUSE
SOCIAL ISOLATION

STRENGTHS
WHANAU LINKS
ART / MUSIC

(*Sourced from: Manna, 2002*)

Outlined within this section are two models amongst many that are currently being implemented or developed across New Zealand. They both meet the recommendations made by the Mental Health Commission regarding a cultural assessment process for Māori using mainstream services (Mental Health Commision, 2001). This document prescribes that the process of cultural

assessment and treatment should entail a powhiri (welcoming ceremony), karakia, *mihimihi* (introductions), assessment by a cultural assessor, a cultural formulation, sharing the formulation with clients and team members, pre-discharge meetings and a *poroporoaki* (farewell ceremony).

3.4.3   Kaupapa Māori services

While bicultural models, practices and services are a positive step, they are limited in that the cultural interventions are carried out within a mainstream setting. Durie (1996) cautioned that "some Māori leaders are concerned about the potential for cultural distortion when Māori culture is practiced within a predominantly Western institution," (p.64). Māori clients may also feel misled if a seemingly culturally sensitive approach turns out to be a distinctly non-Māori experience. Alternatively, other non-Māori clients (and clinicians) in bicultural settings may object to an emphasis on Māori culture.

Susan Tawhai is a Māori woman who proudly attested in her story that she has been mentally well for over 15 years. She was diagnosed with depression, experienced multiple psychotic episodes and had been hospitalised for her 'illnesses'. She attributed her journey towards recovery to whanau relationships and going home to find out about herself as a Māori.

> All of us want to know why. At the end of the day you go back to where you came from to find out why. In the early days, Māori lived at home in their whanau situation. If you started to hear voices or you were showing signs that you weren't the same as everyone else, you were accepted as being like that. You could be considered to be gifted, and so there was an answer for you straight away because you were right there and there were people that could tell you why. Now, it's different. (Tawhai, 1999, p.118)

Kaupapa Māori Services (KMS) are developed to facilitate healing through access to cultural resources within a service run by Māori, for Māori, in a Māori way. The environment of KMSs are based on traditional cultural values and practices. Tohunga, kaumatua, cultural assessments, traditional healing and the Māori language are all part of KMS. Durie outlined three guiding principles that are common to KMSs (Te Puni Kokiri, 1993b). These being, tino rangatiratanga (right to self determination and to development), he tangata he tangata (recognise the diverse realities of Māori people as focus for the services) and tatau tatau (Māori health is a collective responsibility).

The first KMS was Whai Ora based at Tokanui Hospital developed in the 1980's (Durie, 1999). Since this time a number of KMSs have been established alongside, and independent from, mainstream services. At present, a number of iwi now run their own mental health services (IRI, 2002). Linda Smith and Paparangi Reid (2000), both female Māori researchers, reviewed Kaupapa Māori principles and practises in a number of health services. They indicate that the health reforms of the 1990's have lead to a dramatic increase in the development of Māori providers within Māori contexts. They describe a number of providers that have provided health services within the Māori community (this list includes some of those I had contact with during this research) such as Waipareira Trust (in West Auckland), Rakau Hauora o Tanui (in Waikato), Te Puna Hauora te Raki Pai Whenua (Marae based health service on the North Shore in Auckland), Ngati Porou te Hauora (range of health services for Māori in the East Coast area), Hapai te Ora (An ocean based programme connecting Māori to tangaroa, *atua*, for wellbeing), The Dynamics of Whanaungatanga (learning and education regarding Māori spirituality for wellbeing), Te Mana Oranga (a Kaupapa Māori mental health service in Northland), Te Kotu ki te Rangi (A Kaupapa Māori Mental health service in West Auckland) and Te Oranga (Health services delivered by my iwi, Te Rarawa). These are only a few of the many services now available. In terms of practice, KMS vary in their delivery although a trend is apparent where mental health services are delivered alongside general health services such as general practitioners, dentists, family support services, community education programmes, social services and traditional healing. This allows clients of KMS to have their health needs addressed holistically in the one service rather than going to a number of sites.

Durie (1996) proposed that KMS have the potential to strengthen secure Māori identities. This can be achieved by the use of cultural assessment models and measures of outcome that are based on Māori indicators of success. Within these services clinical indicators of wellness are considered alongside cultural indicators of wellbeing. Positive outcomes for Māori have been found to encompass a wide range of factors. In a previous project, I asked five Māori clinicians and five Māori tangata whaiora about the content and delivery of Māori mental health outcome measures (Taitimu, 2002). My research built upon Kingi and Durie's (2001) Māori mental health outcome measure that is based upon the four dimensions of the whare tapa wha model (see section 3.1.3.1).

110

The measure they developed was in written format and was designed to access three different perspectives; those of the clinician, consumer and whanau. The results from my research suggested that current clinical indicators of outcome (such as symptom reduction, safety and the ability to care for oneself) form *part* of what constitutes a positive outcome for Māori but do not cover the full range of factors considered to be important. Additional factors for Māori included spiritual wellbeing, reconnecting with family, understanding the experience, having the capacity to help others and cultural identity. Further to this, the delivery of outcome measures was dependant upon the level of recovery (not using them when in acute states, having just been admitted to hospital) and the approach (it needs to be in a Māori way). All participants supported the use of an outcome measure based on Te Whare Tapa Wha.

Other research has aimed to measure successful outcomes at the service level. A recent Kaupapa Māori project surveyed 12 kaupapa Māori health services along with a number of other iwi providers to gain an understanding of indicators of success (IRI, 2002). Indicators of success included: being guided by the vision handed down by the ancestors; being able to determine their own future; operationalising Māori values; and practices and regular self evaluation. Barriers to success included inadequate funding, stress or burn-out of staff, unrealistic community expectations and unbalanced partnerships with the crown.

The limited amount of research conducted thus far indicates Māori are generally satisfied with KMSs. Māori participants in Lapsley, Nikora and Black's study (2002) found Māori service providers had a positive impact upon participants' recovery. Being around other Māori staff and service users and the various treatments available were all considered positive. Participants also found karakia, waiata and other cultural practices comforting. O'Hagan (1999, p.6) also referred to the positive effect of traditional healing cited by a Māori consumer,

> Seeing a tohunga and being blessed by him helped my recovery because it helped me get back in touch with my Māori side. It gave me faith in spiritual things again like karakia, having water sprinkled over me when I was down, visiting my urupa where my old people are, and returning to my turangawaewae when I needed to.

A woman working in Te Whare Marie, established in 1996, shared her experience as an employee of a Kaupapa Māori Service (Amor, 2002). She referred to using both cultural and clinical models

in her practice, being motivated by personal beliefs in social justice and equality and being guided by tikanga in all interactions with clients. She expressed a deep satisfaction in her work despite a number of barriers. One of the major barriers cited within wider literature is the risk of burnout due to limited resources and working over and above contractual agreements (IRI, 2002; Smith, 1997). Overall there is a significant lack of research that aims to legitimise and assess the experience of working in and utilising KMSs (Herbert & Morison, 2007).

3.4.4 Kaupapa Māori psychology

A parallel movement to the development of kaupapa Māori services is the recognition of a Kaupapa Māori Psychology. A basic assumption of this paradigm is that Māori have distinctive ways of thinking, feeling and behaving. This movement does not wish to paint all Māori with the same brush. There exists diverse realities *and* there exists strong indicators that some general patterns are present. Research by Milne (2005) indicated that Māori hold a very different worldview and perspective on healing to Pākehā. One tohunga noted,

> We start with the wairua first, then the hinengaro, then tinana, the healing of whakapapa then deal with the trauma; whereas these others, they start with the trauma first and may or may not deal with the wairua, hinengaro, tinana and whakapapa. There should be recognition of health the wairua first, then the mind. *(p.19)*.

Cram and Reid (2005) metaphorically highlight that Aotearoa is not just a Māori word for New Zealand but a world in which Māori are raised that is qualitatively different from non-Māori. This world is argued to affect the way in which Māori think and behave. Durie (2005) attempted to define how a Māori psychology is different to Western psychology by contrasting centrifugal and centripetal thought processes. He argued that Māori thought aligns to centrifugal thinking that moves outwards, is metaphorical, entails abstracted thought and imagery, while centripetal thinking is akin to Western psychological thought that finds meaning in reductionist terms (Durie, 2005).

Further to this, Kaupapa Māori psychology is guided by cultural processes and encounters. Durie (2001) outlined various psychological values evident in several domains of the marae. The use of space refers to orderliness, personal boundaries and formalisation of movements. Time is

constructed based on a commitment to order and completing tasks (even if it takes a few days). In terms of space, the circle represented reciprocity, mutuality and the restitution of conflicts on marae. Safety is ensured within marae encounters by establishing clear boundaries around roles and responsibilities. Further to this, marae communication is akin to the centrifugal patterns of thought outlined above as conversations often involve metaphorical thinking that can be allusive and indirect. Authority and generosity are also exercised on marae through collective responsibility and mutual enhancement. Interconnectedness is represented by the meaning that is derived from similarities and relationships, for example being either tangata whenua (hosts) or manuhiri (guests). These aspects of marae encounters represent only some characteristics of a Māori psychology.

Research has found Māori who visit marae feel a sense of balance is restored to their lives when they experience depletion of the spirit or loss of direction (Durie, 2001). Therefore, the psychology of this space could be, and in many KMSs is, used in other settings such as mental health settings to facilitate recovery.

In terms of the vision for a kaupapa Māori psychology, Milne (2005) referred to the goal of delivering kaupapa Māori psychological training in psychology courses. This is envisioned to eventually lead to the development of a Kaupapa Māori psychology scope of practice within the profession.

3.4.4.1 Tohunga as practitioners

Tohunga and kaumatua (elders) play an essential role in the development of a kaupapa Māori psychology. As already stated, these individuals represent the custodians of traditional Māori psychological knowledge (Durie, 2001). Despite years of oppression, tohunga have continued to practice 'under the radar' within their communities. This is evident in statistics that reveal tohunga are still consulted for health issues in the Māori community. In 1984, the Māori Women's Welfare League interviewed 1117 Māori women and found that one in five would consult a traditional healer if they experienced 'mate Māori' (Murchie, 1984). A decade later, similar results were found when 397 Māori were interviewed (Te Pumanawa Hauora, 1997). Thirteen percent had visited a traditional healer in the past 12 months and 19 percent indicated a

traditional healer was the preferred practitioner if they were sick. Again in 1998, a Māori household study found 10 percent of the population had sought help from a traditional healer in the previous 12 months (Te Hoe Nuku Roa, 1998). Of interest was that over half of the sample indicated they would go to a tohunga if they were suffering from 'mate Māori'. More recently Lapsley, Nikora and Black (2002) found that almost 66% of Māori participants (all having previously received a DSM-IV diagnosis) had engaged in some form of traditional healing. The most common practices were karakia and whakawatea (cleansing with water). Sachdev (1989a) also commented on his experience as a Pākehā clinician where many Māori patients would accept Western medicine from him yet firmly held on to supernatural beliefs about causation and seek help from a tohunga simultaneously.

Reasons cited in the literature for the perceived success of tohunga healing include helping the individual reconnect with their spiritual selves and strengthening Māori identity (Lapsley et al., 2002). This aligns to the description of the healing process provided by a well respected tohunga, Māori Marsden (1986). He summarised his healing as a process that brings back the lost spirituality in an individual and re-establishes their "Māoriness". Numerous and in depth examples of healing were recorded in a recent PhD project (O'Connor, 2007) investigating a group of healers who had developed a traditional healing service. O'Connor noted that his participants were both patients and healers as opposed to one or the other. This was based on the philosophy that "you have to experience it for your self to understand it" (p.7). The practice of traditional healing is evident in the narrative below:

> So it's important that they learn their whakapapa. Because there is a transition where people know they are being brought up in a Pākehā environment but they know they are not Pākehā. They know that they are Māori and there comes a time when they look for that, look for their roots. Maybe early, maybe later, but there is a time when they ask that question – what is my whakapapa, where is my turangawaewae [standing place], where is my ahi kā, where is my papakainga [home], and that. ... I know they go through that korero here. They do that. Even I do with my students, all the time. You know the mirimiri [deep-tissue massage] is part of a wider process of healing. You have to heal them spiritually, mentally, physically and from a whanau perspective as well ... so that you balance that whole thing out so they feel happier with themselves, more at peace with themselves. Spiritually, mentally, physically, and gathering their family around them as well to give them their moral support. Strengthening their relationships with each other. *It's so important* [Interviewee's emphasis], (p.9).

Recent developments have indicated a change in the tide where tohunga are increasingly recognised as legitimate practitioners. The path towards increased recognition in established health services is currently being paved. In 1995 the Central Regional Health Authority contracted Te Whare Whakapikiora o te Rangimarie for the delivery of a traditional healing service (Lawson-te Aho, 1996). A national body of traditional healers (Ngā Ringa Whakahaere o Te Iwi Māori) has also been established. Members contributed to the development of standards for traditional Māori healing (Ministry of Health, 1999). This document outlined rights of tohunga to their practices, such as the use of medicinal plants, and aimed to define their relationships with clients and health services. This document could be criticised for using Pākehā political means to operationalise processes that are cultural and complex, however it also represents the legitimisation of Kaupapa Māori practices within a mainstream national health organisation. In general, tohunga are increasingly being recognised as legitimate health practitioners who may have a thing or two to teach the rest of mental health.

3.5   SUMMARY

Before European contact, Māori understood illness within a spiritual framework that was extremely different from Western psychiatric models. Colonisation then systematically unravelled the web that held Māori society together, rendering the population open to a number of negative experiences and illnesses that had not previously been encountered. This included increased rates of utilisation of mental health services, especially for the diagnosis of schizophrenia and other psychotic disorders. Based on trends that were progressively getting worse throughout the 20th Century, it was evident that mainstream treatments were not working. A number of factors have been discussed as reasons for this. To address these disparities, services and treatments have begun to align to Māori needs and aspirations. There is now increased recognition of traditional ways of understanding and treating mental health. While there are still several issues in terms of Māori participation in programmes and the development of culturally relevant services, the hard work of a number of Māori tangata whaiora, researchers, clinicians, tohunga, kaumatua and kuia represents a site of hope and reclamation. It is likely that greater progress is yet to come with increased recognition and utilisation of a kaupapa Māori psychology and kaupapa Māori services.

3.5.1   The current research

This research places itself within an international history of indigenous groups faced with colonisation and the subsequent revitalisation and reclamation of culture. Māori, indigenous peoples and ethnic minorities are being diagnosed with schizophrenia at higher rates all over the world. We have all been exposed to the process of colonisation in one form or another and all hold beliefs and express behaviours that are phenomenologically similar to symptoms of schizophrenia. Often these beliefs are based upon a spiritual understanding of the world. The fact that schizophrenia is probably the *most* medicalised disorder increases the difference between Western and Indigenous ways of understanding this range of experiences. The various reasons proposed for the disparities in statistics have been outlined within this chapter and previously, in Chapter Two. Te Puni Kokiri (1993a) and the Ministry of Health (Masters, 1997) reiterate these hypotheses by asking,

- what is the role of cultural alienation and socioeconomic factors?
- Are current criteria sensitive to and accurate for diagnosis in Māori?
- Are Māori misdiagnosed by mental health professionals?
- Is there a lack of culturally appropriate early detection and support systems?
- Are services acceptable and accessible for Māori?
- Are methods of treatment appropriate for Māori?

This research aims to address some of the above questions by,

- Gathering Māori constructions of experiences commonly labelled psychotic in order to better understand the manifestation, course and content and outcome of these experiences

- Attempting to understand current experiences of some Māori utilising mental health services

- Gathering experiences and opinions from Māori mental health workers, healers, elders and whanau on current services for Māori with a diagnosis of schizophrenia

- Conducting research that is solution based. Gathering participants recommendations for the movement towards the development of effective services for Māori diagnosed with schizophrenia

The following two chapters will present the philosophical orientation to the research as well as how the research was developed and implemented.

4 THEORETICAL FRAMEWORK

It is important in research to understand why one selects their particular theory and method. In doing so, we recognise the lens that shapes the interpretations and conclusions placed upon the data. This section outlines some key principles and practices of the frameworks selected for this research.

A qualitative approach seemed necessary to answer the questions in the desired depth and breadth. As a form of qualitative enquiry, Kaupapa Māori Theory (KMT) was considered the primary theory and method for conducting the research due to the topic and the core principles of the researcher. In addition, a second theoretical framework derived from the field of psychology was believed to be important as a complement to KMT in order to integrate the two worlds (indigenous and Western psychologies) in which this research would be conducted.

Personal Construct Theory (PCT) was selected, after a process of careful inquiry, based on three key principles. First, PCT seems to offer a psychological approach and method that aims to recognise the research participants' own constructs and associated meanings of phenomena. Secondly, PCT acknowledges that constructs can affect the course content and outcome of experience. Thirdly, and possibly of the greatest importance, PCT and KMT strike a number of parallels in terms of their underlying principles and philosophical orientations. Both KMT and PCT have already been written about extensively therefore, only a summary of the relevant principles will be outlined here (For more detailed texts on PCT see: Butt, 2003; Button, 1985; Kelly, 1969;, 1991; Warren, 1998; Winter, 1992. And on KMT see: Smith, 2003; Ihimaera, 2004; Smith, 1997; Pihama, 2001). The following sections will discuss qualitative approaches, the theoretical orientation of the research (as derived from KMT and PCT) and the methodological principles and practices of these frameworks.

4.1 QUALITATIVE METHODOLOGY

Qualitative methodologies are increasingly used for answering questions of a psychological nature. Qualitative research is well suited to this form of investigation as it is inductive rather than deductive, aims to access internal meanings of events and experiences and, while a difficult

endeavour, attempts to understand the relationship between context and the development, course and outcome of experience (Gilgun, 2005; Marshall & Rossman, 1995). Creswell (1998) highlights the need for a clear rationale when utilising a qualitative approach. A number of factors should be considered when choosing a qualitative methodology. For example, does the topic needs to be *explored* (variables are difficult to identify and theories are not readily available)? Or, is a *detailed view* of the topic is required? In addition, audience and participant characteristics may suggest they are more receptive to a qualitative enquiry. On a subjective level, a qualitative paradigm may be more applicable if the researcher values being an "active learner" rather than "expert" (Shih, Marcos, Nnaemeka, & Waller, 2005, p.159).

Qualitative approaches also have particular relevance to the notions of reliability and validity. Reliability of qualitative research has been criticised from a positivist perspective. However, many now argue that due to the unique type of knowledge gained from each paradigm (quantitative and qualitative), specific criteria for validity and reliability must be set (Golafshani, 2003; Morse, Barrett, Mayan, Olson, & Spiers, 2002).

Reliability and validity in qualitative research has been variously defined. Principles such as credibility, neutrality, confirmability, trustworthiness, dependability and transferability have been used by various researchers (Lincoln & Guba, 1985; Merriam, 2002; Seale, 1999). On a practical level, reliability and validity is established by various methods such as multiple viewing/listening or reading of data by the individual and/or others (participants, advisory group members, colleagues), checking data with participants, checking consistency in categorisation of qualitative data between individuals and negative case analysis (Lincoln & Guba, 1985). Furthermore, it is recommended that evaluation of reliability and validity is maintained throughout the process of research rather than as an evaluative component at the end. Morse and colleagues (2002) cautioned, "in the time since Guba and Lincoln developed their criteria for trustworthiness, there has been a tendency for qualitative researchers to focus on tangible outcomes of the research rather than how verification strategies were used to shape and direct the research during it's development," (p.8). In this sense, qualitative research is argued to place as much emphasis on the journey of research as it does on the outcome. The rich and thick descriptions inherent in qualitative data, coupled with a detailed description of the process of the

research, also provides an opportunity for the reader to assess reliability and validity for themselves (Merriam, 2002).

Qualitative research can take on many forms. The numerous methods that fall under this paradigm broadly fall on a spectrum from relativism to critical postmodernism (Flick, 2002). Relativist methods assume that the world is socially constructed and therefore multiple realities exist. However, relativist enquiry (including constructivist and interpretive approaches) does not necessarily focus on change and is more invested in descriptions of meaning.

The post-modern paradigm tends to be more invested in instigating change via critical reflection (Pihama, Smith, Taki, & Lee, 2004). Critique is directed towards distributions of power and how this affects the way in which some constructions are valued over others. Praxis is a key concept of this paradigm and refers to a process where the research lens is turned back onto what has been promoted as truth by dominant hegemony (Smith, 1997). Accepted truths are recognised as social constructions that are informed by social, political and historical factors and are therefore susceptible to change. Critical theory and action research are derived from this paradigm. The current research lends itself to a post-modern perspective. Pihama aligns KMT to critical theory;

> Intrinsic to Kaupapa Māori Theory is an analysis of existing power structures and societal inequalities. Kaupapa Māori theory therefore aligns with critical theory in the act of exposing underlying assumptions that serve to conceal the power relations that exist within society and the ways in which dominant groups construct concepts of "common sense" and "facts" to provide ad hoc justification for the maintenance of inequalities and the continued oppression of Māori people, (Pihama, 1993, p.57).

Based on the principles outlined by Pihama, this research aims to represent schizophrenia as a social construct that is not necessarily a fact, but a particular description of a set of experiences endorsed by a particular group of people. These descriptions are also recognised to be commonly used *by* dominant groups *on* minority or indigenous groups who may not necessarily hold the same meanings. In essence, the aim of this research was three fold:

- to represent Māori constructions of EOE and schizophrenia;

- to discuss the relationship between Māori and psychiatric/psychological understandings of the same set of experiences; and

- to make recommendations on how *change* can take place in our current assessment and treatment practices with Māori.

The research aims indicated that a qualitative form of enquiry, from a post-modern critical perspective, was appropriate. However, unlike Western traditions in research, KMT is not about claiming the superiority of Māori knowledge or theory over others. KMT recognises the rights of people to develop and hold their own constructions of experiences whether they are personal and/or derived from their wider traditions, culture and language. Ultimately, KMT advocates for the "right of Māori to be Māori on our own terms and to draw from our own base to provide understandings and explanations of the world," (Smith, 1992).

4.2 KAUPAPA MĀORI THEORY

4.2.1 Emergence of KMT

While similarities exist between KMT and critical theory they are not the same. Pihama (2001) argued that KMT is derived from this land, Aotearoa and it's unique social political and cultural history while Critical Theory is derived from European history. KMT is unique in that it is derived from Tikanga Māori, ways of knowing and behaving present before all forms of Western contact. In this sense, Kaupapa Māori is described by Graham Smith (1992, p.1) as "the philosophy and practice of being and acting Māori." Kaupapa Māori recognises Māori have always been researchers as evidenced by our long standing astronomical, navigational, botanical, medicinal and educational knowledge systems. While KMT was present before encountering European knowledge systems, it has also become a means towards resisting the dominance of these systems. In this sense KMT is also a theory of struggle.

KMT cannot be discussed without recognising the process of colonisation. KMT and research (as it is utilised within this research) is a response to traditional Western methods that misappropriated indigenous knowledges and stripped the knowledge of it's context and meaning (Smith, 2003). Research has historically served a role in the colonisation of Māori by propagating

the ideological and political agendas of the colonisers and suppressing, pathologising or distorting indigenous knowledges (Mead, 1994; Whitt, 1995). Jahnke and Taipa (1999) describe traditional Western research methodologies as a process whereby knowledge was taken, manipulated to fit a Eurocentric framework and represented back to the rest of the world in a form that is unrecognisable to the original custodians. Bishop (1998, p.200) outlined the dangerous consequences of Western research in that "many misconstrued Māori cultural practices and meanings are now part of our everyday myths of Aotearoa/New Zealand, believed by Māori and non-Māori alike, and traditional social and educational research has contributed to this situation."

According to Smith (1999), damaging research is part of the landscape of Māori history since colonisation. In her text 'Decolonising Methodologies' Smith referred to early research that measured Māori skulls against European skulls to support an ideology that Māori had primitive minds during. This represented the philosophy of science at the time that believed everything that could be measured could be understood. In addition, in the name of archaeology, burial caves were desecrated and remains sent around the worlds as artefacts to be displayed in museums. By the early 20th Century, 60 years after te Tiriti o Waitangi was signed and over 100 years since the process of colonisation began in New Zealand, research had turned towards recording the practices and rituals of a dying race lest our traditional knowledge was lost.

Percy Smith (1913) and Eldson Best (1924) played a significant role in the written documentation of Māori knowledges. While theirs and similar works have proven useful to Māori and non-Māori alike, the methods employed have at times been criticised from a Māori perspective. In the tradition of KMT, one must recognise the factors that influenced the way in which these texts were developed and presented such as: the time (late 18th Century); the gender of the researchers; disciplinary backgrounds (anthropologists who often objectify their participants); ethnicity; and political positions held by researchers (Eldson Best held a number of political positions throughout his career).

These early works also served to set in place common myths such as the presence of a more peaceful race, the Moriori before Māori came to Aotearoa. While the Moriori myth, as it is largely articulated, has been discredited on a number of occasions, it remains a part of the New

Zealand narrative. It has been argued that the Moriori myth has been constructed to serve a colonial agenda by generating an ideology that Māori are not indigenous and were once colonisers themselves (Beattie & Tikao, 1939; Walker, 1990).

The history of psychological research in New Zealand paints a similar picture. Stewart (1997) mapped the interface between Māori and psychology through the 20th Century, specifically highlighting early theses conducted by Fitch (1938), Tizard (1940) and Bathurst (1940). They all portrayed Māori spiritual beliefs as primitive and redundant. Further to this, the Kowhai and Rakau studies (Beaglehole & Beaglehole, 1946; Beaglehole & Ritchie, 1957), produced by researchers living within Māori communities, aimed to illuminate the beliefs and practices of Māori in their everyday lives. While the communities welcomed these researchers with trust, a number of damaging Eurocentric interpretations were made regarding Māori society including the nature of parent child relationships, the lack of hygiene within these communities and the perceived *lack of* commitment to European education and ideals. Stewart (1997) argued these studies "were instrumental in providing the justification for the enforcement of assimilationist agendas at the political and social levels," (p.87).

During the period of Māori development in the 1970's and 80's, KMT sought to address the past trauma of Western research by "retrieving lost land and resources, reclaim [ing] intellectual and cultural knowledge, and remak[ing] social and economic institutions" (Kepa, 2004). In essence, KMT aimed to develop principles and practices of research that held the goal of Māori development at it's core. This research was to be conducted *by* Māori, *with* Māori and *for* Māori as opposed to traditional Western research that was often conducted *by* dominant groups members (namely Pākehā in New Zealand), *on* Māori and *for* the researcher and their own agenda. Jackson (1996) commented that KMT affords Māori the space and resource to set our own research agendas and guidelines. In the absence of this, Māori are at risk of having their knowledge misinterpreted by others in ways that is not their own. This generates research that is damaging to us as Māori.

4.2.2 KMT and research

A number of researchers have been instrumental in articulating KMT. Linda Tuhiwai and Graham Hinangaroa Smith (Smith, 2003) have laid the foundations for KMT in the academic arena. Leonie Pihama (2001, p.96) has also been instrumental in developing Kaupapa Māori approaches to research which she describes as "a process of engaging the academic community in a way that will create cultural and theoretic space for Māori within the university." KMT is used in diverse settings such as education (Pihama, 1993), medicine (Jones, 2000) and psychology (Ihimaera, 2004). There are also a number of websites dedicated to Kaupapa Māori researchers, research and theory (e.g. www.kaupapaMāori.com).

KMT has also been utilised within psychological research. Lyndon's 1983 study was conducted within her own community with the aim of representing Māori beliefs and practices from within the cultural context. Ihimaera (2004) also used KMT in her research regarding the facilitation of wairua in mental health services. She aligned her research to KMT by recognising her own history and attitude to knowledge that draws from traditional and contemporary māutauranga Māori as well as Western scientific knowledge. The core concepts of her framework included oranga (active protection), tikanga hauora (options), whanau ora (partnership and participation), ngā mahi to tika (dual cultural and clinical competency of the workforce), āhuru mōwai (strong and adept leadership).

4.2.3 KMT principles

Due to the evolving and diverse nature in which KMT has been used in research, a clear definition is difficult to ascertain. As a primary principle, Kaupapa Māori Research aims to deconstruct traditional power displacements maintained by Western research methods. KMT turns the research lens back on traditional Western paradigms and replaces what has long been accepted as the "status quo" with the assumption that Western knowledge is also culturally or socially constructed. Graham Smith (1997) argued that KMT provides "counter hegemonic practice and understandings" in the process and practice of research. For example, KMT asks questions such as: when was the research written? What was happening at the time historically, politically and socially? And what do we know about the author?

Concurrently, KMT is invested in the emancipation of Māori ways of knowing, doing, developing and transforming. This renaissance has occurred within the context of indigenous research methodologies worldwide. KMT is invested in self-determination or *tino rangatiratanga*, defined as the right and responsibility to determine our own constructions of health, illness and wellness. KMT and indigenous research asks questions such as, "how does the research historicise, politicise and strategise it's methodological practices to advocate for and benefit indigenous communities?" (Worby & Rigney, 2002). Linda Smith (2003) provided a list of other questions a Kaupapa Māori researcher must ask:

> Who is asking the research questions? For whom is the study? Who will benefit from the research? What knowledge will the researcher gain from this research? To whom is the researcher accountable? What are some possible negative effects? And, How can these negative effects be addressed?

Kaupapa Māori constitutes both theory and practice (Pihama, 2001). The *process* of KMT has been outlined by a number of researchers. Bishop (1996) operationalised research conducted under a KMT framework via principles of initiation (who asks the question), representation (whose knowledge/s are represented in the research?) legitimisation (whose realities are constructed?) and accountability (who is the researcher accountable to and how will the research be disseminated?). Pihama, Smith, Taki and Lee (2004) outlined practices of KMT as te reo me ona tikanga (access to cultural, social and economic resources), mana (control, power prestige), tapu (potential), tika (what is right and proper), pono (integrity), aroha (love, compassion, self-worth, respect), tino rangatiratanga (self determination), ako Māori (recognising Māori ways of learning and teaching), Kia piki ake i ngā raruraru o te kainga (recognising Māori socio economic disadvantage) and whanau (collective responsibility). On a more practical level, Smith (2003) and Cram (1997) have delineated culturally ethical research encounters under a Kaupapa Māori framework (see Table 3 below).

Table 3: A community-Up Approach to Defining Research Conduct

Cultural values	Researcher Guidelines
Aroha ki te tangata	Meeting in spaces determined by participants
He kanohi kitea	Meeting face to face
Titiro, whakarongo...korero	Looking and listening before one begins to speak
Manaaki ki te tangata	Researcher as learner. Being generous, sharing results
Kia tupato	Being cautious. Cultural safety and being reflexive. Understanding power relations
Kaua e takahia te mana o te tangata	Do not trample on the mana or dignity of a person. Being transparent and not paternalistic about the research process.
Kaua e mahaki	Do not flaunt your knowledge. Sharing knowledge without being arrogant.

Whanaungatanga is a core principle of KMT (Bishop, 1996; Wihongi). Pa Tate (1993) defined whanaungatanga as, *whanau* - to birth, *ngā* - the, *tanga* - collective. Whanaungatanga allows all key stakeholders to define both present and future commitments in reference to each other. Whanaungatanga is inherent in the relationships between the researcher, participants, research advisory groups, the researcher's own iwi, the participant's iwi, the institution or body that has mandated the research and ultimately any individual or agency that will access the research once it is disseminated. By reading this thesis you are engaging in the whanaungatanga of the research.

The principle of whanaungatanga recognises the researcher as part of the research process. The researcher is a subjective participant as opposed to objective observer. Examples of whanaungatanga in practice include: consultation with iwi (one's own and any that will be included in the research) before, during and after conducting research; holding hui to discuss research questions, results and implications; voicing and resolving conflict during the research

process; and as a researcher, understanding one's role as tuakana/teina (older or younger sibling), manuhiri/tangata whenua (guest or host), wahine/tane (female or male) and so on. Whanaungatanga also protects those involved in research. For example, power displacements inherent in research can be addressed by first meeting in the participant's own space, such as their house or marae, as opposed to a formal interview situation. This places the researcher in the position of manuhiri (guest) and may provide the tangata whenua (participants in this case) increased opportunity and confidence to express their questions and concerns in regards to the research.

4.2.3.1 On being a Kaupapa Māori researcher

Kaupapa Māori research places significant emphasis on the researcher and their journey. It is evident in Kaupapa Māori research that authors share personal characteristics such as their iwi affiliation and often times their personal journeys that led them to conduct their research. This requires the researcher to understand their own identity and how the process of research moulds one's constructions of themselves and others throughout. Smith (1999) argued that Kaupapa Māori research is "undertaken by a Māori researcher, not a researcher that happens to be Māori."

Linda Smith (2003) recognises the unique issues Māori researchers face. She refers to the conflict inherent in conducting kaupapa Māori research within the context of academia that is largely founded upon "the denial of our existence as Māori," (p.3). To address this dilemma, Māori tend to conduct research in a manner that makes it their own. Māori position themselves within the text, share personal narratives and celebrate their identities. We liberate ourselves (and hopefully our participants) through the process of research by centering our stories as facts, truths and realities (Pihama, 2001).

I have attempted to balance the priorities of academia and te ao Māori within my own research. At certain times during the beginning of my research there were parts of me that I tended to suppress in order to feel heard and accepted within a particular environment. In effect I was trying to reconcile two different worlds. A Kaupapa Māori process allowed me to bring the competing values of the Māori and academic paths to the forefront so that these were able to be consciously resolved. This process enabled me to walk ahead as a whole person, drawing upon

the strengths from both worlds. Outlined in Table 4 below are some of the dimensions that I attempted to negotiate.

Table 4: Kaupapa Māori Research: Finding a balance

Māori path	Pākehā path
Life experience	Academic experience
Interdependence	Independence
Oratory skills	Reading extensively
Time accommodates task	Task accommodates time
Protection of knowledge	Dissemination of knowledge
Subjectivity	Objectivity

Life experience versus academic experience:

> "E kore te kumara, e kore mo tana reka."
> "A kumara never speaks of it's own sweetness." (Māori proverb)

Within academia, achievements are general expressed in a very public manner. The signifier before one's name being Doctor, Professor or Emeritus Professor indicates the level of academic achievement. I have found within academia, being a young Māori PhD is generally looked upon as positive. The faster you get there the better. Researchers within academia will often tell each other of their own publications and qualifications, providing lists of their credentials (via academic CV's and websites) and share their articles as an indication of their respective "sweetness" (in reference to the whakatauki/proverb above). In contrast, on the Māori path,

there is no fast track to the position of kaumatua or kuia. You just have to listen and learn as much as possible during the span of your lifetime to get to this position. One does not gain respect just by virtue of being old, but is judged on the role one performs in the community and the contributions they have made. This judgement is for others to make. In this sense, a kumara never speaks of it's own sweetness.

Interdependence versus independence:

> He aha te mea nui o te ao. He tangata, he tangata, he tangata.
> What is the most important thing in the world? It is the people, the people, the people.

The above whakatauki brings us to the next contrast in values. The Māori path values interdependence while the Academic path values independence. In order to evaluate my preparedness to conduct a PhD, the academic path focused on my internal attributes of commitment, motivation and even my ability or willingness to isolate myself for long periods of time. The major question on this path was, "am I independent enough to take on this task?" Alternatively, within the Māori community the pertinent questions were, "do you have whanau and community support?" and, "Are you willing to work with them in a reciprocal manner?"

Oratory versus written skills:

> Ko te kai a te rangatira he korero
> The food of the chief is his words.

Even though Māori have become skilled writers since contact with Europeans, our knowledge was traditionally transmitted in our spoken words and the carvings of our meeting houses. A good speaker was, and still is, considered a powerful person as indicated by the above proverb. When recruiting, consulting and interviewing, one must meet face to face and talk, *kanohi ki te kanohi*. I had to be careful about what I said and respect issues of tikanga while doing this. I also had to be confident to speak publicly in various settings with a wide range of audiences. Within the Māori path, my oral examination was at the beginning of my research, not at the end. By way of contrast, I have found that the academic path places a premium on the written word,

especially for a PhD. In terms of outputs of the research, information will be disseminated (via reports, and journal articles). However, I believe the greatest benefit will come from the korero and the seeds planted through human interactions when I discuss the findings in public forums within the Māori community (see section 7.9).

Time accommodates task versus task accommodates time:

Within Māori meetings, time accommodates the task. Māori meetings will extend time until all items on an agenda are addressed. Some meetings may extend to a full day. The meetings I attended for this research included mihimihi (introductory speeches), whakawhanaungatanga and the sharing of kai (food) before I commenced the discussion of the research. One meeting took us all day to establish our links and share values and stories that brought us to the same place. I came back a second day to actually discuss my research. In an academic setting, agenda items are structured to fit an allocated time frame. Within the university, my meetings have tended to be limited to an hour.

Protection versus dissemination:

> Ka tu mai a Toki, ka ki, "Emea ana koe, kua oti ngā tohunga Pākehā te hahae I te kahu o te Ao? Ka ki atu au, "Ki taku mōhio, ae." Ka ki mai a Toki,"E taea e ratou te tuitui?" Ka ki atu au, "Ki taku mōhio, kao." Ka ki mai ano a Toki, "Na, koia tena te mate o te whangai i ngā māutauranga tapu ki ngā tutua, ka tukinotia i a ratou."

A loose translation of the above story relayed by Māori Marsden (2003) is as follows. He was asked about the Atomic Bomb by his elders. The only way in which he could describe the bomb in Māori terms was that it could tear the fabric of the universe. One of the elders replied, "Do you men to tell me that the Pākehā scientists have managed to render the fabric of the universe?" He replied, "yes". Another question, "I suppose they share their knowledge with the politicians?" Again, the reply was "yes". The elder then asked, "but do they know how to sew it back together again?" The answer this time was "no". To which the elder replied, "that's the trouble with sharing such tapu knowledge. Tutua [politicians] will always abuse it".

The academic setting is based upon the dissemination of knowledge. Academics store their publications in public libraries and on the internet. In contrast, Māori knowledge is about the

protection of, and rights to, knowledge. Wholesale public access can diminish the tapu nature of knowledge. Our kaumatua/kuia and tohunga are the libraries and protectors of our knowledge and they disseminate it in a manner that strives to maintain and uphold it. I constantly held the issues of protection and dissemination at the forefront of ethical decision making within this research (see section 7.2 of discussion).

Subjectivity versus objectivity:

> We do not have the luxury of being objective, we live in the communities that we research (anonymous Māori researcher)

While academia is invested in establishing the objectivity of researchers, Kaupapa Māori researchers are, by definition, part of the communities they research. I returned to my rohe (iwi area) to conduct a number of interviews. Each time I called my nanna she would tell me of another participant she met at the last hui (meeting). From a Kaupapa Māori perspective, subjectivity enhances (rather than diminishes) the validity of the research. The reliability of the information is not necessarily a priority. We are not invested in the reproduction of past research and findings. It is impossible to research the same sample, with the same variables and get the same result. Each sample and individual is different, has unique relationships and interactions with researchers and all constitute a unique space and time. For example, Māori believe in a concept of *ahua*, the general feeling in the room as a function of the space, the people there and other spiritual entities. The *ahua* of a space cannot be replicated. In this sense, KMT is practical and invested in making connections to, rather than reproductions of, previous research.

4.2.3.2   KMT in practice

Balancing these priorities is a task of the Kaupapa Māori researcher. It is generally accepted today that our knowledge can and should be shared nevertheless, striking a balance is required, "in now managing the interface between Māori and European societies, the issue for Māori may not be simply which way is right but how to find the balance," (Durie, 1998, p. 4).

I attempted to align these values through the establishment of the rangahau whanau (advisory group. The rangahau whanau represents the practical aspects of the theory behind KMT. To

increase the balance between these two worlds the Advisory Group (see section 5.2.1 for more on the advisory group):

- Met in both Māori and academic spaces

- Included Māori community members and Pākehā and Māori academics

- Utilised both Māori and Pākehā language

- Shared knowledge between both groups (introducing both Māori and Pākehā concepts and references)

- Utilised Māori and Pākehā structures for the meeting. For example, we started meetings with a karakia and mihimihi. We also had a written agenda and set the time frame for completion at two and a half hours instead of one hour, or a whole day.

During the first meeting, a great deal was learned about the wairua (spirit) of my project. The kaumatua of the rangahau whanau shared the story of a visit he had from my deceased grandfather. My poppa came to him late at night, he did not say anything, instead he just nodded. We all agreed that the visit from my poppa suggested we were on the right path. This was the most important form of ethical approval I received.

By attempting to resolve the competing values of the Māori and Academic path, this project also addresses the issue of balancing the objectives of two worldviews and recognising the reality of the world in which Māori live today. In this vein, the following section will outline the process undertaken to find a psychological theoretical framework to compliment and parallel KMT.

4.3   FINDING A PSYCHOLOGICAL THEORY

> Indigenous methodologies are often a mix of existing methodological approaches and indigenous practices. The mix reflects the training of indigenous researchers, which continues to be within the academy, and the parameters and common sense understandings of research that govern how indigenous communities and researchers define their activities. (Smith, 2003)

In line with the title of this research "standing at the crossroads" this research positions itself at the intersection between two worlds, te ao Māori (the Māori world) and te ao Pākehā (the Western world). In order to embody this position, two theoretical frameworks were selected to represent how Māori and psychological thought can enter into a dialogue together.

Before deciding to use Personal Construct Theory (PCT), a number of additional theoretical frameworks were investigated and/or piloted. Narrative methodologies were primarily considered as mātauranga Māori is often embedded within stories or narratives (Jahnke & Taiapa, 1999). Mankowksi and Rappaport (2000, p.490) refer to the importance of narratives within spiritually oriented cultures by stating:

> Storytelling vitally contributes to the survival and development of spiritually based communities. If experiences are not narrated, they are more likely to be forgotten and therefore, unavailable as resources for instilling hope and inspiration, deepening tradition and a sense of history, or coping with and changing negative personal or social conditions.

While it will be evident in subsequent chapters that narratives are indeed an inherent part of the research results, this method for interviewing and analysis was considered unsuitable for the initial stages of the research. During consultation I was advised that asking participants directly about their experiences would be too personal during the first stage of interviewing (see section 5.2.1). Narrative interviews were recommended as a second stage once I had the opportunity to establish a relationship with participants; this was not achieved as the first stage resulted in a significant amount of narratives.

I also considered adopting a phenomenological approach to the research. Two major factors led to phenomenology being discarded. First, much of the literature indicated that the process required for a phenomenological inquiry was extensive (most studies appeared to interview participants three or more times) and may have been outside of the scope of this research (Moustakas, 1994; Polkinghore, 1989; Schweitzer, 1983). Second, the interpretative process of phenomenology seemed contradictory to KMT. The phenomenology of bracketing the values and beliefs of the researcher and rendering these beliefs independent of the construction process was not desireable. For example, "Hursserl's interest in God was in describing the *experience* of God while treating as inadmissible beliefs concerning God and the divine nature because they

were to be bracketed as part of the phenomenological method,"(Devenish, 2002). The aim of this research was to access the beliefs and values that influenced one's interpretations of their experience.

4.4 PERSONAL CONSTRUCT THEORY

4.4.1 Emergence in the field of psychology: knower and known cannot be separated

George Kelly first outlined PCT in the 1950's (Kelly, 1991). Kelly's theory was largely influenced by his own experience as an engineer and psychotherapist (Kelly, 1969). PCT presented a radical alternative to psychology in the 1950's by describing the individual as an active agent in making meaning of their experience. In essence, the individual and events they encounter are integral. According to PCT, individuals have their own unique construction system derived from their personal experience of the world and they use this system to interpret, predict and encounter experiences.

4.4.2 The experience cycle

PCT is not only interested in the constructs people hold, but also the *process* of construction. The experience cycle describes a validation process undertaken when an individual encounters an event (items, people, experiences). The individual first *anticipates* the event with the use of their personal constructs which can limit or enhance the range of anticipations one has for an event. Norton (2006, p.22) stated "we can only learn what our construct system allows us to see in events." The individual then makes an *investment* in the outcome before they *encounter* the event. The stage of encounter is also influenced by the constructs held by others in their environment. Group reactions can serve to either validate or invalidate one's anticipatory constructions of an event. The individual consequentially experiences either *confirmation or disconfirmation* of their predictions.

During the process of construction a number of questions arise: are the constructs elicited able to assist a meaning making process? Does the experience *fit* the constructs used or (more appropriately), do the constructs *fit* the experience? Are the individual's personal constructions congruent with the constructions of others around them at the point of encounter? Is this a

novel experience that does not fit neatly into any of the constructs available to the individual? The individual is also interested in whether the constructs they have chosen help to predict the outcome of a given event. Based on the outcome, an individual may have to undergo a *revision* of their construct system. New constructs may need to be developed; some constructs may need to be loosened so that they apply to a wider range of events. Some constructs may even need to be discarded if they are outright invalidated.

It is important to recognise the impact of social, cultural and historical context on the construction process. Colquhoun and Martin (2001) refer to the distress and anxiety of holding certain core constructs that are threatened with invalidation by the constructs of others. It is argued that one will seek out groups for validation, especially when their superordinate (core) constructs are at strong variance with those held by dominant groups. Norton further postulated that ideologies of dominant groups can affect one's potential for constructive creativity by prioritising certain narratives about history and preventing others. Parker (1992, p. 103) argued, "institutions do not simply structure social life, they also constrain what can be said, who can say it, and how people may act and conceive of their own agency and subjectivity." This assertion draws strong parallels to the core principles of KMT that aim to uncover hegemonic practices in the gathering and sharing of knowledge. The implications for this research are that schizophrenia is recognised as a construct that is privileged by dominant ideology when talking about a particular range of experiences. This construct has also served to suppress indigenous ways of understanding and influencing the same set of experiences.

4.4.3 PCT: philosophical position

While PCT is based upon a unique philosophical position (Kelly, 1991), connections can be found in other philosophical orientations. Kelly developed the term 'constructive alternativism' to define the underlying philosophy of PCT. In this sense, PCT draws strong parallels to constructivism. Both are invested in a meaning making process and acknowledge there are always alternative constructions available for a given event, object or experience. It is via these alternatives that individuals are recognised to posess the agency for reconstruction. Kelly also made connections to empiricism as individuals are considered scientists in the way in which they

make hypotheses about events, tests their validity and reliability and revise their tools if they prove to be less useful than expected. PCT also draws parallels to the phenomenological concept of *intentionality* based on the relationship between the world, constructs and events (Butt, 2003). Narrative constructivism resonates with PCT in that throughout our lives "we are making meaning and constructing, not just uncovering our psychological realities," (Hoyt, 2002, p.280 see also Vinney, 1992). While PCT relates to a number of intersecting philosophical and psychological positions, the principles of PCT present a number of unique contributions.

4.4.4   PCT Corollaries

PCT is primarily based on 13 core principles or 'corollaries'. These corollaries helped guide the interview structure, interpretation and presentation of the data within this research. Only the aspects of the corollaries that directly relate to the current project are outlined. Firstly, a brief description of each corollary will be provided. The reader will then be presented with the relevance of these corollaries to the questions and aims of current research in Table 5.

The *Construction Corollary* posits that events are never identical; if they were they would lose their identity. We therefore construct events based on their similarities and differences. We judge similarities and difference based on our own lived experience. When referring to the construction corollary Kelly stated, "under a system that provides only for the identification of similarities the world dissolves into homogeneity; under one that provides only for differentiation it is shattered into hopelessly unrelated fragments," (Kelly, 1970, p.13).

The *Individuality Corollary* assumes there are no two identical constructions systems. Each personal holds a unique construction system based on their own interpretation of their past lived experiences. Each system is also organised in a unique manner.

The *Organisational Corollary* outlines that constructs are hierarchical in nature. A construct system is made up of superordinate and subordinate constructs (similar to the hierarchy of core beliefs and assumptions). Superordinate constructs are considered to have a wide range of convenience or relevance in terms of their applicability to events, be fundamental to an individual's worldview and be more resistant to reconstruction. Subordinate constructs subsume

the superordinate, apply to a more limited range of experiences and are more readily revised. The *Fragmentation Corollary* posits that some superordinate and subordinate constructs can be contradictory. Kelly also recognised that the organisation of the system evolves and is continually taking new shape. Kelly commented on this evolution:

> Now it so happens that a person must occasionally decide what to do about remodelling his system. He may find the job long overdue. How much can he tear down and still have a roof over his head? How disruptive will a new set of ideas be? Dare he jeopardise the system in order to replace some of it's constituent parts?...our view is that it is not consistency for consistency's sake or even self-consistency that gives man his place in the world of events...If he acts to preserve the system, it is because the system is an essential chart for his personal adventures, not because it is a self contained island of meaning in an ocean of inconsequentialities." (Kelly, 1991, p.41)

The *Choice Corollary* refers to an individual's ability to choose the construct that increases the utility of their construct system as a whole. In sum, a construct will be chosen based on how well it *fits* with the predicted outcome of an event. In this sense, individuals have agency over the constructs they use as well as the ability to reconstruct their experiences.

The *Range Corollary* assumes that constructs are only relevant for a finite range of events or experiences. To access the range of convenience of a construct, participants should be asked to describe other experiences or elements that may be interpreted under the same construct. Individuals can also be asked for examples of experiences that do not apply to particular constructs. This method was used within the current project (see interview schedule in appendix D).

The *Modulation Corollary* prescribes that the range of convenience of a particular construct can be modified. Permeability refers to the flexibility of constructs to allow for new experiences to be construed within it's framework. According to this assumption, change takes place when we have the capacity to embrace new experiences or elements within our current constructs.

The *Commonality Corollary* assumes that constructs can be similar between people and groups however not identical. Kelly recognised that similarities can occur on a number of levels such as in experience, age, expectations, constructs and culture. Kelly argued that similarities in

construction, rather than simply being exposed to similar events or experiences are what define culture.

> People belong to the same cultural group, not merely because they behave alike, nor because they expect the same thing of others, but especially because they construe their experience in the same way. It is on this last similarity that the psychology of personal constructs throws it's emphasis, (Kelly, 1991, p.66).

The *Sociality Corollary* indicates the process of construction is social to the extent that we construe another's constructions. Social processes are argued to be about understanding another's outlook rather than assuming their outlook. In this vein, Kelly stated the PCT involves "interpersonal understandings, not merely a psychology of common understandings," (Kelly, 1991, p.67).

In addition PCT posits that constructs can affect the course, content and outcome of experience. Kelly (1991) indicated "not only does one's network of hypotheses reflect one's experience of the world; the hypotheses also come to influence and condition it." As already mentioned in Chapter One, a Google search was conducted on the construct "schizophrenia." To understand more about how this construct may affect one's lived experience the associated words used to described schizophrenia were gleaned. Some of these constructs were "chronic and disabling", "devastating", "disease of the brain", "frightening" and "severe disturbance." The use negatively loaded terms are alarming if one considers the aforementioned principle of PCT. If the words we place upon experiences can affect their course, content and outcome, then how are the constructs associated with schizophrenia affecting individuals' experiences of this diagnosis today?

Additional implications of PCT on the current project in terms of the aims and questions of the research are outlined in Table 5. It is evidence within this table that PCT draws strong parallels to principles and questions derived from KMT.

Table 5: PCT principles in relation to current research aims and questions

PCT principles/philosophy	Current research aims and questions
Validation-invalidation in social context:	Aims: Challenge dominant knowledges that silence others. Recognising context has the power to either validate or invalidate one's constructs. Questions: How has the medical model affected Māori ways of constructing their experience? What environments are validating or invalidating for Māori?
Construct Corollary Choice Corollary Modulation Corollary	Aims: Recognise tino rangatiratanga. To acknowledge an individual's agency to *choose* constructs based on what is similar and or different to their own lived experience. And, to understand more about the *process* of construction Questions: What constructs do Māori choose and how is this related to their lived experience? When they chose a construct/s, how does this affect the actual or perceived outcome of the event?
Individuality Corollary	Aims: Recognising diverse Māori realities Questions: What are the constructs used by various groups and individuals do these differ?
Organisational and fragmentation corollary	Aims: Recognising constructs may emanate from larger belief systems. Questions: When constructs are used such as mate Māori, how are they related to wider or superordinate spiritual/cultural beliefs?
Range Corollary	Aims: To understand the range of experiences that are interpreted as cultural experiences or illnesses for Māori.

	Questions: Where do the boundaries lay between what is considered a Māori experience or illness and a psychiatric illness, if any exist at all?
Commonality Corollary	Aims: To recognise culture as integral to understanding experience decifer
	Questions: What are commonalities between constructs shared by participants?
Sociality Corollary	Recognise research is not a pure representation of constructs but an attempt at making meaning of another's meaning. The researcher is subject and part of the data.
Constructs are not independent of experience	Aims: Recognise constructs affect the course, content and outcome of experience.
	Questions: How do psychiatric constructs affect the experiences differentially to Māori constructs?

4.5   SUMMARY: KMT AND PCT UNDER A QUALITATIVE PARADIGM

This chapter outlines three broad frameworks that were utilised in the development and implementation of this research. The underlying principles and assumptions derived from these frameworks are:

- We all have subjective understandings of reality that are shaped by our lived experience.

- Internal meanings are investigated (from within the cultural context) as opposed to external observations.

- The process of construction is influenced by personal, social, cultural and historical factors.

- The researcher and participants are subject rather than object.

- Individual's have agency (self determination, tino rangatiratanga) in their construction of reality.

- Change can occur on an individual, social and political level through reconstructive processes.

- Current medical constructions have come to the fore as a result of specific social political and historical events that determine the distribution of power *not* because they represent universal and essential truths.

The overall theoretical orientation of this research represents a means by which Indigenous and Western theory are able to compliment each other. The methodology of this research aims to align to the title bestowed upon it, Ngā Whakāwhitinga by incorporating and acknowledging Kaupapa Māori and Western psychological theory. This vision is in accordance with the recommendations of Sir Apirana Ngata, a well respected Māori researcher:

> E tipu e rea mo ngā ra o tou ao.
>
> Ko to ringa ki ngā rakau o te Pākehā hei ara to tinana.
>
> Ko to ngakau ki ngā taonga a o tipuna hei tikitiki mo to mahuna.
>
> Ko to wairua ki to Atua nana nei ngā mea katoa.
>
> Grow up and thrive for the days that are destined to you.
>
> Your hands to the tools of the Pākehā to provide sustenance.
>
> You heart to the treasures of your Māori ancestors as a diadem for your brow.
>
> Your soul to God, to whom all things belong.

5   METHODOLOGY

I understand that methodology sections are traditionally limited to a description of what occurred during the research itself. However, Kaupapa Māori research holds a broader view of the method. To demonstrate this view, I have chosen to include a description of a somewhat layered journey. The first stage is entitled, "Who am I?" Within this section I will outline my personal journey leading up to the research (including the journey of some of my whanau and tupuna). This aspect of the methodology aligns to notions of "reflexivity" where the values, beliefs and role of the researcher are made explicit (Mead, 1934). The next stage, "Where did I want to go?" outlines the development of the research aims and questions. The final stage, "How did I get there?" documents and reflects on the journey of the research itself (including recruitment, interviews and analysis of the data).

5.1   WHO AM I?

I am a 28 year old, Māori, female, born and raised in Australia until I was 18 years old. My mother was raised with nine other siblings in a rural area in New Zealand. My grandmother, Maria Taitimu, is of Te Rarawa descent; her hapu (sub-tribe) is Te Uri o Tai. She was raised in a family with 21 children (to my knowledge 15 survived through to adulthood), all born to my great grandparents, Matewhiro (nick named mama goose) and Waata Hunia. The name "mama goose" is spoken on our marae in a respectful and, at times, fearful way as she was reportedly a firm woman. I often stare at a photo of Matewhiro that is placed on the wall in our marae (Morehu Marae) wondering about her life and the significant changes she must have faced with the coming of the Pākehā. Before mamma goose, my great-great grandmother, Riperata Ngarangi, had the role of the community midwife and undertaker. My grandmother recalled that Riperata would prepare all of the bodies after death *and* delivered most of the babies in the area. She was part of the beginning and end of many lives in Pawarenga. My grandmother recalled a time when Riperata was preparing a body after death. My grandmother heard Riperata talking to the body and asked, "why are you talking to them when they can't hear you?" Riperata replied, "They can hear me, their wairua is still here." It is a common belief that the wairua of the dead will remain with the body for a few days until various rites have been completed.

Riperata's father, my great-great-great grandfather – Tarapatiki - is a well-respected tohunga from Pawarenga. I have heard various stories about my tupuna and all indicate he was a man of great mana. When mama goose was a little girl, she and her siblings would hide in the bushes to watch Tarapatiki bathe in the river each day. When he entered the water, stingrays and flounder would gather around him, a spectacle for the children, as they would see splashing everywhere. These two aquatic beings are *Kaitiaki (*guardians) in our family and it remains a good omen to see one. The tohu (sign) on the front of this thesis represents a stingray. Placing this symbol on the front of this publication ensures it's protection. I have been told Tarapatiki had the knowledge and power to heal. I have heard many stories about this including instances when he was able to deflect makutu.

My grandmother attended a Catholic Convent school in Pawarenga. They were restricted from speaking Māori. My grandmother recalled with irony that she learnt to lie at convent school to protect her and other students from punishment. She recalled one student whose hands were deformed from repetitive beatings. My nanna recalled that Māori beliefs in things such as tapu and rongoa were suppressed and punished by the school or the church. She noted that even the Māori priests suppressed such beliefs until more recently. As an example of this suppression, she can remember a time when her leg became severely infected (despite Western medication) and the doctor stated they would have to amputate it. My great grandfather tried to reason with the doctor and asked if he could try and heal the wound with rongoa. The doctor did not like this and wanted to proceed with the amputation. My great grandfather took my grandmother home in anger declaring she would not lose a leg. Shortly after, the doctor turned up at the house with Social Services to take my grandmother away. My great-grandfather refused to hand my nanna over and chased them off the land (with force I believe). They both hid for a while in fear of nanna being taken away. My nanna recalled a ritual several times a day where a particular plant was boiled and the warm water poured over her wound. After a while (a few weeks I believe) the "poison" (infected fluids) gushed out of her leg through an opening at her knee (she still has the scar) and the swelling immediately subsided. Shortly after, she fully recovered, and, she states with amusement, "I still have my leg!"

After my grandmother and grandfather married, they moved from Pawarenga to Kaukapapa (still rural but closer to Auckland) in the hope of a better education and future for their children. While living in Kaukapapa, my grandfather worked for the local dairy board as a driver for many years until his retirement in 1980. Two of my uncles also worked with him. My mother and her eight brothers and sisters were one of the only Māori families in their school. The community was mainly Pākehā dairy farmers. While it was no longer legally enforced, they were not allowed to speak Māori at school. My mother recalled a story from primary school when the principal would not let them (the Māori children) swim in the pool. My grandmother told a Pākehā neighbour who was outraged and stormed down to the school to discuss the issue with the principal. During this discussion the neighbour supposedly threw my mother into the pool to

make his point, clothes and all. In general, my mother found school boring and left as soon as she could at age 14.

When my mother was in her early twenties she met my father (who was an Australian on a surfing trip) and moved to Australia, as did many Māori of that generation. Australia had increased job opportunities and not to mention more sun! My father, being the practical joker, told my mother there were ants called "bull ants" in Australia (which there are) and they are as big as bulls (which they are not). Being from a very small town, I think my mother believed him, if only for a while. My mother did not bring me up in what I would call a traditionally Māori sense. We did not say karakia; I did not learn te reo. However, upon recollection there were aspects of our upbringing that were distinctly Māori. Primarily, we knew a number of other Māori whanau on the Gold Coast through playing sports with them and school. On one occasion, my brother had a girlfriend at age 11 or so who was a Proctor. When I told mum she looked very alarmed and told Dean she could be our cousin! She ended up being out 3rd cousin. We identified strongly with other Māori whanau, in a way that was not entirely conscious, by forging strong friendships and a healthy competitiveness in sports. Another aspect of my upbringing I recall with warmth was that we always had other children from the neighbourhood at our house, especially those who were having a hard time. Even though our family had it's own issues and we lived week to week financially, we fed and housed a number of other children at different times. While this is not uniquely Māori, this was part of my mother's upbringing as a Māori and I think it influenced her practice. We were told such things as "always set an extra plate at the table," and "never turn up at another's house empty handed." These are values my grandparents instilled in my mother. Further to this, mum would always tell us stories of "back home". She told us of Opo the dolphin from up north, of her rural upbringing and funny stories about her brothers and sisters. We visited New Zealand only once while I was growing up although we met many family members when they came to the Gold Coast for holidays. After finished high school, I moved in with my Aunty in New Zealand in the hope of doing my degree here. This was my big trip abroad (not too far but at the time it felt like a huge leap). I am grateful my Aunty talked me into coming back. Only now can I appreciate the profound effect the move back here has had on my identity as Māori.

During my degree I began to learn more about myself by visiting my grandmother (who moved back to Pawarenga with my poppa in the 1980's) and family up north and connecting with aunties and cousins living in Auckland. In addition, there were ways in which I approached my learning at university that did not neatly "fit" with academic processes. I did not agree with many of the ways in which psychology and sociology was constructed and taught. My expectations of the learning I would engage in were not met. I thought psychology would challenge me in other ways than trying to stay awake! During my study, I became part of the Psychology Māori *rōpu (*group). Finally I was having conversations with people who I felt understood and shared certain values. These individuals also felt alienated from the materials taught in classes. Only once I attended university did I become more conscious of my own beliefs and how these differed from "mainstream" or scientific perspectives. As outlined in Chapter Two, the need to define your position and who you are increases when faced with others who are obviously different, or actively opposed, to your beliefs. Through interactions with other students and conversations with my family about my study, I began to realise that the way I thought was because I was Māori. Even though this knowledge was not formally taught to me and I grew up in Australia it was *part* of me.

I have found the difference between Māori and mainstream beliefs and practices to be even more marked since working as a trainee clinical psychologist. Conversations I have had with tangata whaiora and Māori working in mental health settings have repeatedly ended up on the topic of wairua and how this foundation of one's existence is consistently overlooked or misunderstood in their work. This was often discussed out of ear shot from non-Māori lest they be judged or pathologised. Or, when we did discuss these concepts with Pākehā colleagues, they often responded with silence. I am not sure if this is out of respect for our beliefs or sheer fear of talking about things that they don't understand. I think a bit of both. I found it personally astonishing and frustrating in multidisciplinary team meetings that after "commenting" upon the spiritual and cultural aspects of an individual's experience the team would proceed to interpret the person through a psychological or psychiatric framework that intellectualised and decontextualised our experiences.

One example was during a discussion of a young boy who was hearing voices. The assessment information indicated that he had matakite in his whakapapa and that he had requested to see a kaumatua. In the end, safety (in terms of self-harm) comprised the majority of the assessment and treatment. While I agree safety was a primary issue, I wondered if his self harm was secondary to his experiences of seeing and hearing things within a wider social context that understood these experiences as abnormal. He had limited access to cultural resources despite being in a bilingual unit at his school. In his assessment and treatment, cultural issues were only haltingly discussed and not really addressed at all. When I challenged this within the team meeting, I was told the school was going to get a kaumatua. That was it. I thought that considering we were employed for health this was part of our commitment, the school was there for education. At the very least we could try and work alongside the kaumatua to gain a more holistic understanding of this young man's issues. The few cultural issues mentioned rang alarm bells for me that they were central to the formulation and assessment, although I felt powerless to do more as I was only a student.

As my work, life and academic experience continued, I began to consult with members of the Pākehā and Māori community who are considered knowledgeable in the area of wairua and mental health issues for Māori. I had to do a PhD to get registered as a psychologist and I wanted to do something that would address these issues. One of the major concerns raised was the bleak picture for Māori diagnosed with schizophrenia. What was also evident was that many Māori held an abundance of knowledge and understanding regarding the nature of these experiences *and* well established ways of dealing with them. However, these were not meaningfully acknowledged within our mental health system and often used as last resorts if Pākehā treatments did not work.

Therefore, I decided to conduct research regarding Māori ways of understanding experiences commonly labelled schizophrenic by psychiatry. This was my starting point based on my own personal history, conversations with Māori working in and using mental health services and my own clinical experience. I hoped this journey would not only be positive for my own spiritual and educational journey but, in some way, for Māori encountering mental health services and those trying to help them.

5.2   WHERE DID I WANT TO GO?

For this section I am grateful that I took the advice to keep a journal documenting the research journey. At the beginning of my research I began to consult about what aspect of Māori mental health to research. Possibly due to the circles I was in at the time, the issue of Māori being diagnosed with schizophrenia repeatedly arose.

Outlined below is an excerpt from my journal that lists my assumptions about the issues regarding Māori and schizophrenia. I wrote these down during the consultation stage to bring my attitudes and beliefs into consciousness. This is considered an important aspect of qualitative research (Braun & Clarke, 2006).

- Individuals with more contact with mental health would hold stronger biogenetic beliefs and psychiatric explanations of experiences.

- It may be difficult for tangata whaiora to describe their experiences without pathologising them because of the influence of mental health system.

- Pathways of healing or help seeking may be different depending on the individual's construction of their experience.

- That many tangata whaiora believe spirituality was related to their experience in some form and that they were not asked about it or were scared to talk about it.

- That a major difference between Māori and psychiatric pathways is the meaning given to the actual symptoms *and* this meaning can affect the course, content and outcome of the experience

- That non Māori clinicians would hold more biogenetic explanations.

- The diagnosis of schizophrenia would be criticised by many participants and little understood.

- That some participants and/or the general community may be apprehensive to talk about these experiences because of the tapu nature of the experience and the background of the researcher (young, female, Western educated).

5.2.1 Preparing the ground

To develop the research aims and questions I consulted widely within the Māori community. A number of kaumatua, kuia, clinicians, academics and whanau were instrumental in guiding the direction of the research. Overall, I obtained a consensus that this was a very important topic but I also encountered comments such as "glad it's you and not me," "that will be very hard," "this is a huge project" and "you will need a lot of support."

One recommendation from consultation has already been outlined regarding the use of narrative interviews at a second stage of the research. Concern was also expressed around opening myself and/or the participants to negative spiritual experiences due to the tapu nature of the topic. To address this issue I was advised to develop an interview schedule that incorporated the appropriate tikanga to protect myself and participants. This included mihimihi, karakia and the sharing of food; holding interviews in a Māori space or providing participants with a choice; that participants should have the choice to decline answering questions; and the correct support should be available for the participants. For example, I should give participants a choice to have a kaumatua from the research present if they wanted to do the interview in te reo or allow the participant to bring their own support if needed. In terms of wider support, a rangahau whanau (Advisory Group) was recommended.

Further to this, I researched and consulted about an appropriate term to use when describing that range of experiences that might be variously interpreted as psychotic, spiritual or a Māori illness. These experiences have been described in a number of ways in the literature such as numinous, mystical, anomalous, paranormal, transient psychoses, kundali experiences and the list goes on. In consultation with one of my supervisors and the kaumatua and kuia of the research the term "Extra-ordinary experiences" (EOE) was chosen. This was considered to be a neutral term that neither pathologised nor idealised this set of experiences.

The rangahau whanau was established in order to consult about the development, process and outcomes of the research. This is in line with recommendations regarding the development of a "whanau of interest" (Bishop, 1996) or "whanau of supervisors" (Irwin, 1994) in order to have an organisational structure to guide the research. Smith (2003) highlighted that a research whanau is a means to "regaining control of investigations into Māori peoples lives," (p.185). A research whanau represents a space where Māori and research intersect on equal terms. To ensure that multiple stakeholders were represented seven members were asked to be part of the rangahau whanau as outlined below:

- Two supervisors from the university of Auckland one Māori and one Pākehā, Dr John Read and Dr Tracey McIntosh.
- Five members of the Māori community with various backgrounds in Māori health research and development. Two of these members, Uncle Pio and Aunty Kiri Jacobs, were the kaumatua and kuia of the research and played the pivotal role of blessing the research journey at the beginning as well as guiding the process throughout. One member, Dr Jason Turuwhenua, had conducted a PhD in science and held the position of Māori liaison officer in the Science Faculty. Another member, Dr Rhys Jones, was a Māori researcher and lecturer within the Department of Population Health at the University of Auckland. The final Māori member, Naida Glavish, held the role of Tikanga Advisor to the Auckland District Health Board and was the mother of a child who has been labelled with schizophrenia.

- A Pākehā female, Dr Patte Randal, with extensive experience in rehabilitation psychiatry and research interests in the area of spirituality and psychosis. Patte had also utilised mental health services in the past during her experiences of spiritual emergency that were interpreted by psychiatry as psychotic.

The rangahau whanau met together on two occasions. Initially, to establish a pathway forward, reflect upon the journey and discuss the research findings and implications. Throughout the research process I met with individual members of the rangahau whanau between one and five times. At these meetings, both academic and cultural issues were discussed. In general, each individual was consulted for his or her expertise in particular areas. For example, the kaumatua and kuia of the research were asked to comment upon the results section that specifically dealt with traditional Māori concepts, while those who had previously conducted kaupapa Māori research were consulted regarding the method and theory of the thesis. Through the advisory group, the core principles of whanaungatanga and tino rangatiratanga were maintained in the research process. Without this guidance and protection, the research would not have been sustained.

With the help of the rangahau whanau and the wider consultation conducted within the community, a number of research aims and questions arose. All fell under the broad areas outlined below:

- Do Māori really have higher rates of schizophrenia or are the statistics caused by other factors such a misdiagnosis?

- How do Māori understand experiences labelled as schizophrenic?

- What are Māori pathways of healing and how can Māori gain access to these in both Māori and Mainstream settings?

The main research questions were subsequently developed:

- What are Māori constructions of EOE and schizophrenia?

- How do these compare to current clinical constructions?
- Why do Māori think disparities exist in statistics for this diagnosis?
- What implications does this information have for ways in which Māori are assessed and treated in the future?

5.3 HOW DID I GET THERE?

Outlined below are the recruitment procedures, participant characteristics, the process undertaken for pilot interviews to develop the final interview schedule, analysis of the data and issues pertaining to the research process.

5.3.1 Recruitment process

Based on statistics available from Te Rau Matatini (Ministry of Health, 2005), I attempted to gain a cross section of the Māori mental health workforce. This meant accessing both DHB (District Health) and NGO (Non-Governmental) employees. DHB employees were recruited through Māori community networks rather than their services. It was also considered important to access Māori who have encountered experiences commonly labelled schizophrenic from the community, including those who have used mental health services. This would ensure that Māori perspectives that have, and have not, been influenced by psychiatric services could be accessed. Further to this, I also wanted to interview kaumatua/kuia and tohunga for their knowledge of this range of experiences. This was expected to provide a range of constructions from various perspectives and contexts.

After approval and support was gained from the Māori community and within my own whanau, approval was sought from the University of Auckland Human Participants Committee. Following this, a number of avenues were utilised to establish connections with participants. Primarily, Māori networks were asked to disseminate a brochure about the research (see Appendix A). Media was also utilised as a means of accessing the wider Māori community. Two radio interviews were conducted and articles were published in local newspapers and newsletters. In line with Kaupapa Māori research procedures, public hui were also held (one in Auckland, at Waipapa Marae at the University of Auckland and one in Northland, at Te Runanga o Te

Rarawa) inviting general public, mental health workers and consumers to attend and find out more about the research. Finally, NGOs known to work with Māori with a diagnosis of schizophrenia were contacted to gain access to kaimahi and tangata whaiora for interviewing. Managers were the first point of contact in NGOs to gain initial approval and a visit was arranged to first discuss the research kaupapa with staff. After this, tangata whaiora and staff were referred or volunteered to participate. I also interviewed students at the University of Auckland. These participants approached me after seeing advertisements in public spaces, hearing about my research from conversations in Māori spaces or receiving an email via Māori networks.

On all occasions the participants either contacted myself directly or were approached by another person aware of the research to see if I could approach him/her about the study. Once interest was expressed, an initial mihimihi (introductions) meeting was held to establish links, discuss the kaupapa of the research, provide Participant Information Sheets (see appendix B), share food, discuss participants' rights and confidentiality and answer any questions. If they then agreed to participate (all participants agreed after the first meeting) an appropriate time and space was then made for a second meeting to conduct the interview. I met most participants twice; only those requesting to have the introductions and interview in the same session (often due to time constraints) were met with once.

5.3.2 Participants characteristics

A total of 57 participants attended the semi-structured interviews. Demographic data is summarised in the Table 6. As can be seen, almost twice as many females participated in the interviews. The 40-49 year old age group represented the highest number of participants. Most participants were of Māori descent (self identification) while five participants were tauiwi (non-Māori) clinicians. The greatest number of participants belonged to the cultural support worker category. Most managers and cultural support workers were employed within NGOs. All clinicians were employed by DHB services. Nine kaumatua worked either within a DHB or NGO while the rest of this group were part of the wider Māori community. Managers all had more than 10 years experience with mental health services, while clinicians' level of experience varied in an even spread from less than 10 to more than 20 years. Half of the cultural support

workers and over half of the kaumatua group had more than 20 years experience. Tangata whaiora's contact with mental health services also varied with almost half having 20 plus years contact. Overall, participants represent a significant level of experience and contact with mental health in New Zealand settings.

Table 6: Demographic frequencies and percentages of interview participants

GENDER	Male	Female
	21 (37%)	36 (63%)

AGE		
20-29	10 (17.5%)	
30-39	9 (15.8%)	
40-49	15 (26.3%)	
50-59	12 (21.1%)	
60-69	9 (15.8%)	
70-79	2 (3.5%)	
AGE RANGE	20 - 78	

PARTICIPANT SUBGROUPS	TOTAL*	YEARS OF CONTACT WITH MENTAL HEALTH SERVICES
Tangata Whaiora (TW)	16	< 10: 4 (25%) 10-20: 5 (31%) > 20: 7 (44%)
Kaumatua/Kuia (KAU) Current place of work	14 7 NGO 2 DHB 5 Community	< 10: 2 (22%) 10-20: 2 (22%) > 20: 5 (56%)
Cultural support workers (CSW) Current place of work	20 13 NGO 7 DHB	< 10: 3 (15%) 10-20: 7 (35%) > 20: 10 (50%)
Clinicians (CLIN) Current place of work	11 11 DHB	
Psychiatrists Psychologists Nurses	3 (2 Pākehā) 4 (2 Pākehā) 4 (1 Pākehā)	< 10: 3 (28%) 10-20: 4 (36%) > 20: 4 (36%)
Managers (MAN) Current place of work	7 6 NGO 1 DHB	< 10: 0 10-20: 2 (29%) > 20: 5 (71%)
Students (STU)	11	

	3 DHB**	< 10: 3 (27%)

* some participants belonged to more than one subgroup

**Three students were also cultural support workers or trainee clinicians within a DHB service

Iwi identification was gleaned from my own records and interview transcripts that covered our whakawhanaungatanga and mihimihi sessions. Some participants claimed links to more than one iwi which included Tainui, Ngati Whatua, Te Arawa, Ngati Kahungunu, Ngaiterangi, Tuhoe, Ngati Porou, Whanau a Apanui and Kai Tahu. The majority of participants were of Ngā Puhi Nui tonu descent and represented the iwi of Te Rarawa, Ngai Puhi, Ngati Kahu, Ngati Hine and Te Aupouri.

5.3.2.1 Participant sub-groups

The way in which participant groups were defined is outlined below. Each participant group will also be presented with a code. For example, Tangata Whaiora is represented by TW. These codes will be placed after participant's comments in the results section. If a participant belonged to more than one group, both identifiers are placed after the quote.

Tangata Whaiora (TW)

Tangata whaiora (people seeking wellness, consumers) were categorised based on a current or past diagnosis of a schizophrenia spectrum disorder. Tangata whaiora, their support workers or whanau were screened before interviewing to establish whether a previous diagnosis was present. Two participants discussed the issues surrounding their children's diagnosis and journey within the mental health system; their comments will be identified by *"TW-mother"*.

Kaumatua/Kuia (KAU)

It should be noted that kaumatua/kuia (elder) were not categorised solely based on age. Participants who either self identified as assuming the role of being a kaumatua or kuia and/or were identified as such by their community were included in this subgroup. All kaumatua/kuia had been brought up within a rural environment, often on their turangawaewae and were well versed in tikanga and te reo. While many no longer lived in their own iwi area, they maintained

strong whanaungatanga relationships with their community Many had also aligned themselves to urban-based marae as part of their role.

Cultural Support Workers (CSW)

Cultural support workers were categorised according to their identified role as Māori support or cultural workers in a DHB or NGO service. Three cultural support workers were also tangata whaiora. Two kaumatua/kuia were CSW's. While most cultural support workers were working within an urban environment, all were very involved within the Māori community. Indeed a definition of their role is to connect tangata whaiora to Māori community resources.

Managers (MAN)

Managers of mental health services (both DHB and NGO) were categorised in the Managers subgroup. Three managers were also kaumatua/kuia.

Clinicians (CLIN)

The clinician subgroup included psychiatrists, nurses and psychologists, both Māori and non-Māori. Some Māori clinicians maintained strong links to Māori communities either in their urban environment or to their iwi area, others did not. All spoke from a position of a strong cultural identity as Māori. Non-Māori clinicians' comments will be signified by the code "*CLIN – non-Māori*" in the results section.

Students (STU)

The student subgroup comprised of university students enrolled in either a psychology or Māori studies course at both undergraduate and post-graduate levels.

5.3.3 Pilot Interviews

The development of the final interview was preceded by a pilot interview stage. All pilot participants were part of a wider network of Māori health professionals, students and tangata whaiora I had access to. The pilot participants were not part of the final participant group.

Pilot interviews were utilised to trial the draft interview schedule and methods that included a PCT process of triadic sorting, semi structured questions and a Likert-scale questionnaire (see Appendix C and D). Triadic sorting comprised of presenting participants with three small vignettes of experiences and asking them to group two based on how they are alike and different to the third. All of the vignettes of experiences used are included in the items on the questionnaire (appendix D). Triadic sorting is based on the Construction Corollary of PCT that suggests we construe the world using similarities and differences (Kelly, 1991). A literature review was conducted to find an appropriate questionnaire that included a range of experiences. However, most of the scales available had constructs that were culturally loaded (i.e. Paranormal Beliefs Scale, and Schizotypy Scales). For example, "have you ever felt you have magical powers," (Mason, Claridge, & Jackson, 1994) may not be applicable to Māori ways of understanding this range of experiences. Therefore, I developed a questionnaire with a sample of vignettes that would be more accessible to Māori participants (Appendix D). The questionnaire was developed to assess the use of constructs such as normal-abnormal or negative-positive to understand various experiences. It was decided that if a quantitative questionnaire was to be used it should be at the end of an interview where the individual has the opportunity to meet the researcher, ask further questions and elaborate where necessary. This recognises the important role of whanaungatanga and the principle of ka nohi ki te ka nohi outlined by Smith (2003). An integrated method that incorporates qualitative and quantitative paradigms is considered complementary as both in depth information and general patterns can be obtained (Zhang, 2001).

Ten pilot interviews were conducted to assess the interview process. All pilot participants were asked to comment on the content and process of interviews. While participants felt the process of triadic sorting was interesting, they reportedly found the comparisons forced and unnatural. Further to this, the questionnaire was described as too repetitive and it asked the individual to make difficult distinctions that were unable to be made at times (for example, determining if the experience is negative or positive when it could in fact be both). Most pilot interviews lasted between two and three hours. Participants considered this too long and overly repetitive. They believed the answers they provided in the triadic sorts were repeated in the semi-structured questions and again in the questionnaire. After trialling some revisions, it was suggested a smaller

number of vignettes be used and more open-ended questions regarding participants' understandings of the experiences included. Even though triadic sorting was not used, PCT principles still guided the data collection and analysis. For example, the technique of laddering proved useful in interviews to access superordinate constructs and determine the range of convenience of particular constructs. Laddering involves a process of asking the participant for examples of other experiences that may be understood under the same construct *and* for examples of experiences that do *not* relate to a particular construct. This method helps to understand the range of convenience of certain constructs (see Appendix E for questions related to laddering). The questionnaire was also excluded from the next stage of interviewing, as analysis of the first 10 questionnaires did not provide any extra information over and above the qualitative data.

5.3.4 Final interview schedule and process

The final interview schedule is included in Appendix E. Each session began with karakia and a recap of the kaupapa of the research. I also shared with participants the process of the interview and the projected timeline of the research overall. I specifically stated there is only one form of wrong answer they could provide, an answer given because they think it is what I want to hear. I emphasised the centrality and legitimacy of *their* perspective and that this space was non-judgemental and confidential. Consent forms were then signed (Appendix F). Demographic data was then gathered via whakawhanaungatanga.

The interview began with presenting participants both visually (on laminated cards) and verbally with a small vignette of an EOE. For example, "A person hears a voice putting them down and/or telling them to hurt themselves." Seven different vignettes were used to cover experiences that may be construed as auditory hallucinations, visual hallucinations, delusions or disorganised speech within a psychiatric framework (see Appendix E). I specifically wanted to use vignettes that were decontextualised to access the contextual factors participants believed were important. Each participant was then asked various open-ended questions about their interpretation of that experience. These questions are listed below:

- What does this experience means to you /how you make sense of it?

- What do you think might cause a person to experience this?

- What questions would you ask someone who was experiencing this to gain a better understanding of what is happening to them?

- You said the experience means....can you give me examples of other experiences you think are similar? And different?

- What advice would you give this person if they wanted to know what to do?

- Who should they get help from? Why?

- Have you or anyone you know ever experiences this?

The next stage of the interview then asked participants about broader issues regarding Māori and the diagnosis and treatment of schizophrenia. This section was purposefully placed after we accessed participants' constructions of EOE so as not to influence their earlier comments. Participants were asked what the term schizophrenia meant to them. They were then asked what they understood to be the various Māori and/or Pākehā treatments for this condition. Where relevant, I asked participants to comment upon their experience of these treatments. We then discussed current disparities in statistics for Māori diagnosed with schizophrenia in terms of utilisation rates. I asked for participants' opinion on the reasons for the disparities and solutions they may have to offer. Finally, I asked participants what questions they would like to be researched further in the future. All interviews ended with karakia and the sharing of kai to move from a state of tapu to noa.

Not all interviews followed the same course. At times a number of questions were answered in one narrative, others needed more prompting once a question was asked, while others felt they did not have the relevant experience to answer some questions. The interviews in general covered a significant range of concepts, experiences and knowledges. It has already been mentioned that Māori communication patterns often move outwards to greater meanings. This was evident in the interviews. I often followed participants on their journeys in conversation and experienced learning over and above what I would have if I had have held too tightly to my

agenda. One extreme of this form of communication was an interview that lasted from about 10am until 11pm at night. Suffice to say a few tapes were used and eventually exhausted at which point I relied simply on notes. In general, most interviews lasted for about an hour with an additional hour for whakawhanaungatanga and the sharing of kai.

As a venue, participants were given a choice between an office at The University of Auckland's Psychology Department, Waipapa Marae (The University of Auckland) or their work place. Ten interviews were held at the university, 25 at a kaupapa Māori mental health service, 12 in participant's homes, eight in DHB services, one in a quiet corner of a park and another in a quiet corner of a McDonalds Restaurant. One interview was conducted as a focus group with five employees (one manager, two kaumauta and two cultural support workers) of a Kaupapa Māori Service who preferred to be interviewed together. The various spaces and methods used were a function of meeting in places chosen by participants.

All participants were asked if they needed support persons or wanted to be interviewed in te reo Māori. Five participants had support persons present and no requests were made for an interview in te reo Māori. There were times when participants and I spoke in te reo (I am at a beginner level). Where clarification was required, participants would often translate for me. I also accessed consultation for the translation of transcripts where required.

5.3.5 Managing and analyzing the data

As already stated, KMT and PCT principles guided the methods that were used for data analysis. For example, rather than expecting the themes to "emerge" from the data the researcher was considered to be an active agent in the analysis process. The following quote alludes to the misuse of the term "emerge" that is so common to thematic analysis:

> The language of 'themes emerging' can be misinterpreted to mean that themes 'reside' in the data, and if we just look hard enough they will 'emerge' like Venus on the half shell. If themes 'reside' anywhere, they reside in our heads, from our thinking about our data and creating links as we understand them," (Ely, Vinz, Downing, & Anzul, 1997, p. 205).

All interviews were audio-taped and transcribed by the primary researcher. This enabled an in depth understanding of the data. Where possible, copies of transcripts were sent to participants

to substantiate their korero and, once feedback was incorporated, they were prepared for thematic analysis. Overall, 15 participants provided feedback on their transcripts. In general only minimal changes were made. For example, one participant elaborated further upon the concept of wairangi mentioned in the interview. Nvivo, a qualitative data analysis package, was utilised to analyse the interview transcripts.

Kingi (2002) referred to the process of thematic analysis in his research as a means to facilitating the development of a conceptual framework from the data. Holloway and Todres (2003) argued "Thematicising meaning" is one method shared across various form of qualitative inquiry. Thematic analysis can be conducted under various theoretical frameworks and has been used in Kaupapa Māori Research in the past (Ihimaera, 2004; Kingi, 2002).

The process undertaken for thematic analysis in this research is outlined in Braune and Clarke (2006). This research utilised an inductive approach where themes were developed from the data (Braun & Clarke, 2006). All transcripts were read and initial coding was based on repeated patterns of meaning. Braun and Clarke (2006) argue that one must determine whether they wish to represent the range of themes inherent within a data set or provide a more detailed account of one theme or a group of themes. The former technique was chosen for this research as it was considered an exploratory project. An exploratory method is required when there is a limited amount of research available in the area. After reading transcripts through twice, over 200 codes were initially developed using Nvivo. Subsequently, maps of the codes were analysed to either separate or collapse each code into 92 sub-themes. Each of these sub- themes were further grouped into 19 higher order themes (outlined in Table 7 on page 149). For example the sub-themes of porangi, wairangi and makutu were grouped into the theme labelled 'Mate Māori: Māori Illness'.

At first, I attempted to group each of the 19 themes into a Whare Tapa Wha framework. However, upon consultation with my supervisors it seemed I was trying to fit themes into separate dimensions when many, if not all, were relevant to all four dimensions of the Whare Tapa Wha model (whanau, wairua, tinana and hinengaro). I then went back to the original 19 themes to find any other patterns and observed that the themes basically fit the structure of the

interview (see Appendix E). For example, participants either talked about EOE and how we heal from them or current disparities in statistics for Māori and what we can do to address this issue. Therefore, the following four categories were developed:

- Making sense of EOEs

- Pathways of healing from EOEs

- Making sense of the statistics and,

- What can we do about the statistics?

These categories were also considered to be more readily accessible in the real world. For example, tangata whaiora accessing the thesis can find other ways in which these experiences have been understood while policy level stakeholders might look to the section for what we can do about the statistics. It should also be noted that in line with Lapsley and colleagues (2002) research, the interpretative process was not limited to the stage of analysis before the written thesis. Throughout the write up, themes were being generated or collapsed as further understanding and analysis of the data was achieved. For example, I develop a further sub-theme for the theme 'trauma' labelled 'trauma and spirituality' as I realised this was a distinct topic that a number of participants referred to.

After the results had been written, each section was given to various rangahau whanau members (depending on their area of expertise) for triangulation and to increase the validity and reliability of the coding. In addition, both supervisors read drafts of the analysis. In response to this feedback some quotes were either removed or moved to other themes. The greatest amount of help was in reducing the size of the results section. My initial draft of the results was about 200 pages long. I found it hard to take out quotes as I thought they all said something different and important. Those quotes finally selected were chosen for their fit with the themes and to provide a range of comments from various participants groups.

Finally, as will be evident in the Results and Discussion section, the data has been interpreted at both explicit and latent interpretive levels (Boyatzis, 1998). Explicit interpretations simply describe or present data as close to the participant's words as possible. Interpretation is kept to a minimum. The results section is considered explicit in that the author's interpretations have been limited to allow the reader to come to their own conclusions regarding participant's comments. It is recognised that the results are not free of interpretations as the thematic presentation of the data is inevitably influenced by my understanding of how participants' comments related to each other. The Discussion section assumes a latent interpretive position by attempting to understand the factors that may influence the findings (power relations, personal and cultural factors), the implications of the findings and how change can occur as a result. The first level describes the *what* of the data while the second aims to discuss the *how* and *why* on a constructivist and critical level.

6   RESULTS

This chapter will present the four categories derived from qualitative analysis (outlined in Chapter Five). The categories are: 'making sense of EOE', 'pathways of healing', 'making sense of the statistics' and 'what can we do about the statistics' (see Table 7 below). Each category consists of themes derived from common patterns of meaning found in the qualitative analysis. Some themes also have lower-order sub-themes. For example, the theme "Māori illnesses" is broken into three smaller sub-themes: pōrangi, wairangi and makutu. Only the categories and themes are outlined in Table 7. Sub-themes will be included within the relevant section of the results.   Themes are ordered for conceptual flow rather than importance or frequency of discussion.

Table 7: Summary of four categories and themes derived from participant interviews

Making sense of EOE	Pathways of healing	Making sense of the statistics	What can we do about the statistics
Common/everyday experience	Mainstream pathways	Urbanisation	Primary prevention
Whakapapa/Tupuna	Māori Pathways	Assimilation	Early intervention
Matakite: Gift	Cultural / Clinical Interface	Racism and discrimination	Tertiary education
Mate Māori: Māori illness		Misdiagnosis	
Trauma			
Haurangi: Drug and alcohol abuse			
Boundaries: Cultural experience vs. Pākehā illness			
Making sense of schizophrenia			
Silence			

While a number of quotes loaded onto each theme only two or three have been provided due to limited length. In addition, some quotes are included in more than one theme. For each theme, the number of participants who made comments is stated. In some instances, all participants were asked about a particular theme. For example, all participants were asked for their understanding of the term schizophrenia. I attempted to ensure that all participant groups were represented in the quotes that were finally chosen to represent themes. The participant groups are identified at the end of each quote. In addition, identifying information has been left out of comments to protect participants' privacy. There are some instances where comments need clarifying in terms of the context of the conversation. At these times I have included information in square brackets within the quote or introduced the context before hand. Non-Māori clinicians' comments have been placed in the cultural-clinical interface section as they are considered key stakeholders of this space *and* most of their comments loaded onto this theme.

6.1 MAKING SENSE OF EXTRA-ORDINARY EXPERIENCES

Table 8: Themes and sub-themes for making sense of extra-ordinary experiences

Theme	Sub- themes	Number of participants coded
Common everyday experiences	Acceptance Validation as real experience	12
Whakapapa / Tupuna	Help during difficult times To get something done Transfer of knowledge Kaitiaki	14
Matakite: Gift	Responsibilities of matakite	19
Mate Māori: Māori illness	Tapu Pōrangi Wairangi Makutu	41
Trauma	Trauma and hearing voices Trauma and spirituality	21
Haurangi: drug and alcohol abuse	Age Drugs and spirituality	30
Boundaries: Cultural experience vs. Pākehā illness	Content Control Context	57**
Making sense of schizophrenia	Diagnostic constructions Biomedical constructions Limited knowledge of diagnosis and biomedical constructions Rejection of the diagnosis	57*
Silence	Withholding one's understanding from Pākehā	15

* All participants were asked for their understanding of the term schizophrenia

Table 8 includes the themes and sub-themes for the category "making sense of extra-ordinary experiences". This section will provide examples of quotes that loaded onto each theme (the total number of participants who commented on a theme is provided the final column of Table 8).

6.1.1 Common everyday experience

6.1.1.1 Acceptance

Some participants indicated the experiences were so integral to their everyday life they did not need to be analysed or pathologised. Twelve participants stated they would not question many of the EOE discussed and merely accept this as a part of life for Māori.

For me hearing voices is like saying hello to your whanau in the morning it is nothing unusual. CSW

With Māori, it [hearing voices] is nothing to be worried about; it is just a part of who we are. CLIN-Māori

That's [hearing voices] you know a lot of times if it's the same thing as what I've been bought up to believe I'm not going to question it. STU

6.1.1.2 Validation as real experience

Participants also suggested that EOE should be accepted as *real* experiences.

The key thing is that this person is real that is coming to them. It's not like we're making it up. KAU

My understanding of that is that I absolutely accept that if someone tells me that they see someone standing in the room that I can't see that there actually is. They actually can see it. I understand that. KAU/MAN

A lot of them are like me and you, they are not just a ghostly figure. That is why when I see someone else I can't believe that others cannot see them. TW

A number of participants who had themselves experienced seeing people or things described difficulty in determining whether the external event is a real person or a spiritual being.

One case just happened two or three weeks ago. We were in Paeroa, and what happened then was that I was sitting outside on the balcony and I was talking to these people... later on my wife came along and said, 'you been talking to ghosts', because I had said to her, you should bring a blanket out, these people

are getting cold and she came out and looked at me, nothing. She said you know, you have been out here for an hour and you've been talking to ghosts. KAU/CSW

The following themes outline examples of experiences and constructs that are more likely to require some form of intervention, however predominantly within a Māori context.

6.1.2 Whakapapa/ Tupuna

The role whakapapa plays in understanding EOE was discussed by 14 participants, often at length. The majority of these comments were made by kaumatua.

The participant below was asked how he understood negative EOE such as having one's thoughts controlled or hearing distressing voices.

I think when you talk about particular whakapapa you look at whether there is any hara [conflict] in a whanau. Because hara stays around for a long time and sits on the wairua and tries to dig away....With our people usually it is way back. You have to go far deeper. KAU

The following participant was asked how she would understand a person who believes they are ill, about to get ill, or die as a result of being cursed.

if they were willing to share their whakapapa with me, I'd ask about their whakapapa and any stories they might know happened, maybe someone killed another and utu [revenge] was not sought...in the old days it was about balance...and I believe there may be an imbalance there...they need to go home, find out the imbalance and offer the utu. STU

Many participants shared the meaning they derived from learning of people and events in their whakapapa which helped to explain their current experiences.

At one stage I heard from one of my nephews that we were cursed, I wanted to know why and I found it too. It was my great-great grandfather. He left his wife up there and left for the south island. He got down there and he stayed there for a while and he saw this chief's daughter and he asked if he could have this chief's daughter for a wife. He already had one up here. He said, no, he's too old. But because she was adventurous and only young he managed to get her to come with him. She came up but he didn't

167

go back to where his wife was, he moved somewhere else up there. They had 10 kids, that's where it was, it was from his first wife's family. KAU/TW

In my family we had to go back a fair way to get an understanding why all of this was happening now [diagnosis of schizophrenia in family]. We had to visit the place where it started and get some of our kaumatua to talk to them to find out what really went on and then how we could go about finding some sort of resolution or utu. CLIN- Māori

More recent whakapapa narratives and events were also shared by some participants.

My brother died when he was not even a baby, he was still in my mum's stomach and he came away. And I was left in there. I was at my nana and poppas house at the beach, I woke up and I just felt someone staring at me and then I looked up and see this boy... and he looked so familiar. And he was talking and asking how's mum and everything and I was like what?...He's like, I'm your brother...Then I remember mum told me that one baby came away. It was really weird because he wasn't even a baby. It was easier to understand because he was a spitting image of my dad and it was just like really weird. My nanna is a hard out Christian and she said that anything bad can't touch the bible, and I was freaking out, so I went like this [offered him a bible] and he took it and was like [looking confused], he just put it on the table, and I was like, okay, I'm happy with that... I think it was about him moving on because he said that he was really angry at me because he came away and I have a chance to live my life and show everyone that I love them and care for them and that I don't do enough of it...I woke up in the morning and I was in my bed and I thought nah. It can't have been a dream. And I got up and with my nanna, she was out the back and the bible was where he put it. TW

Some participants discussed whakapapa in terms of inheritance of a gift to see and hear things from generations passed (additional comments relating to being gifted or matakite are included in section 6.1.3).

And there was families who were like that. That's when that korero used to come 'he momo tangata he wena', and they were known for that sort of thing and the rest of the whanau accepted they're like that. They come down from a line of tohunga and it's being able to understand those people and still accepting them for what they are and supporting them. KAU

168

I needed to go back and find the stories, it wasn't enough to know I might have this ability because someone, somewhere back in my history was gifted too. I needed to dig down and find the stories and understand how that related to what I was going through [seeing and hearing spirits or ghosts]. CLIN-Māori

The experience of seeing or hearing one's tupuna was discussed by all participants in response to making sense of the EOE of seeing or hearing spirits or ghosts. In general, tupuna were believed to present themselves for specific reasons.

6.1.2.1 Help during difficult times

Many participants discussed seeing or hearing their tupuna as a sign of help during difficult times,

I used to say to my girl, many times you tried to commit suicide and many times you failed, she said to me, mum, I keep seeing the ancestors and they keep saying to me tai hoa [wait] it's not your turn, you can't come before your mother. I said, good job, it is not my job to bury you. I said, I suppose you've given up. She said yeah, no matter how many times I try I am not going to succeed until you leave, I am not allowed to leave before you. Oh well...So it is about understanding why these things are happening. KAU/TW

The woman below had reinterpreted the voices and visions she had during acute states as her tupuna coming to help her.

They come to me when things are about to get bad...they sometimes tell me what to do and if I do it then I get through. I used to think them coming meant I was going crazy again but now I realise that when times were tough, they were there to help me through. TW

6.1.2.2 To get something done

Others understood their EOE as being a request to get a specific task completed. Both participants below indicated that tupuna can at times be very persistent when they want something done. The first participant shared throughout her interview that sometime the experiences are distressing for her as a result of the persistence.

Yep a lot of them have something that needs to be done. You will know when you're supposed to do it, they're not subtle, they will show you what you need to do and they won't stop until you do it. TW

I have them talking to me but because I don't speak Māori, they are speaking Māori. My cousin said I can't understand why you're here [meeting for unveiling for uncle] doing this for uncle XXX, I said cause he told me to do it, he is hoha with all the fighting that is going on between his brothers and sisters still and he hasn't got his roof over his head. She said, 'what do you mean?' I said, 'his headstone', and she goes, 'what's that have to do with you?' I said, 'well he keeps coming to me and telling me to get in there.' TW

6.1.2.3 Knowledge transfer

Others believed EOE were a legitimate means of knowledge transfer from ancestors.

What I am suggesting here is that maybe what is happening for them in their experience and visions and these voices is that this is another ways and means of bringing that knowledge [māutauranga Māori] back. KAU

The statement is that old men will have dreams and young men will have visions. Without the visions the people perish. When we, when people are having visions or dreams and we medicate or ignore it our people will perish because there is no visionary as to where we go on, our people, our values and who we are. KAU/CSW

This one man who came to see me [in a vision], his korero was just out of this world and when I questioned others he was someone from my own family. That is what I was told, it was him teaching me how to do things and what to do... Now one of our whaiora was actually in the room and I had to draw upon what this person had told me... I don't know how it worked. I went and got some water and then I just started praying in words that I have never known, I am not a fluent speaker but this woman thought I could speak...I don't know what I did, all I know is that I started to karakia and waiata, but they were old ancient chants. That is that learning I got from that man, because he said to me the time will come when you know to use it. CSW

170

6.1.2.4 Kaitiaki

Seeing or hearing one's Kaitiaki [guardian] was generally discussed as a positive experience that was related to a sense of protection,

That's choice seeing your Kaitiaki. That would be choice. If there is someone protecting me then choice. TW

Um, for me it's, I don't know maybe it's a need for me to have somebody there. Not somebody there in a physical sense but someone there, it's comfort I think, for me it's comfort.TW

In a Māori context it might be a Kaitiaki that they see, because you know my grandparents were brought up believing in that, having a Kaitiaki, seeing someone no-one else could see. Especially early in the morning, that is the time the wairua are supposed to be walking around.TW

One tangata whaiora believed that Kaitiaki were not present within mental health institutions,

I believe that my Kaitiaki and that will only give me so much when I am in the hospital. It is not an environment for them. They shove needles in you and give you drugs. It's different when you are in hospital to when you are out and walking around with your illness. TW

Another Māori clinician found beliefs in Kaitiaki difficult to support in her work,

That is beautiful. It is [Kaitiaki]. For me as a nurse we have to understand that we don't encourage that kind of behaviour, we try and keep it real for them, it is about the here and now and taking control themselves. CLIN-Māori

6.1.3 Matakite: Gift

The construct matakite, or being gifted, was discussed by 19 participants.

Did you know that over 90% of people presenting with psychosis have reference to a spiritual being, demons, god, Jesus, angels? That is why I believe schizophrenia is an opening to a spiritual realm and it makes sense too because it is our mauri, our life force from Io. KAU

Schizophrenic is like, do you know what a person is when they tell you something, clairvoyants, schizophrenic people are like clairvoyant people, they can tell you stuff. TW

Did we have it [schizophrenia] that much in the old times? No back then it was matakite. KAU

People diagnose it as that thing [schizophrenia], but we would say he was a divine healer. If I ask if a person has these things, what would you call them? We would say a healer. But they say sickness and diagnose KAU/CSW

Another kaumatua uses his position as a cultural support worker to explain matakite and wairua to tangata whaiora in his service:

There is a couple of the guys from over here who are matakite. I've been talking to them and helping them to understand it [wairua]. And they are quite happy now, it doesn't freak them out now. One guy we had here, he is out in the community with his whanau now. He was going through hell but they were giving him pills. I just spent a lot of time trying to explain to him what was really happening in his wairua. Now he's been discharged, he's not on any medication and he understands what is happening. KAU/CSW

The same participant was cautious about *who* he shares these understandings with,

I hear voices all the time and I see people and if they got a hold of me they would probably diagnose me with schizophrenia or something but this is a gift we have, Māori people. Mainstream doesn't understand there are some tangata whaiora in our service that have that gift but I'm keeping it quiet because I know they are going to diagnose them with something else. It's not a sickness it's a gift. KAU/CSW

6.1.3.1 Responsibility

Being matakite was believed to involve roles and responsibilities associated with the gift.

I never wanted to accept it, I said no it isn't, it isn't [matakite] but it wouldn't stop and in truth I knew what I had to do, help my people, I didn't want the responsibility but here I am. They helped me understand it and told me what to do with it. KAU

I think that the right way is, you use it [gift of hearing voices] when you are objective. You've got nothing to gain except to offer help...It's only through my own experiences that I have discovered this. KAU

6.1.4 Mate Māori: Māori illnesses

Mate Māori was described as a Māori illness. Forty one participants referred to various illness states that could be understood as mate Māori.

A number of participants commented on their preference for using constructs associated with mate Māori to understand EOE instead of foreign constructs such as schizophrenia.

I would put schizophrenia with the same thing as pōrangi, pohauhau, wairangi all those different states of confusion. My understanding of schizophrenia is like having two or three states of that confusion. Schizophrenia is so big, it's one word but covers a lot of things. The same applies to pōrangi, pohauhau, wairangi, they cover a lot of things in themselves. But those are Māori words that I know that cover those things, that is mate Māori. KAU/CSW

You know when hearing a voice in Māoritanga there is only two things with mental health, there was only pōrangi and wairangi but now they've got another one, haurangi [under the influence of alcohol or drugs] a new one has come through. There wasn't any such thing as bipolar, schizophrenia, we didn't lock ours up and throw away the key, that's it. KAU

Pōrangi, wairangi meant the same to me. They were off their face. Wairangi was something that affected the person spiritually or physically. Wairangi once had a mental illness stigma to it. Pōrangi was when they got themselves into a state and they didn't listen to anybody and they wouldn't accept they weren't okay. CSW

6.1.4.1 Tapu

The concept of tapu was believed to be integral to understanding Mate Māori. Eleven participants referred to the concept of tapu and it's relationship to Mate Māori.

Ko tapu is only, a tapu is not something bad it is a form of respect. If I say that TV is tapu, people take it the wrong way. Tapu does not mean don't touch, it is a mark of respect, you respect it...you're gonna get hurt or sick or something if you don't respect it. KAU

Even people from the area that the hara may have occurred, like if they have gone somewhere on a holiday and then ever since they had been to that place they have been seeing things or something then maybe they infringed tapu on the place they visited or something. It's dependant upon the kawa of the rohe that they have come from. KAU/MAN

One of our neighbours that lived next door to it [tapu area], one day a bit of rock had broken off and she took it and put it next to her letterbox... just to decorate the garden...the following night her daughter woke in the middle of the night and the woman describes it as it was almost as if she [her daughter] was sleep walking and just walked to the window and was pointing out that she could see dead people in the garden where the rock was placed. So they just put the rock back and did a karakia and it just went away. I guess for that family they didn't even know that they had breached any tapu or anything until that happened and then the woman though oh shit maybe there is something going on there. STU/CLIN

Maybe the have breached tapu and this is why they are seeing these things. I had this woman and...she keeps seeing people dripping in blood, and something was happening at her house where she keeps seeing dead people outside and apparently we got a kaumatua to see her and he said that there were battles that went on there so they blessed her house and stuff and that worked. Even though that was quite distressing for her and she was seeing those horrible visions it didn't mean that she was mentally ill, this was a Māori thing. KAU/CSW

The woman below was discussing her understanding of the experience where a person believes others are controlling their actions and thoughts.

Our belief is that our people are spiritual and it's very very spiritual and that's who we are and something comes in and there's a breach of tapu that shocks you personally, the breach is there and so you are open to all negative spiritual things. KAU/CSW

6.1.4.2 Pōrangi

Pōrangi has been discussed in section 3.1.4.3. To reiterate, this terms has been variously defined as a state of foolishness or a spiritual state of illness.

Within this research participants shared spiritual understandings of pōrangi. States of imbalance between the concepts of "being in the dark" and "being in the light" were discussed as explanations for pōrangi. These comments were made when discussing the experience of hearing distressing voices and acting in ways that are out of ordinary for the person (e.g. catatonic behaviour).

Pōrangi is that the poor person is in darkness, his mind is in darkness. If we go back to rangi and papa [sky father and earth mother] and his mind is in darkness, he doesn't see any light at all, his world is in darkness. KAU/CSW

I did a thing where they talked about papatuanuku and mother earth coming down and you're kept in there with pōrangi ay, in the darkness. It wasn't until the sky father lifted that we were placed in the light. Well that is what happens ay, they get caught in that state of te Pō [when hearing distressing voices]. They are in darkness rather than the light. CSW

There is a word called pōrangi and it is associated with mental illness. Pōrangi is people who don't know, Pō is the night and rangi is the day. They don't know the difference between day and night. KAU

Some participants believed that an individual may become pōrangi as a result of not being recognised by those around them as gifted or matakite.

She died in Carrington hospital, when my grandfather passed away he couldn't look after her anymore. Our family knew that she wasn't schizophrenic, she didn't have a mental illness we were quite clear that she was a tohunga however her immediate family believed that she had schizophrenia and she was in hospital when she died...I think she was pōrangi because no-one recognised her gift as a healer she just needed to be at home with us. I am sure her fate would not have been like it was if this was the case. KAU

6.1.4.3   Wairangi

Wairangi was discussed by participants as a state where an individual's wairua or spirit is not in line with or connected to the mental and physical dimensions of the self. Participants discussed wairangi as being related to dissociative states such as talking in ways that others cannot understand (world salad or tangential thinking) or not talking at all and staring off into space (catatonic behaviours).

When the wairua goes wandering that is wairangi. People are not their whole selves. They do not have the ability to communicate or fully function. KAU

When they have got something wrong with the wairua you find that the wairua is actually off balance and you've got to bring it back through the karakia to get it right again. Then all the korero and whakaaro will start to change. Sometimes with too much Western drugs it is very hard to bring back [This participant was referring to psychiatric drugs as well as illicit drugs]. KAU

One woman expressed her experience of her wairua being disconnected from her physical self.

The main person that was behind me was my father. He passed away in 1998, so he was pushing and I was being dragged through, there were familiar faces and not so familiar faces, and some faces that had been long gone, and getting through that, it actually terrified me, I had all these body sensations. I knew where I was but I felt as though I was somewhere else and that somewhere else was actually in [home town]. I actually found myself standing in [my home town] and I was standing in the cemetery and as fast as I tried to get back, if you can call it get back from there, I was held there, my wairua couldn't get back to my body. TW/CSW

A kuia also expressed her sense of confusion and disorientation while waiting for her wairua to realign with her physical body after it has gone travelling during her dreams.

This [wairua disconnected from self] usually happens for me when I am back on my land, my tupunas land. When I awake I don't know where I am. When I'm coming out of my sleep there is total confusion, I'm trying to look around my room to identify that I am in my room. That has been quite a frightening experience, it lasts about five minutes. How I understand that is that I've been somewhere

and I haven't comeback into my own body for me to awaken. I think it is something more than just a dream. I feel like my wairua has left and it's still getting back. KAU

6.1.4.4   Makutu

Every participant was asked about makutu or beliefs a person may hold regarding being cursed. Many promptly replied that they would accept makutu or curse as a reality or possibility.

I would believe that if they feel that way, somebody has pointed the bone at them whatever, and it is real for that person let's make it real, let's not shove it under the carpet, let's deal with it rather than trying to suppress it. STU

For some people it could be a very real thing depending on the history around that. That needs to be validated, it needs to be. CLIN

Some suggested makutu can affect some who do not even understand the construct.

It poses a huge problem for that person because a lot of the time their belief system is not always congruent with what is happening. Sometimes they don't realise that a makutu has been placed on them, many treatments have been tried and they don't work. KAU

Some expressed a lack of understanding of or apprehension about working with makutu,

When it comes to makutu I don't go there. I don't have the experience to go and investigate makutu. I am not going to go and put myself on the line, I am not talking about within the clinical structure; I am talking about the spiritual connotations of makutu and actually dealing with that. CLIN

I think this [makutu] is a specialised field, you don't want to delve into anything in case there is a flash back or whatever. I would go to someone who is more knowledgeable. I would have to say there is a group of people who can do that. CSW/MAN

Some shared their own experiences with makutu,

Coming through a Māori situation I believe that [Makutu] is real for our people. I am the oldest of eleven... the first two boys drowned in the river and they drowned standing up, that is what my mother told me. The whole thing was, the families from then on were petrified that the boys were cursed. My mother would always send the sisters back to XXX but she would never send the boys, if the boys went back she would take them back herself, she would hold onto their hands only stay for an hour to do the dutiful thing by meeting the aunties and uncles and leave straight after and go to XXX where my father came from, she was petrified for the boys. KAU

Some kaumatua referred to the signs that indicated makutu was involved.

I remember this lady coming to see me about her moko [grandchild] who had makutu, and the moko her voice had changed, it was high pitched, and telling her mother,' you're not my mother'...I was there beforehand, and I couldn't feel anything from the land, I went inside, didn't feel anything... They brought her out and in the door way there was this blonde blue eyes girl, she looked at me and her eyes were black. KAU/MAN

Well it is quite easy how I deal with people, if I'm not too sure, the people show signs, like in their eyes they tell you it is a makutu. KAU/CSW

I believe in a lot of that kind of stuff [makutu] because I have seen it myself, inside my family, outside my family and also in my mahi [work]. I believe that there are some people that are hit in that way...You can tell especially if you can feel a different energy in the room. CSW/MAN

Other kaumatua described various ways in which a makutu can be experienced.

Because you've got different makutu, you've got the whaiwhaia, which is when they get a clothed part of you, clothing or a hair then they curse it, that's whaiwhaia. Then they've got the whakamānawa which is if you are unwell and come to me and I say to you oh gees you had better give me that ring because if you don't give it to me it's going to make you sick and you give me everything, that's whakamānawa that one, that is the worst too. I think people are still nurturing that today. KAU

There is various levels of depth to makutu. And of age. The older it is the stronger it is, because it has had time to get a grip. That's deep and that's heavy and you really need to be quite powerful to stop

178

those... So in terms of makutu, the strength of it, how long, and then being able to explore back to where it came from. KAU

Reference was also made to the pivotal role fear plays in the continuation of this experience through post-European contact in New Zealand.

I know different tohunga have tried to get rid of it but unfortunately it is still happening to this day. Because people are nurturing it, people keep believing and fearing it. That is how makutu works, it feeds off fear. KAU/CSW

6.1.5 Trauma

6.1.5.1 Trauma and hearing voices

The role verbal, physical and sexual abuse plays in the process of understanding EOE was referred to by 21 participants. A process whereby abuse is internalised and experienced as hearing voices that are distressing was outlined.

Is that mum in the background? Is that the abusive parent? Is that mum always putting them down or is it in relation to some sort of trauma when they were growing up? I think quite often things can be explained by people's nurture and how they got to that point prior to seeing you. That is why the context is so important in relation to how they got there. CLIN

I've got a friend who was abused in a ritual sense by a group of people who claimed they were Christian. For her, what she thinks over the last two years especially, because she thought that she was quite demonic but with therapy she has come to a place of understanding that she is not a demon any more than the people who abused her. It was the way they abused her that led her to believe that she was evil. TW

Was it a throw back to something else they had experienced? I don't think anyone just goes around and hears voices. I just think that everything is experience, it has to be. Some recall of arguments. If it was something that upset someone they would very easily recall it. KAU

Participants also referred to the trauma associated with the EOE themselves.

I never felt like they [voices] were Kaitiaki, I felt like they were trying to hurt me. It was just like they were spectators of the whole thing. TW

It is really scary when you start to hear people who aren't physically present, you freak out at first. Especially when everyone around you doesn't want anything to do with you, you feel so alone, it is one of the scariest things I have ever had to go through. TW

6.1.5.2 Trauma and spirituality

Some participants believed that it is through trauma they were exposed or connected to a spiritual realm and encountered EOE.

I think with trauma it's almost like you've opened up to something, you've opened up a side to you. Our belief is that our people are spiritual and it's very very spiritual and that's who we are and something comes in and there's a breach that shocks you personally, the breach of tapu is there and so you are open to all negative spiritual things. KAU/CSW

[How do you understand the relationship between abuse and hearing voices?] Even when that happens, [abuse] because it happens to you emotionally and physically, there is no anchor for you anymore, there is no anchor it has been taken away from you. It opens you up to another realm [spiritual] which you don't really understand. CSW

6.1.6 Haurangi: Drug and alcohol abuse

Thirty participants referred to drugs or the construct of being haurangi (under the influence of alcohol or drugs) to make sense of the development of EOE for Māori.

I would probably ask them if they have taken any drugs if they are hearing voices. TW

Quite a lot of our clients come from a background of drug and alcohol abuse, whether this is caused by using drugs or whether they are more susceptible because they have used drugs in the past to bring forward the voices to the fore, that might be a cause. CLIN

I'll be honest; I'll put it damn straight. Our people, take this house for instance, there is only two really that are actually mentally unwell, the rest of them are drug and alcohol. That is where it is. It puts them into a system to label them as schizophrenia. We have more alcohol and drugs than people with mental illness. But what do they do? They use the drugs for schizophrenia. The drug and alcohol is the issue it is not mental. KAU/CSW

Some believed drugs led to certain types of experiences such as being violent or paranoid.

The issue for me is I think too many of our whanau are getting sick due to the use of drugs. This is different to getting sick. Because what you are doing, when our young people become mentally unwell because of drugs it is a European drug that has caused it. I think that is where we get a lot of our paranoia from. KAU/CSW

She [daughter] has a wacky backy then hell breaks lose. But if she doesn't have it, she is good, the minute she touches those things then, whoo, she thinks everyone is against her. KAU/TW/mother

Some highlighted specific drugs that are affecting Māori rates of diagnosis and paranoid EOE.

A lot of that [believing others are against you, talking about you] comes from possibly built up anger and tension inside where we have had a number of clients more to the fore recently with the use of P [Pure: methamphetamine]. That seems to be a drug that tends to predispose people to these types of delusions and they become quite tense anxious and angry, they become suspicious and feel people are after them, be it the gangs, be it the drug dealers and suppliers and things like that. CLIN

[if it was] some kind of psychotic experience...[I would ask] Is it drug induced, by drugs, by marijuana or P, which I seem to keep coming back to, I have seen it happening in my work. It is so distressing for them. P is the one they take now. CSW

6.1.6.1   Age

The age of the person was considered important by some participants regarding the relevance of drug and alcohol abuse.

If it was a younger person I would tend to look at the drugs. Is it a drug induced psychotic experience? CLIN

If they are younger you would need to take their history and find out whether or not they have taken drugs before which can alter things. KAU

6.1.6.2 Drugs and spirituality

Some participants believed that the use of drugs could also affect an individual's wairua. A theme of drugs opening an individual to a spiritual realm in the absence of control or protection to navigate this realm was evident.

It opens them up [drugs]. When my daughter has a smoke, she can relate, she can tell me what is going on with her nannies. She will tell me what she sees. But they are trying to bring her on track. It's a big job trying to bring her on track. KAU/TW/mother

I think it's more the drugs [voices that are distressing], but because we are more spiritual people it makes us more open to the voices. We are open to suggestion. CLIN

6.1.7 Boundaries: cultural experience vs. Pākehā illness

Participants made various distinctions that would assist in determining whether an experience was a cultural experience (mate Māori or matakite) or Pākehā illness (mental disorders such as schizophrenia).   Summarised in Table 9 below are the boundaries that were drawn by participants which commonly referred to the content, control and context of the experience. These boundaries were not unanimously shared. A line drawn by one participant was not necessarily a determining factor for another.

Table 9: Thematic boundaries placed between cultural experience and Pākehā Illness

Cultural Spiritual experience	Pākehā Illness
Positive content Māori content Positive effect	Negative content Pākehā Content Negative effect

Control	No Control
Context: Age Access to cultural resources	Context: Age Access to cultural resources

6.1.7.1 Content

Some believed negative content of the experience would indicate a Pākehā illness.

I think people with schizophrenia...the problem is I have difficulty seeing it as a gift. Mostly because people are so tortured by what they hear...if you think about it rationally ... if you have someone that is that tortured, appearing quite unwell, unable to manage very well at all unless in a low stimulus environment, how can that be a really good person to guide your people? It is a shocking group of symptoms, schizophrenia and I cannot see it as being a gift. CLIN

Hearing voices. To me, I guess there is different ways you can look at it. To me, hearing voices may not be a big issue that some people have that gift and that ability to hear voices of the supernatural. Then there is other people who hear voices they find really distressing that I think could possibly be related to some sort of illness. CLIN

We have seen earlier however, in the section on mate Māori, that negative experiences can also be interpreted as cultural experiences. For example,

You can still have makutu if you don't understand, there is probably quite a few of our young one's hanging around that are affected by this but don't know how to deal with it. They can start to look and feel pretty bad too, like schizophrenia or even physically ill, some die as a result. CLIN

I have worked with people who have talked about voices of their tupuna and it is quite distressing and it is negative things being said to them, they still need help but not psychiatric help. CLIN

Some referred to content being either Māori or Pākehā as a determining factor,

I try to identify who is the voice. A lot of them, how I can tell it's a gift is when they refer back to a Māori voice. That I know. But if they start talking about a Pākehā one I say, oh you're on another planet. KAU

183

Just again if they know who it is or if they can recognise any links between the voices and anyone that they know. You know if they said they were hearing Pocahontas or something I'd be a bit suspect of that you know I'd kind of thinking well why's Pocahontas trying to talk to you sort of thing. STU

I have one particular client who believes Helen Clarke is her mother and Sylvester Stallone is her father. I mean where is the connection in that? I think these words just pop into their heads because they can't control, they can't control their processes. CLIN

On the other hand, some related Pākehā content to Māori spiritual experiences. The first quote is a stream of conversation,

I've got a young fella who's got 260 million coming from America. He believes this money is going to be deposited in the Westpac bank so he goes in there and demands his 260 million dollars that's going into the bank. They called us up and nearly called the police in to remove him from the bank, but it's still there [belief]. It just won't shift. KAU

M: For you what is going on there?

KAU: I think a lot of it comes from wairua, because it started from XX [marae of client]. He's got this huge multimillion dollar marae and building that he is going to put up in XXX. That started a long way back. There is a whole history to this for him. KAU

A cultural support worker understood her client's presentation to be a result of her level of acculturation from her culture. The only frame of reference the client had to understand her Māori ancestry was through a Pākehā lens,

One of mine believes she's royalty. At fist I thought it was funny, we thought oh this one thinks she belongs to the British royal family. But as time moved along for me, I thought it's not about British royalty, it's about Māori royalty. It took me a long time, to work it out. That opened my eyes. I thought, you know she's not as crazy as what people think she is, she's actually connecting to her Māori royalty, now it's not such a big thing to me. It's just that she's used the British royalty names. CSW

A number of participants highlighted that distress or a negative effect on one's everyday life would suggest a Pākehā illness.

Then there is other people who hear voices they find really distressing that I think could possibly be related to some sort of illness. CLIN

I would first and foremost ask are these voices distressing them. Are they command, asking them to hurt themselves and then I'd offer them some medication, I know it's mainstream but yeah, when it is really distressing it is difficult to understand that as a Māori spiritual thing. CSW

I know when I am getting worse because things get harder to manage at home. That is when I know that I have to get more help not just when the voices start but when they start making other things in my life hard to do...I think those one's are about the illness they are not my Kaitiaki, they are effects from negative things that I have had happen in my life. TW

However, other participants believed that cultural experiences can also have a negative effect on one's life. This was evident in comments made in section 6.1.4 regarding mate Māori.

Those are the things that can be interpreted as something like an illness like if it is something that is quite distressing to them or quite negative. I must say I have worked with people who have talked about voices of their tupuna and it is quite distressing and it is negative things being said to them. CLIN

I would ask them if it troubles them to see these, whatever they are seeing, are they troubled by it? And if they were troubled by it, I'd recommend they speak to someone in their family who they can trust. Someone who can be open to what they are seeing or experiencing and see if they can talk to them bout it. Get some depth or reassurance that there is a reason behind it. Don't go to the Pākehā doctor because all they will do is tell you that you are crazy when you may not be. TW

6.1.7.2 Control

The level of control over the experience was also considered a factor. Cultural experiences tended to be seen as being under the control of the individual, while illness type experiences were more uncontrollable.

One [Pākehā illness state] is very controlling, it consumes them actually and they can't function. The other one [matakite] is fully operating as a person they can tell you about what is happening and they say it in a very authoritative way because they are in control. CSW

The distinction is very clear from Māori who do hear and see things because they will tell you my mind is absolutely clear and they are in control. KAU

The use of drugs was considered to reduce an individual's level of control and indicate mental illness rather than a cultural experience (see section on drugs for more detail).

In this day and age with the Pākehā one, a lot of the problem is actually caused by the drugs you know…They can't control their processes or what is going on inside or around them.   Drugs is not a Māori sickness it is really a Pākehā one. KAU

According to the following participants, the experience of being out of control is a function of not having the guidance to understand their experience. Being out of control was still understood within a cultural framework as opposed to being perceived as a Pākehā illness.

I used to be so scared of the voices, they were terrifying…now I know what they are trying to say and who they are, I can also control it and tell them not now, it's is choice for me now. TW

Kind of, my nan just said to me, oh it would be one of the old people. My initial response was that I was frightened…when I was older I realised those visits were under my control and I could actually say no. Sometimes when I am aware that I am not alone I let it be that way and other times I want them to go away so I say go away. STU

Some uncontrollable experiences on drugs were also considered to be related to being exposed to negative spiritual entities without the protection or understanding to navigate these experiences. This was distinct from Pākehā illnesses,

How I see it, [when on drugs] your mind is opened up, you are not in control of your mind and therefore someone else is able to control your mind. All sorts of other negative forces can come in...That is not a mental illness that requires karakia to bring them out of it and get rid of those negative forces. KAU

6.1.7.3 Context

Some participants commented that age would indicate certain contexts that the individual is exposed to and therefore increase or reduce the likelihood of the diagnosis of a mental illness.

For an older person I guess older meaning older, I would think more traditional Māori causes, their background. KAU/CLIN

With younger people it is often illness related because of the drugs. CLIN

Some participants discussed that if the individual could hear voices from a young age it would mean they had a spiritual gift or ability rather than an illness.

When you ask them how long they have been hearing voices, this can give you a pretty good idea if it is matakite. They hear these things usually from a really young age unless it has been suppressed in them. KAU

for instance if it is a five year old child I am going to be thinking along different lines to if it's somebody that comes to me in my capacity as a psychiatric registrar. CLIN

However, encountering EOE at a young age did not preclude a later diagnosis of schizophrenia. Narratives of encountering EOE as a child and later being diagnosed with a mental illness were shared by tangata whaiora. The woman below shared her story of being accepted as someone who could hear voices as a child and later being told this experience was part of a mental illness.

At the stage of interviewing her experience continued to be interpreted as a "Pākehā illness" by herself and those around her.

When I was a little girl I was around my mother's knees almost twenty four hours a day. I used to run to her for comfort because the voices were there... when I became around psychiatry I was told not to take any notice of the voices... I used to hear the voices when I was a little girl. Sometimes I played with the voices. Now...I got arrested, taken in the police car and to Carrington hospital and sedated on some tablets and an injection. TW

A theme evident throughout the results is that a major boundary between whether an experience is considered a Pākehā illness or cultural experience is the context in which one first encounters EOE and the level of access one has to cultural resources. For example, how others react, has a significant impact on the label ascribed to the experience.

For me, it is they [tangata whaiora with a diagnosis of schizophrenia] don't understand, I think they need help with understanding it better rather than saying hey you need to be doped up or whatever. For me it is a gift but they call it an illness...if they were brought up back home they would not have this label. KAU

She died in Carrington hospital, when my grandfather passed away he couldn't look after her anymore. Our family knew that she wasn't schizophrenic, she didn't have a mental illness we were quite clear that she was a tohunga however her immediate family believed that she had schizophrenia and she was in hospital when she died. She wouldn't have been schizophrenic if she was allowed to just come with us. KAU

For me, one the most significant distinctions is who is around you at the time? Do they think you are crazy, because if they do, then you probably will be. It is easy to become what others think you are. Us Māori have been doing that for ages, taking on these things that the Pākehā put on us. But if we are around our own, they may not be told it is crazy to hear things and see things, and guess what? Maybe we won't be crazy just by virtue of being understood and told this experience actually has a perfectly plausible explanation. CLIN

6.1.8 Making sense of schizophrenia

All participants were asked in the latter part of the interview what the term schizophrenia meant to them. Most participants did not use this construct to make sense of EOE until it was specifically discussed. Many participants had limited knowledge of the clinical definition of the term. Others knew the diagnostic criteria but rejected it as a meaningful or useful label.

6.1.8.1 Diagnostic constructions

Some participants expressed their understanding of schizophrenia according to DSM-IV criteria or within a biomedical framework,

There are three broad clusters positive symptoms, negative symptoms and the cognitive type symptoms. Certainly within the first episode psychosis service we tend to use the diagnosis of psychosis not otherwise specified partly because of stigma issues and partly because of the stability of the diagnosis. CLIN

I could read the DSM- IV backwards and forwards but I won't. I won't give you the textbook definition. I was going to say losing touch with reality. I guess that is my experience of schizophrenia... KAU/CLIN

One tangata whaiora appeared to have totally incorporated his diagnosis and treatment into his sense of identity,

My name is BK, I'm 42 years of age, I'm a new Zealander, I live at XXX. I've been here for two years, I'm a psychiatric schizophrenic affective patient. I do hear voices, I get shaky, I'm on medication, epilim, olanzapine, mataphormin, cogentin and there is a few others. I've been on the psychiatric report for about 10 years. I'm getting much better than when I first was in my illness. That pretty much sums it up. TW

Even when prompted, the above participant found it extremely difficult to access alternative descriptions of himself that were not derived from an illness model. He appeared to believe only doctors and nurses have the right to make sense of his experience.

That's not for me to say, I'm just a patient. I never tried to allow myself to speak for a doctor or a nurse. For a start, they know what they're doing, they write reports. I've been here for 2 years. We help with the dishes, we do the lawns and that sort of thing but I wouldn't really say, I wouldn't touch that sort of thing, I'm just a patient who's a schizophrenic affective person who hears voices and has sight of seeing things. TW

6.1.8.2 Biomedical constructions

Only three participants referred to beliefs regarding chemical imbalances in the brain that cause the development of EO experiences.

My understanding is that it is basically a chemical imbalance. That is probably it in a nutshell. Which could possibly present as hearing voices from a TV or the TV is turned of. Maybe the voices are quite bizarre, asking that person to do socially unacceptable things, self harm to self or others. CLIN

That's just the diagnosis of what schizophrenia is isn't it? Yeah schizophrenics, it's a mental illness ay, an imbalance. Yeah the doctors say it's an imbalance. Yeah in the brain, it's a chemical imbalance. TW

When the above tangata whaiora was questioned further, he did not seem to hold a deeper understanding of the mechanisms in which a chemical imbalance affected his behaviours or illness. Nor did he know how his medication treated the chemical imbalance in his brain.

6.1.8.3 Limited knowledge of diagnosis and biomedical constructions

Most tangata whaiora appeared confused about the term "schizophrenia" that had been used to define their EOE.

[Schizophrenia meaning] Like you are not all there or something. Like so stressed out... I suppose a part of that person has been taken away. They are not their full selves or something. I have never had the term explained to me and that is what [my son] is supposed to be. Psychotic, schizophrenic. TW-mother

Learning a lot I suppose. Being a schizophrenic. Learning new things that you've never really believed in. That is something new. Oh, I don't know...TW

I think it means choosy with their time or something? [long period of silence]TW

Some participants, including cultural support workers in mental health services, believed schizophrenia meant split personality or multiple personality.

Now I believe that [schizophrenia] is split personality. TW

First of all it is multiple conflicting personalities is what I think of as schizophrenia. When I say multiple, they have the personality that they are known as then they have completely different set of responses that you see as being someone else again. KAU/CSW

6.1.8.4   Rejection of the diagnosis

Thirty nine participants expressed views regarding the limited utility of the diagnosis of schizophrenia for facilitating understanding of EOE. This construct was believed to be developed within a particular cultural context that may not be applicable to Māori or contemporary clinical contexts.

Initially we couldn't understand it purely from a Māori perspective. The first thing, having the psychiatrist fail miserably to help us to understand what's happening... So as a whanau we did a search in our whakapapa. We did a search in our whakapapa down both sides to discover whether anyone in our whanau had had any form of mate Māori... Then we looked to searching into the realms of makutu. I'm a high profile person, was there something aimed at me that hit the vulnerable?...I didn't find anything in there...So I did not ever accept that there's been a psychiatrist diagnoses of schizophrenia of which is a name I knew nothing about. I'd never heard it before at that time... it was a medical term for a medicated model...And I never ever, ever left it at that. I searched and continued. TW-mother/MAN

[schizophrenia] is a specific clinical term for an illness as defined by the DSM. It says nothing about the person, the unique features of that person who has the illness. CLIN

It's about another perspective making a judgment on another based on their own cultural norms of what hearing seeing and believing is and labelling that as schizophrenia when in fact that may not be. CSW/MAN

The generalised nature of the diagnosis was criticised. Some believed the diagnosis can serve a purpose of social control.

The origins of this term is that they used to use it for social control so anyone who was different to their notions of normality were placed in this category. CLIN

I think it's a catchall concept. They used to talk about the schizophrenias; I think it is very stigmatising and frightening for people and has little relevance to our understanding today. CLIN

I don't believe in that anyhow. I believe that schizophrenia covers everything. It doesn't really give us anything to work on. KAU/CSW

It was believed by some that utilising a symptom framework may be more applicable than the broad category of schizophrenia.

I really believe that schizophrenia does not exist as a diagnosis. And we need to identify the symptoms from the field of psychosis. So when people say to me oh he is schizophrenic, that means nothing to me. But when we talk of it in terms of he is hearing voices or whatever, then I have something to work with. KAU/MAN

I think there are more useful differences that could be discussed of the variety of understandings of psychosis and the different symptoms that are associated with this experience. And this will be more useful for both Māori and Pākehā. CLIN

Beside these views about whether the term "schizophrenia" is useful for understanding EOE, many participants also commented on the diagnostic process in clinical practice (see 6.2.1.1).

6.1.9   Silence

6.1.9.1   Withholding ones understanding from Pākehā

Fifteen participants expressed apprehension around discussing their understanding and/or experience with Pākehā.

When they asked me, they didn't ask me what I saw. I was like, okay, I want to get out of here so I had better start talking their talk. You don't tell the shrink because you want to get out so you just try and make up stuff that they want to hear so you can get better or so that you can get out of there. TW

It got to the stage when we decided that if the psychiatrist asked if XX was hearing voices we would just tell them no, otherwise they would give him more meds. TW-mother

Mainstream doesn't understand there are some tangata whaiora in our service that have that gift but I'm keeping it quiet because I know they are going to diagnose them with something else. KAU/CSW

One participant provided an explanation for why he remains silent about his own understanding of his experiences,

If you fight against being a psychiatric you're going to go down, you're going to get locked up you're going to get hurt. I've done lake Alice, that's a highly psychiatric prison, I've been to Lake Alice and you've just got to face it, the truth is psychiatrics, you're getting punished by god. TW

6.2 PATHWAYS OF HEALING

Contained within this section are participant comments regarding pathways of healing from EOE. In general, comments were directed towards what is currently being delivered within Mainstream and Māori pathways. A significant amount of discussion was also entered into regarding how these two pathways intersect at the cultural-clinical interface. The final part of this section will outline the questions various participant groups would ask an individual encountering EOE as part of their own assessment processes.

Table 10: Summary of themes and sub-themes for what can we do about the experience

Pathways of healing	Sub- themes	Number of participants coded
Mainstream pathways	Diagnostic process Compulsory treatment Medication Talking therapy	42
Māori Pathways	Māori values Taking them home Marae Kaupapa Māori Services Tohunga/kaumatua/ministers Healing practices Barriers: counter narratives	37
Cultural/Clinical Interface	Māori participation Successful collaboration Pākehā recognising own values Tikanga Barriers On being a Māori clinician Keep them separate	26
A cultural assessment for EOE	Clinicians' questions Students' questions Kaumatua/Kuias' questions Tangata Whaioras' questions	57*

* All participants were asked this question

194

6.2.1   Mainstream pathways

Forty-two participants discussed issues regarding biomedical and psychological models in the assessment and treatment of EOE.

6.2.1.1   Diagnostic process

While the previous section shared comments that referred to ways in which participants made sense of EOE and the diagnosis of schizophrenia, this section refers to the process of diagnosis in clinical settings. This process was viewed by many Māori as problematic.

I'd have to say that the profession has not been brought through with a very wholesome way of seeing the world. And with schizophrenia, well I'm saying to you people that it would be preferable if you don't treat our people and diagnose them because you are going to make the wrong one. KAU/MAN

I think people are misinterpreting the symptoms obviously and giving them this diagnosis as soon as they hear something to do with hearing voices then they automatically give them a diagnosis of schizophrenia. I always thought the policy was you never diagnose on the first admission but I quite commonly hear health professional say oh it's definitely schizophrenia but they might not document but that is already their view as soon as they see common symptoms that fit into that category of schizophrenia they automatically think that person has this disorder. CLIN

On one hand you have the biological classification that has a list of boxes and they reflect the general symptoms that present in schizophrenic patients and on the other hand you have a cultural perspective that suggests that some of those experiences that are defined by the medical model are in fact quite natural occurrences. So you will have diverse understandings of a single experience and along with a biomedical model that doesn't accept those things as being normal, then you are never going to get them to accept that that is a possible realm for someone who is perfectly mentally well. At these times I am very worried we have so many from the biomedical working with our people, they should not. KAU

Why don't we put the magnifying glass back on them? Why don't psychiatrists get their diagnoses audited? Have a look at the diagnoses they have been making and see of they are appropriate or alternative explanations have been explored. If not, why not? And if there is need for education regarding cultural assessments and the like we can give it to those who need it. It doesn't need to be punitary, more so supportive. They need to acknowledge first and foremost that there is still a lot to learn. TW/STU

The stigmatising effect of a diagnosis of schizophrenia was discussed,

I tell you one thing...I wouldn't want any of my whanau to get that label, it has so much that goes with it that is negative and isolates you from everyone around you. Once you are schizophrenic it is so difficult to get a normal reaction out of anyone you interact with. CLIN

For those experiencing it, it's a death sentence; it's like a mental health cancer. If I ever had a mental illness and if someone said schizophrenia to me, I would be devastated. CLIN

6.2.1.2 Compulsory treatment and hospitalisation

Clinicians found compulsory treatment limited their choices in terms of treatment for tangata whaiora.

If they are under the MHA [mental health act] they don't have a choice. A part of that is that as nurses within the mental health system we don't have a choice either. The mental health act will state that they are at risk of harm to themselves or others, therefore they must have treatment. The treatment that we have is a biomedical model system of treatment. CLIN

Where I work now, the person is already on a highway and there are only a few exit points that you can take. So I think it is about how can you safely travel down this highway with everything that is going on at the moment, because at the moment you can't really get off it [Mental Health Act compulsory treatment orders] and we don't have many choices in terms of how we help either. CLIN

Two mothers felt restricted regarding medication as an option for treatment when encountering the Mental Health Act,

There is no way we wanted medication and then that is when they told me, if we didn't do it then they were going to put the Mental Health Act on and then I would have no legal right to XXX so we went voluntary all the time. Now I realise shit, they had fully taken our rights away. TW-mother

When they put them under that compulsory treatment I had no say, the other Māori staff had no say and we were basically being told this is the only way. TW-mother

Some narratives regarding being treated within an inpatient setting suggested this experience in itself can be traumatic,

Where am I? Two men came running down and they grabbed me and put me on the bed and they started saying stuff and they pinned me down on the bed and dislocated my shoulder. It was two orderlies and I didn't know who they were. I can't remember much, I woke up in a ward, I remember they gave me an injection too... I can only remember bits and pieces of hospital. I don't know if it's because of the drugs. What they do to you when you're in there or what. TW

They shove needles in you and give you drugs. It is actually one of the scariest things I have ever had to go through. It's different when you are in hospital to when you are out and walking around with your illness. TW

6.2.1.3 Medication

Medication was discussed by all participants as a form of treatment for schizophrenia. This mode of treatment was often the first discussed in response to the question 'how do you think Pākehā treat these experiences?' The majority of responses were critical of medication as a treatment for EOE. The following will outlined these criticisms in regards to the current overemphasis on medication in Mainstream settings, the effectiveness of this form of treatment, the negative side effects and the prospect of being on medication for life. Some participants discussed instances in

which medication can be effective and used collaboratively with other forms of treatment. These quotes are included in the sections regarding effectiveness and collaboration.

Overemphasis on medications

Medication was criticised for being the first and often the only option for treatment.

I think the medication is used for any little symptom that is present. In some circumstances I think it's wrong that medication is seen as the first stop off for treatment and I think the medication just works to dampen down the voices. CSW

I don't like medication as a single treatment...major tranquilisers and minor tranquilisers certainly do reduce anxiety and there is a correlation between the intensity of voices and the distress of the voices and over arousal. Medication can help that. But antipsychotics have enormous side effects. I think it is better to manage stress and distress rather than be on long-term antipsychotics. CLIN

One reason offered for a reliance on medication as the first and sometimes only line of treatment is the late presentation of Māori at acute stages of their experience

I think it [medication] just adds another problem. We always get them in crisis rather than before so that we might be able to deal with them in another way other than medication. KAU/MAN

An associated negative effect of medication as the only line of treatment was considered the higher risk of relapse.

Most of the readmissions are non compliance. In fact every admission is non compliance. When they don't take their meds, and this is all they are given to cope, it is not surprising. CLIN/KAU

A lot of people believe they can sustain themselves without the medication, it's like a headache you know, they only need to medicate to cure a headache that is what they believe in. They have no

insight into the fact that they need the medication for a lot longer. They resist the idea that they need medication when they are well again and this just leads to a relapse. CLIN

If it's just medications people are going to be admitted again and again. TW

[medication] lies them down to pick them up and then push them back down again and back up and it's just a continuous cycle. TW/CSW

Another criticism of the use of medication was the multiple medications tangata whaiora are required to take.

I was just talking to one of my clients the other day and they said, you know, I'm getting one medication for my diagnosis, I'm getting another medication to counter attack the after affects of that medication and another medication to help that medication and I thought oh my goodness you get sick just hearing about it. CSW/MAN

Trialling multiple medications for the treatment of schizophrenia made tangata whaiora feel as though they were being experimented upon. The rhetoric of being a "guinea pig" was frequent throughout interviewing.

I feel like they are experimenting. They didn't know what they were doing instead they just kept trying another one and another one it never got rid of the voices. XXX has been through just about all the antipsychotics and it never got rid of the voices or the people that is for sure. TW-mother

With psychiatrists it's always medication, we are a guinea pig, it is like, is this going to work or not? TW

I am on 11 medications. Sometimes I think we are used as guinea pigs. TW

You feel like a guinea pig, they trial you, see how you are doing. You can't even stay focused, I suppose, I wouldn't even put a dog through that. TW

Some participants also shared their experience of a greater emphasis being placed on medication for treating Māori when compared to non-Māori.

But what I do say and get very angry about is I look at the drug charts with the meds and I will say to the consultant, why is this Māori on a thousand milligrams of this particular antipsychotic and another patient may be on 200 mgs. CLIN

On one hand in my experience there are Māori patients who have been treated with high doses of antipsychotic medications for all sorts of reasons, some clear and some not so clear. CLIN

We are getting medicated at higher doses than non-Māori. Why? Is it because the psychiatrists think we are more unwell or that we need more sedation than others? I don't know but I don't like it. CLIN

The issue of medical treatment of Māori becomes a greater concern if one considers the following comment that Māori and pacific people may be more susceptible to negative side effects.

Māori and PI seem to get more side effects and it tends to help them less. CLIN

Effectiveness

Some criticised the effectiveness of medications by indicating this treatment often targets the symptom and not the cause.

You've got to wonder whether it's just a band aid ay, these medications are just a band aid to addressing the real issues. Suppressing, oppressing, pulling them down. And when they stop, the reality of stuff starts coming out. TW/CSW

We call it a chemical straight jacket ay...they are so much easier to deal with when they are doped to their eyeballs. I remember learning about the fact that medications don't cure anything, they just make the person so numb to what it was that made them ill in the first place that it no longer affects them the way it used to. CLIN

My understanding of the mental health system [medication] is that they treat the symptom not the cause and if you want a person to get well, holistically, you treat the cause not the symptoms. CLIN

A smaller group of participants believed that medication was a positive treatment method. This was primarily related to the reduction of distress and to ensure safety.

A low stimulus environment helps, keep them in that environment for a day or two. Then we can start treatment and it is usually an antipsychotic treatment with those people. CLIN

It is mainly drugs and therapy follows. We slow the processes down so that they can think better and appear more rational. So you need to stabilise the mood. CLIN

What we usually like to do is try to calm the thoughts, reduce the distress, try to chill them out, because the more they are elevated the worse they become. Mostly because I work in the hospital situation it is a medical intervention. CLIN

I know when I am getting worse because things get harder to manage at home. That is when I know that I have to get more help [referring to medication] not just when the voices start but when they start making other things in my life hard to do. TW

Sometimes it is good for the safety of our people. If they are a threat to the public then I do support the drugs. KAU/CSW

If they are bad or negative then I would have to seek more professional help [medication] because they may hurt themselves and that is a safely risk. KAU

Negative effects

A large number of comments were made about the negative side effects of antipsychotic medication.

Huge, weight gain. And that is another reason why they stop taking medication because they are trying to lose weight. The hands start shaking, the legs are going, the tongue is rolling because the mouth is dry, there is blurred vision. There is just huge amounts of negatives. They totally outweigh the good. For some drugs you have to take weekly bloods, and some people don't like needles. Those are all huge. CLIN

XXX used to be a quiet natured, skinny boy. With all the medication he has gotten fat so he is not confident in himself going through the abuse. There has been nothing positive about it. TW

Well I reckon it doesn't help us [medication]. I reckon it's dangerous. It's most probably more dangerous than the dacking and drinking alcohol. The Carrington shuffle, that wasn't because they were sick, that was because they were drugged. KAU/CSW

Some participants had found through their practice that psychiatric drugs can often interfere with the healing effects of karakia [prayer].

Tohunga have ways of working on it, there are ways. The worst part about it, they do it after they are doped to the eye balls. If you listen to most tohunga they say you should have come to me first,

before you took them to the tau iwi [non-Māori, mainstream pathways]. Now I've got to work three times as hard to get that toxin out of the body. KAU/MAN

With some of the tohunga that we work with at work they prefer to not work with people that have been on medication or just received medication because not only does it dampen down your thoughts but it affects your ability to connect with your wairua because of what it's doing, because of the dampening down. KAU/CSW

Medication for life

Some participants believed they may take medication for the rest of their lives. The following participant actually liked his medication as it was a substitute for the drug and alcohol addictions he had in the past.

I'll take medication for life, I'll take the injection for life. TW

Another seemed to be waiting for the prescribing clinician to tell her whether being on medication for life is a prospect for her future.

I don't know when I'm going to get off the meds. Maybe I'll be on them forever, they haven't told me when. I ask and they just say that I will be on them for a while yet. TW

According to some clinicians, this pathway was an inevitable future for some individuals.

There is a good group of people that hear voices and get on with their lives and there is a lesser size group that get very distressed by them and in some ways for some reasons that passes and it doesn't come back. Then there is another group that probably a combination of medication or psychosocial intervention is adequate. I also think there is a subset where medication is going to be there for life I think. Sadly, but my life experience is one of that appears to be the way it is, I don't know whether I've been brain washed but it just seems that way. CLIN

There are some that are so chronic and have been in the system for so many years, they will most likely need some form of pharmacological treatment for the rest of their lives. I have seen this in a number of patients. CLIN

One participant criticised the current "system" that medicates individuals for life,

Part of the problem is, is the way we cure people is that we load them up with drugs so that they are pretty munted in their existence and they are zonked out on the couch, overly sedated doing nothing they've got a sickness benefit, they are not participating in the world anymore, they don't recover and they are thoroughly dependant upon services for the rest of their life, that is recovery, they are fixed. Bullshit!! What kind of life is that? CLIN

The economics of medication

Several participants linked the strong emphasis on medication to the financial gain of prescribers or manufacturers.

So drugs might be good because the symptoms go away. It keeps the drug companies on one end and it keeps the psychiatrists and psychologists in a job. But if they cured everyone holistically then they would be all unemployed. KAU

I can understand too why people are on medications for the rest of their life…I just think they are leaving them dependant on the state to keep them in a blinkin good jobs. It is not like they give you any positive good suggestions that are going to help you. It's just all about medication. TW

I think they want you to stay on the meds and keep you coming back, there is something more to why they want you to come back, it might have to do with having money in their pockets. TW

Collaboration

Overall it was recommended that one must try to find a balance between the positive and negative effects of medication.

Some of them have got no medication too. Some Māori whanau will not accept medication at all for their whanau. So they will leave their whanau absolutely off the moon. The other thing is when they put them into the medication world, they so induced they're off their face that side, so there is a fine balance it's always got to come back to the middle ground. CSW

I think it [medication] can be just as effective if it is done collaboratively with Māori and that person having choice around what they want. Of course it is not going to be effective if there is no choice. But that is just the same with Pākehā. CLIN

I think it's important that medication is there because sometimes that is all. But it's how people are prescribing it, Māori people don't want to take it ay. It someone imposing on them most of the time. There's not enough work done around getting people to accept that this might actually be of benefit to them. The whole thing, when people become unwell everyone is like medication and it's always seen as a bad thing, not a good thing. But if you spend some time on education, if they are explained in the right way and reframed for Māori it could be really useful. CSW/MAN

Understanding individual beliefs about medication and how they are affecting the individual was viewed as a means by which this balance could be attained.

We can see the outside appearance from the whaiora taking their medication. But the inside is coming from them. We don't know what they feel like when they take their medication. We don't know what it does to their own sense of Tino rangatiratanga. To me I always listen to them, how it effects them. KAU/CSW

6.2.1.4 Talking therapy

Talking therapy was not discussed by participants in depth. A number of participants indicated they had not encountered talking therapy for the diagnosis of schizophrenia. Some believed this form of therapy was particularly lacking for this diagnosis. Some tangata whaiora indicated

that they were not offered talking therapy for their EOE within Mainstream settings adding they would like a space to talk to others.

Do you want to talk about all therapy approaches, like a CBT approach? I think it is pretty absent. Yeah, from a community perspective I probably wouldn't have even heard about it. In an inpatient setting it can be useful but I don't think it is used. STU/CLIN

I think along the lines of voices it would be really good to have some good therapists there that can talk them through it rather than stop it. And bring them through, whatever it takes, however, bring them through, don't stop it because then they become stronger each time. If they can convince and stop one voice or two voices. CSW/MAN

I would really have liked to talk to someone, just let the mamae [Pain] out. They weren't interested though and actually I don't think I would have trusted the one's in the hospital, they probably would have tried to keep me in there. I would prefer to talk to a Māori, I don't think they'd judge me.TW

The following participants discussed talking therapy within a Māori context.
My nieces and nephews refuse to go to outsiders they come to me. I don't know how, but they seem to be alright by the time they leave. I just let them natter away, I don't say a word, so I can get the drift of what they are talking about. Once they come right, I don't see them anymore. KAU/TW

For Māori, I wouldn't recommend a psychiatrist, I am sure we can pull them up somehow by letting them talk about their experience and knowing that we are not going to shoot them down. Because once they talk about it they don't feel so bad, it's unloading the burden I suppose, sharing the load I suppose. KAU

6.2.2 Māori pathways of recovery

Thirty seven participants made comments in this section. These comments are predominantly derived from answers to the question, 'what advice would you give if they wanted help?' when discussing various EOE. Later in the interview participants were also asked, 'how do you think

Māori treat experiences that could be labelled as schizophrenic?' Themes that were developed from participant comments were, incorporating Māori values, kaupapa Māori services, taking them home (which outlines narratives and comments about reconnecting tangata whaiora to cultural resources), the use of marae for healing and access issues regarding Māori pathways.

6.2.2.1 Māori values

As a foundation to Māori pathways a number of core Māori values (although not argued here to be exclusively Māori) were discussed:

You are Māori first and happen to be having an experience …First start with who they are. CLIN

In the old days we had people who were like that, that was their role in life, it was a normal thing and I think if they were labelled with that schizophrenia our people were much better at managing it because there was ongoing support tautoko, awhi, manaakitanga, tuakana/teina. I don't think it became something where they were left out there on a limb. CSW/KAU

Whanaungatanga

Including Māori principles of whanaungatanga into healing was considered key to Māori engagement within therapy.

There is differences and one of them is that, if it is based on whanau ora, the wellbeing of the whanau then that whole attitude comes through in terms of the organisation and staff, and that automatically makes me feel, I could be alright here. KAU/MAN

I usually start with whakawhanaungatanga, especially if they're from up north you know, we're making those connections. CSW/ KAU

The role of the whanau to awhi, tautoko and nurture the individual was considered paramount.

Whanau helps too, whanau helps a lot ay. Sisters uncles, brother, aunties. I like to awhi around with my whanau and talk. TW

They've got to go back to their whanau I think [what should tangata whaiora do to heal]. The best bet is go back to the whanau. KAU/TW

I think Māori the whanau can help them pull through. We need to pull our own people through. KAU

6.2.2.2 Peer support

Talking to people with similar experiences was perceived to be a normalising process conducive to recovery.

I found that taking the road and the path of checking it out with people who are in the light that they too have similar experiences then I didn't feel alone, I didn't feel crazy, I didn't feel insane, I didn't feel fucked up either. But how's this? I learnt that I was fucked up and crazy when I went to get help, I was in the wrong waka [boat]. TW

They can teach the rangatahi their experience, be open about it ay. One of them said to me, it is people like you we need, people who understand. TW

6.2.2.3 Taking them home

A number of narratives and comments were shared about going home to heal.

Whanau can be anyone they have to support them from the community and if they don't have anyone we should have access to their extended whanau, hapu iwi back home. Give them someone that is their own they can identify with. CLIN

Again a person we saw was insistent that he had been summoned to go back up home, back up to XXX and he didn't have any family, they were all in Wellington. But he was insistent, let me go back to my marae and I will be fine, I will be well, I'll be fine. Under the mental health act no, he had to accept treatment. So I went to the psychiatrist and said, you know, this man really believes this, this is what he thinks and just trying to link back. So he set him free from the MHA so he could go and do that. That guy has never been back. He managed to go back home and his uncle took him to the tohunga and he has had a real blessing on his life. He's not back in mental health services you know. So he is still living and he is working up there. Got seen by a psychiatrist again, pronounced well. CLIN

You must take them home wherever they come from...you seem to fix them up quite quickly taking them home...it works, you can't put a number or a theory on that, it just works. KAU

However, it was also recognised that 'taking them home' is associated with a number of barriers within the Māori community. These barriers include, stigma within our own communities, trauma experienced within Māori whanau, the limited resources of whanau to look after their family members and limited access to cultural resources.

Stigma

While Māori pathways were generally considered to be normalising and nurturing, some participants highlighted that discrimination and judgment are not outside the realms of our own communities. Within this environment, 'taking them home' would not be therapeutic.

[when discussing the stigma a tangata whaiora diagnosed with schizophrenia had received by whanau] I believe it comes down to power struggles, no help, no understanding, he might be one of us but who cares, we don't have time to waste on one of you people, you're no-one you're nothing...I look at those people and think, my goodness, where is the aroha? I believe the greatest gift we can give anybody is to hear them out, at least to listen and hear them out. Give them the benefit of the doubt. KAU/CSW

We are not all hugs and kisses when it comes to serious mental illness. We are just as stigmatising as non-Māori sometimes in our communities. Yes we espouse that we are an accepting people, we nurture our own. Well if we nurtured our own, why are there so many of us ending up in Pākehā hospitals. CLIN

When they have hallucinations or something, they've got no-one to turn to ay. If they do go to their parents, oh go away, you're mental and they go into all their little groups to try and help each other. TW

Trauma

According to some participants, Māori may not necessarily want other Māori involved with their assessment or treatment because of past trauma.

The other thing we have to understand is that just because they are Māori doesn't mean they want to be treated as Māori sometimes Māori is where the illness started so they don't want to be involved. CLIN

Usually Māori who don't want Māori services involved is because there has been some level of whanau trauma. A lot of it is around abuse, physical mental emotional and sexual. CLIN

Whanau resources

The breakdown of whanau structures within the community was viewed as a barrier to early detection of negative and distressing EOE.

Home. I'd go home and get myself home. Be with nature. It's just that we haven't got anywhere up there for us. TW

I'm not sure where they would go because you don't have the family and community and support you used to, not today. I think they would quick and lively put them into Kingseat. I think that happened a lot. KAU/MAN

6.2.2.4 Marae

Utilising marae as a space for healing and access to community members who can help with recovery was recommended by all participant groups,

If the person wasn't comfortable I would take them onto a marae whether it be their own or somewhere else and just let them feel free to walk around until they felt comfortable and then integrate with somebody else from there. And to gain their trust to be able to speak out. That is something I always go back to. CSW/MAN

A lot of people don't like going to the marae but I think that is the best place to take them. Let all the mamae just ooze out…I used to take them down and we'd all go down and tell stories and next minute they are fast asleep. We stay there for hours waiting for them to wake up. That is a huge healing. CLIN

The iwi can still look after them ay, like in Waitangi where we lived for a while at Te Ti Marae, a lot of mauiui [sick] folks, they were whaioras but they were good on the marae, they were home, people cared for them ay. TW

They're too quick to whip you in and diagnose you. I would take the short road go through marae and tohunga through a Māori field. Definitely not through Pākehā. TW

Marae based services were discussed as an extension of the above,

I'd like to see alternatives [services]. Especially on marae. Take the young people onto the marae. If it was on a marae it would be a lot different than just coming over here. Different setting, get the wairua feeling into them. CSW

I would love to see a marae or iwi type services where we have our own therapeutic type members, tohunga, kaumatua, kuia, extended whanau and we have clinical people come in at the invitation or

come along side. It's kind of like, what do you have now?... you have the DHB [District Health Board], all those CAT [crisis assessment] teams and psychiatric teams and then you have Māori who are kind of like the alternative. I would like to see that swung around I think. Māori be the mainstream and then we have the alternative over there. CSW/MAN

6.2.2.5 Kaupapa Māori Services

Kaupapa Māori services, delivered for Māori, by Māori were discussed as being built upon the foundations of Māori values. Being seen as an equal was highlighted by tangata whaiora as an advantage of utilising Māori pathways of healing.

That is a difficult question [if you could change anything about your treatment what would that be?]. I reckon maybe a kaumatua, someone who is not going to judge, and say oh here's that girl who believes in god again. Being in a place like I am now [Kaupapa Māori Service] where I don't feel under everyone else. We sing we pray and we talk to each other. TW

This Kaupapa day programmed here is looking at the whole person. I think there need to be more services like this. I walked into this room, I was diagnosed when I was 19 during my first hospital admission. Last year [currently in 40's] I walked into the room here and when I walked in I felt amazing, it really hit my heart, and I haven't been brought up around Māori but when I came here I just felt like it fit like a glove. TW

A kaupapa Māori support worker who is now in a management position shared her experience of the increased support her service was able to offer a whanau when a tangata whaiora became acutely unwell.

A few years ago we had a person who was quite deluded. They were really unwell and they didn't want to give them medication. So I was able to advocate for that and put some support around the whanau. Someone was there with the whanau and saying every few hours how are you getting along? This person was tearing wallpaper of the walls and became totally unmanageable for the

whanau, but they had our support there. I think that something like that could work if you had the right place and lots of people devoting time and energy to that, it could work. CSW/MAN

The ability of Kaupapa Māori Services to provide both cultural and clinical interventions was perceived as an issue.

I think we need two parallel pathways working within Kaupapa Māori Services. We need the clinical in there to get the referrals and respect from the world that we work in. It would be ideal to fill these positions with Māori but they are all whisked away once they get qualified to high level, high paying jobs in DHBs so in that sense we need the resources to make the positions more attractive to our own professionals. Secondly we need a cultural pathway that recognises cultural expertise in working with tangata whaiora. Not employing people just because they are Māori but because of their experience too. We need kaumatua to be in managerial positions along with younger Māori. We need more collaboration in our services and a work ethic that is aimed at excellence, constantly working and striving towards to upskilling ourselves both culturally and clinically. KAU/MAN

One kaumatua highlighted that adequate leadership is a key driver for the success of Kaupapa Māori Services.

Now those Kaupapa Māori Services within mainstream that are on to it, there is some neat things in place. Their kaumatua group is strong, their leaders are strong Māori people, within their own whanau, hapu, iwi. I contrast that with groups that are, that, when I've been asking questions, it dawns on me that, Kaupapa Māori, you're not Kaupapa Māori, you happen to be a mainstream service that is staffed by Māori. KAU/MAN

6.2.2.6   Access issues

Difficulty in finding access to Māori practices and healing was discussed by a number of participants.

It's a bit hard because I haven't really had anything like that with me. I haven't had any kaumatua come and talk to me about it. Because most of our marae are really far away from here. TW

I see it all the time where Māori tangata whaiora are looking for Māori ways of healing and health and even for a place such as this [inpatient unit], where is our access to kaumatua and kuia? Where is our access to tohunga? I guess trying to get tikanga into here, where it is all Pākehā based, is like trying to fit a square peg in a round hole. CLIN

No I have not seen a kaumatua or tohunga. But that would have been nice. When I was in last time in [mental health unit] I grabbed my breakfast and sat down and I was really angry. I forgot my karakia, so it would have been nice for a kaumatua or someone to be there to do that with me. TW

While the tangata whaiora below did have access to a Kaupapa Māori Services they did not yet have he opportunity to see a tohunga.

I haven't been to a tohunga, I would like to see someone from my own iwi. I have two, my grandmother is from one and my grandfather is from another. TW

I don't know because we haven't come into contact with the Māori ways of healing. It's been five years and we are still waiting. We did try to access Māori services, they said he would get tohunga and that but it never happened. Oh they kept saying he wasn't ready for it, this and that, and I thought when the heck are you supposed to be ready? See we wanted a tohunga right from the start. TW

Being based in an urban setting was considered a barrier to accessing cultural interventions early in the process of recovery.

I know that it [cultural interventions] can be done in a hospital setting. But when you are in Auckland it can be difficult because you have less access to that individual's hapu, iwi depending on who we know and it's based on our own networks, it's not networks that the hospital has established.

So it's more who you know and who you can access. Then there is the issue of who is going to pay for it. Why should Māori professionals kaumatua and tohunga be working for free when psychiatrists are being paid so much for the mahi they do, I guess it brings in all of those sorts of issues. CLIN

One participant highlighted that referral pathways were not explicit however added that finding the right person was only a matter of picking up the phone. However, this participant was well connected within the Māori community.

I would go to someone who is more knowledgeable. I would have to say there is a group of people who can do that. They are not in the telephone book or anything like that. But you just get on the phone and say hey, do you know someone, and you would be surprised at the number of people who would say yeah, so and so was good like that or so and so can deal with that. CSW/MAN

Limited resources as well as the level of Māori identity required to access Māori pathways were of concern.

We need Kaupapa Māori right across the system. It's kind of sad too, because Māori. There is kind of this ideal that the only way to treat Māori is Kaupapa Māori. A lot of Māori reject Kaupapa Māori because they are urbanised Westernised, they are divorced or separated from their culture, they don't know where they are from, they don't have their reo and because they don't have their reo they tend to shy away from things Māori. They are more whakamā to stand up within a Māori area because they can't speak Te reo Māori. CLIN

We need to make our services more open to accepting all Māori too, not just the one's who speak Te reo or know their whakapapa. Most we get in here don't know who they are, we need to help them too, and they are still Māori no matter what. CLIN

6.2.2.7 Tohunga / Kaumatua / Ministers

The role of tohunga in Māori pathways to healing was referred to by many participants.

We need people who know and understand wairua. That doesn't mean they need a BA under their name. Because the one's who do understand it are not necessarily Pākehā educated. The healers in our world don't have PhD's MA's and the rest of it. They just are. You can't label that, you can't advertise for it. You won't get it, you won't get the one's who can do it. They will come up with a new trendy name you see, advertise that and that is what it will mean. And we need the one's with the old knowledge too, not just the hybrid of what has come out of the bible. KAU

If it's a spiritual entity [voices] we employ a tohunga or a priest because we've got to find out the background and why it's coming down generations and if it is, who the spiritual entity is, and how they are controlling, if it is. KAU/MAN

Tohunga will help. We had one here today who explained the spiritual side and to us it is personal, you have to talk them through it. It can't be a one off session, you have to talk them through it. It can't be in a one hour slot. It's the way you do it, it's a way of life, and you slowly come out of it. You have to incorporate a part of their living. Whatever works. CSW/MAN

We went to a tohunga because of some evil that they perceived was happening amongst the family and addressed that issue as a real issue. And they said, yes you are right there is something not good here and he went through the rituals as he pertained them to be. 6 months down the track you ask them how is things and they say fine. All those things they had wrong gone. KAU/MAN

European thinking though is that anyone who hasn't done 20 years of study cannot perform to a level of expertise as maybe others, but we find for us, some of them are born to it. Not only do they carry the mana of their own physical being but also the mana of their tupuna's before them because some of them come from a line of them. So you get 400, 500 years in some cases of this tohungaism but they can't see it. So we need to educate our agencies to try and believe that we have a way of dealing with the mental health of our own. The manner may be different but if we are going to work together they have to let us. We have to look at different options. KAU/MAN

Utilising church ministers from the community appeared to be a relatively common practice among participants.

I would ask them if they would like to go to church and see a minister. That would be my first response, how bout you and I go and talk to someone other than me? There are some really lovely people in the circle I know who wouldn't laugh at people who did that, who would consider them to maybe have something that others don't. KAU

I would go to ministers of the church and ask them for what they can offer. Some are very good at dealing with that interrelationship with Māori. KAU/MAN

Some discussed the issues of using traditional tohunga and/or Māori ministers.

I think it depends on what sort of tohunga people go to because there is some that are more based on traditional principles and some that their practice relates more to contemporary spiritual things like Ratana, based on Christian principles and stuff, it sort of depends on what the person wants. TW

I guess the Māori ministers doesn't matter what religion have replaced the Māori tohunga. I can remember two or three tohunga I grew up with back home. KAU/MAN

Anyway we went to assemble outside the gates, there were a couple of ministers there, this tohunga turned around and said, your prayers do not go in there, your prayers stay outside the gate, that is real tapu in there, it is not the place for your Christian prayers, only our prayers. This is an example that there are some places that they cant go, they are not allowed to go. Why? Because of the tapu nature of it. And I remember those two ministers just nodded and accepted it, like us, they felt the privilege that they were about to be taken on. Yes, we did see things and hear things while we were there and then we came out and afterwards we came back to talk about what we saw. KAU/MAN

6.2.2.8   Healing practices

Karakia, mirimiri and rongoa were traditional healing practices recommended for recovery.

The role of karakia was discussed extensively as an effective Māori pathway of healing from negative EOE.

I look at the eyes, sometimes the eyes are all negative and that is when I karakia. Sometimes it might not be only that person; it could also be some tupuna coming in from the back. If it is tupuna, I can't see them, I use that method, sometimes that is how the karakia can break it. If not I sometimes try and talk about the now, a time that is unfamiliar to them [tupuna], and maybe the person who is there with that person can disappear. KAU/CSW

Even the methods we use to heal a person, it is usually around water, absolutely around karakia, it was usually taking out something to repair the transgression. The whanau had to participate and I guess that is where the thinking comes from in the tapa wha, whanau ora. KAU

Karakia was often described as having the power to deescalate an individual during times of distress.

One here says when you are in strife, karakia, karakia, and karakia. CSW

I would always come back to karakia too. It is quite funny because you get them in the meeting and that, with one whaiora here you see them relax after the karakia, their reo and that comes out beautiful. KAU/MAN

When I was down there I thought oh this is a load of rubbish and I was in a pretty bad state at that time, but they can lift it. With karakia they can lift it. I felt light as a feather after they did that for me. TW

Utilising touch for healing was also discussed by participants.

Mirimiri [form of Māori massage] can heal in a number of ways. Different places in you body represent different aspects of your emotional and spiritual life too. Through mirimiri we can release

some of the tension across these dimensions. Mirimiri is also a way in which the person can experience good touching, touching that does not harm them but nurtures them. We carry it with karakia the whole time, talk the person through the process, allow them to express their emotions freely and surround them in aroha so that they feel safe. CLIN

I believe in the power of touch. Good food and touch...If you just run your hands above their body you can feel where the hot spot is. You don't tell them, you just be prepared for what is coming. I guess that is part of my belief, and part of that belief comes from being Māori. I have never really made that connection before but it probably is. I don't really like medication try everything else first. STU

Rongoa [Medicinal plants] was perceived as playing an integral role in Māori pathways to recovery.

Rongoa, kaumatua, kuia. They have to be willing if it's successful for their recovery. CLIN

By taking triple therapy, kumarahau, kawakawa and kahikatea [plants]. I really would love to be able to integrate that kind of thing into it. At the moment we have medications that have a limited effect. If our kaumatua and kuia have the knowledge then why aren't we bringing those things that are essential to the health of tangata whaiora through? We need other tools for us to use that are alternative to mainstream, and as we begin to bring that through people will begin to see wellness. Because you apply karakia with rongoa you get wellness, healing. So why isn't it here? CLIN

6.2.3   Cultural/clinical interface

An additional theme was developed for those comments regarding the incorporation of cultural *and* clinical aspects into treatment practices. Twenty six participant comments were coded in this theme. Non-Māori clinicians' comments have been included in this section as they are part of the fabric that weaves the cultural/clinical interface together. Non-Māori clinicians' comments are identified as "CLIN-*non-Māori*".

Tangata whaiora in general preferred a combined approach,

Here [Māori service] they motivate you. They teach a lot about life and death and that too, how to carry on with the Māori side. They still give you the Pākehā side medication because Pākehā have their ideas and Māori have their ideas. I prefer both at the same time. TW

I think the medication helps. It helped me to get to a point of being able to get back to my community and find out more about why this was happening to me. I liked it when my CSW was there when I saw my psychiatrist too. TW

6.2.3.1 Māori participation

The presence of Māori staff during assessment was seen as a means by which a cultural-clinical interface could be enhanced.

What I would like to see is from day one we have a relationship with tohunga. Those amongst us who are good people who can relate with others. People of choice. We should offer tangata whaiora from the first instance a support person. We should also ask the doctor to have the privilege of speaking on behalf of this person, so forth and so forth until such time as we have come to a stage where we can achieve what we set out to do. CLIN

Ensuring tangata whaiora are provided the choice regarding cultural input at key points in their pathway to recovery was considered important.

At their acute stage they may not want Māori services involved. We should not assume that just because they say no at the beginning means this is the case for the duration of their treatment. They should be asked at a number of points. Because they may not be well enough initially so they don't know how to make decisions. CLIN

One solution offered from a cultural support worker was to integrate cultural staff into the clinical team as part of the way in which Māori are assessed rather than providing cultural input as a voluntary option.

But if they don't want karakia, ka pai. Sometimes they [tangata whaiora] don't even like a Māori worker in there but I do say we are part of a multidisciplinary team and we have our job. I say repeatedly face to face with them [clinical team members] look don't say we work at ... blah blah blah and we work in a multidisciplinary team and oh by the way we have a Māori cultural advisor. It's got to be we're part of the team. And they say why? I say, well what if I was on duty and I say to you we are a multidisciplinary team with a child psychiatrist, a social worker, therapists, cultural advisor and by the way we have a clinical psychologist if you want to see them. I just turn it around and say simply you've put me on the back burners already. For families that are not so comfortable and they say oh they're Māori and they panic and go shit this guy is Māori. CSW

6.2.3.2   Narratives of successful collaboration

A number of narratives were shared that indicated meaningful collaboration and participation is possible between Mainstream and Māori pathways.

A girl came to see me, she was 18 this girl. And the father came and he wouldn't talk English [only Māori] except a few times when we were with the Pākehā. And he kept coming back, "we the whanau will look after our girl." Things have happened and we know what they are." Well the clinical director broke the rules and let the girl go home, why? Because we said she needs to be home with her whanau. So we said to him [responsible clinician], what do you want? If the inpatient ward is not here, what do you want wrapped around her, for you to be sure she is okay? [Reply from clinician] I need whanau to be there 24 hours, I need people coming in, I need the cat team making it's regular visits. [Reply from participant] Good, done, if we can arrange all that, if we do all that, can she go home? And this is a very brave man, Pākehā, he says if you do all that, she can go home. So this is just an example of us moving to make things happen. KAU/MAN

I would accept that [hearing voices of tupuna] initially and I won't challenge it with my belief system at that point because my usual path is to start talking to Māori staff here and to be bouncing things of them and hearing what this person has already talked to them about and giving my option as a psychologist what I think but it is not helpful in that first instance to be saying no hang on a second there is another way of thinking about this and I don't think it is helpful. It could be after speaking with other people concerned that then there is a point where I would be sitting down with a Māori client and saying look there are other ways of actually thinking about this. Again it is still open to that person to say well I might have a go at thinking of it that way or, this is being very simplistic, again it is about giving options I think. CLIN-non-Māori

In several instances I have worked along side tohungas where, because I have a good relationship with them and we trust each other we can bring a whole range of different kinds of strategies to that person. So the tohunga who is the expert in that area may say I can do these things to make that go away but maybe we should think about these things that the psychiatrist can do as well from a medical perspective. So try to create some kind of tailored plan that has some flexibility in it. CLIN-non-Māori

Going back to this particular person I was aware that this is something that was outside my expertise, my knowledge of it [hearing voices of tupuna] was limited and I was interested in learning about it from her. But I also encouraged her and she did infact go to the Māori CSW service in tandem with me. So she had access to someone with a more in depth appreciation and understanding of her, that conceptualisation of her voices. The CSW came and sat in our sessions a couple of times. CLIN-non-Māori

6.2.3.3   Pākehā recognising their values and limitations in training

Two non-Māori clinicians outlined a process whereby they offer their understanding of an individual's presentation but recognise their own cultural background and how this may influence their perspective.

In the greater scheme of things when initiatives come up from Māori I assume that they are doing what they can and I do what I can to support that. I don't see, if I have an opinion I give it, as an opinion under a clear understanding and a clear statement that these opinions are my views as a privileged Pākehā. But we need an understanding of the history. CLIN-non-Māori

What I discuss with them will be based on what my training is, where I have been brought up and the values that I hold to important. I need to share this with my client, so that they know this is my understanding based on my experience which is one out of many ways in which that person may choose to understand their experience. CLIN-non-Māori

Some understood the limited training of clinicians to be responsible for their difficulty in recognising their own values,

That's right they can only go by their book and what their knowledge is. So if we're not in the book as Māori, if Māoridom is not in there and the spiritual side, well they can't help. So they just do the best with the information they have supplied to them or whatever they've learnt. It goes right back to training programmes and school and how we educate our people. Because they are told that their truth is the way, they are not taught there are other truths out there. TW

There is a word hegemony that I learnt at college. Dominant culture rules ay. And what I find with the medical model is, all those with medical model training the dominant culture rules...they are not open to our perspective. CSW/MAN

6.2.3.4   Tikanga

Tikanga [code of conduct] was considered the defining aspect that can enhance the cultural-clinical interface.

The bricks that will build the bridge between Māori and Pākehā ways of treating these experiences are made of tikanga. CLIN

I guess, under the question of what is a pathway of care for Māori, in all DHB's it would be said that every pathway we've got works for people whether they are Māori, Pākehā or Iraqi. And to an extent that is true, however, part of the values or the tikanga that ensure that this pathway is comfortable to Māori, for example a very simple one, don't mispronounce my name. Do say tena koe, and if I respond to you with a "hello" don't put me down for it. Be aware of works for me as Māori, what doesn't work for me as Māori. KAU/MAN

6.2.3.5   Barriers to successful collaboration

Participants raised the issue of not being culturally understood within a clinical environment.

When I'm actually in the middle of karakia and knowing the protections that are really around me when I'm doing that work and to know that Pākehā people, not only Pākehā people, mainstream people don't understand, well hell, now are they going to go and diagnose us. KAU/MAN

Like in Whangarei hospital when I got there the first time I thought it was really weird but I realised they only wanted to help me. The Pākehā try and get rid of that gift that you've got. Get you back to a normal life. Some of the Māoris agree with their ideas. The Māori need to tell the Pākehā how we were gifted with the stuff that we've got and they are trying to get rid of that gift. TW

Often we are not listened to in a way that respects our opinion of what is going on. You are scared sometimes to say something just in case they think you are crazy too. They [psychiatrists] talk over you and above you or at you, not with you, they don't often ask, what is your take? They tell you what they think because they are supposed to be the experts. CSW

Another issue was raised around cultural interventions being used as a last resort after clinical interventions have found little success.

That is what we try and do at work, but it sort of seems as though anything other than medication is way down the list of priorities. So it seems to be like, we'll medicate and if that doesn't work then maybe we'll try and do what you want to do. And in one specific situation the medication was

changed over about 10 months and the client never responded and then it was like, go and try your stuff with the kaumatua tohunga. CLIN

I know some tohunga would prefer to work with clients before medication is administered. So it would be nice...for Māori specific treatment to be acknowledged as just as important if not even more important than medication. Sometimes they only come to us if the medication doesn't work. I reckon the medication just fixes the little temporary issues and the distress but it is never going to resolve the underlying issues for that client which I think kaumatua and tohunga can deal with. KAU/MAN

Time

Time was considered a factor that limits current clinical practices in terms of working cross culturally and generating positive rapport.

There are some things that Western don't do, they don't have time to get to know you, that is absolutely critical. So, what I say to them, if you fail to do that part properly, the effect on downstream, on them complying, the effect of them not complying increases. And it takes up more time because you fail to take the time here. KAU/MAN

From my understanding, that profession [psychiatry/psychology] you make an appointment for an hour and at the end of the hour you leave. That's culturally offensive for dealing with those kind of things [EOE]. You need to be able do things as a Māori, in a Māori way, without being tied down to the rules of an hour appointment. KAU

There is no way one hour would cut it. Different people need to come to their own conclusions in their own time. So that not only do they understand it in their hinengaro but it's their wairua too. It's the wairua level that needs to understand. So once that understands it can pick up on the other stuff. Some may take an hour sometimes people take 7 or 8 hours, I will never let anyone leave here even if they are not settled. It may happen on the second time because they are not settled with themselves. KAU

Space

The space was considered important in terms of it's relevance for Māori entering mental health services.

I've found with the opening of karakia it kind of like, you know, put them in a better space…we even just sit by them, like you know not sitting them in the corner. I always sit by the family and the young person if they're a bit whakamā [ashamed]. It comes down to warmth, being warm to the whanau goes a long way. The way we set up our rooms and even the way we welcome people at the beginning is important. At the moment in our [mainstream service] things need to be changed to make the space more acceptable and welcoming of Māori. CSW

I try and seat everyone at the beginning similar to a marae situation which they are often familiar with. Then after the mihi I sit with them to represent the fact that they are not manuhiri any longer. I always say to clinicians there is a right way of doing it for us, because they are going to be giving us information that is personal for them. Especially when you ask questions like do you have mental health on your side of the family mum, nana matua? To me these are questions, even with my own parents I would be quite protective so, I kind of warm them up nicely and I try and keep my feet on the ground so they don't feel intimidated. CSW

Participants commented on the ahua (atmosphere) required in a space for healing to occur. This was considered just as important as the questions that are being asked.

A sort of getaway place, where wairua is there and the person is comfortable there.   Then they can sort it out without medication by just being with people and talking to them. But being in the mainstream, they feel uncomfortable. TW

First we have to deal with the fear. What the cause of the fear is. Then you'd ask them if they would like a karakia or a tohunga or would they like the priest or a minister so we go through those lines if they have a clear understanding. But often when they come to us they need calming, so we calm them down and say lets take a look at the experience more for them…They need to be validated. Okay she

is hearing those things, I don't, I actually don't but I believe you do. Anchor them. Anchoring them is so good because then it is a relief to be able to talk about it calmly. CSW/MAN (Walsh, 1995)

Whanau participation

Some participants referred to contrasting practices when working in either a clinical or cultural framework whereby the whanau and individual priorities clash.

You also need to be able to have the freedom to go and talk to the whanau, go and have a kai with them. But you know it is not a part of the professional ethics because you don't mix socially with the clients. In a Māori world, you mix with the whanau. KAU

Some of our rangatahi are being discharged or admitted to hospital and the whanau don't know. There is no understanding of the collective, just individual priorities. I know there is privacy but these issues need to be discussed from a Māori perspective not a Pākehā legal perspective. CLIN

What about the role where Māori say, oh yeah whanau, everything is built around that, whanau. To the extent that the individual may very well be submerged beneath the needs of the whanau. Here comes the neat question, what if the whanau says an opposite remedy to the individual? Through my own experiences I would support the individual. KAU/MAN

Structure and policy

Tokenism with mental health services and policy was viewed as a major barrier to implementation of a meaningful cultural-clinical interface.

I see it all the time where Māori tangata whaiora are looking for Māori ways of healing and health and even for a place such as XXX, where is our access to kaumatua and kuia? Where is our access to tohunga? I guess trying to get tikanga into XXX where it is all Pākehā based. What are their needs? It's really hard. Because a lot of the stuff that they talk about, Tikanga Best Practice and the like, it's

not real and it's like, blah blah, tikanga Māori, blah blah Treaty of Waitangi. But that is all it is just blah blah. CLIN

Our current policies are made and then sit on a shelf and gather dust. We need working parties to turn these policies into practical ways to work in our mental health services. The blueprint, the framework for mental health all of those have great recommendations but no pathways on how these recommendations can be incorporated into our practice. CLIN

6.2.3.6   On Being a Māori clinician

The difficulty Māori clinicians face in balancing their identity and incorporating both value systems was recognised.

For Māori, when it is coupled with things that are Māori, like I hear voices or see my tupuna, then it's bloody worse for them within a profession that doesn't understand it, or refuses to understand it. To me, I think for the profession it's really hard for Māori clinicians working in mental health to accommodate both their Māori and their clinical training. KAU/MAN

Having limited access to Māori leaders who can teach other Māori clinicians working within mental health was seen as a barrier to a collaborative cultural / clinical framework.

Seeking help is a really difficult thing to do. I think as Māori we are very influenced by Pākehā models. Those are the boundaries in which we work and diagnose illness. Because there is no validity or strong lead from staunch Māori leaders with mana to be able to say, this is how we do it. CLIN

Māori clinicians were viewed as a key stakeholder at the crossroads between Mainstream and Māori pathways.

The people who are really going to make the difference are Māori clinicians. We will have the power to instigate change in the dominant structures of psychology and psychiatry. But we have to be

careful, the longer you are in there the whiter you get, the more exhausted you are and sometimes you become pretty jaded. CLIN

6.2.3.7   Keep it separate

As a result of the above barriers, some participants did not view clinical and cultural practices to be compatible.

Māori for Māori. Tauiwi for tauiwi. CSW

On one hand you have the biological classification that has a list of boxes and they reflect the general symptoms that present in schizophrenic patients and on the other hand you have a cultural perspective that suggests that some of those experiences that are defined by the medical model are in fact quite natural occurrences. So you will have diverse understandings of a single experience and along with a biomedical model that doesn't accept those things as being normal, then you are never going to get them to accept that that is a possible realm for someone who is perfectly mentally well. At these times I am very worried we have so many from the biomedical working with our people, they should not. KAU

The following passage has been included in whole as it touches on comments made by other participants regarding the barriers towards developing a cultural/clinical interface.

We live in a Pākehā world, we have Māori problems. Never mind embracing the Pākehā world to fix Māori problems that's why it hasn't worked…That's exactly why there are more Māori now in mental health. Because we tried to embrace the Pākehā way, we're Māori. So why don't they get off their high horses and realise, Pākehā way don't work. Embracing Pākehā way hasn't worked, in fact it's made it worse for people. Māori problems need to be solved by Māori solutions…So hello, wake up, smell the coffee and the roses and the kangapiro…pull your head out of the mushroom factories. Mushrooms of course grow in the dark and live off shit. Pull their heads out, stick their nose back in the tohe's smell the salt air, come back to reality, forget that you have this nice little degree and you are trying to embrace the Pākehā way. Learn your tikanga, learn your culture, do it a Māori way.

You want to fix your culture? Do it a Māori way. You want to fix the Māori problem? Do it a Māori way. That's where our people have failed for years. We've always gone that way, they've never come our way. You want to solve our problem, you move from your neck of the woods our way. Because it doesn't work us trying to go in your system. Statistics show it doesn't work. Pākehā statistic show it doesn't work. What will happen is, if Māori do get their own system, all those fellas will be out of a job. The whole history of our people, that's where we screwed up last century. Māori tried to fit in to the Pākehā system. They tried to go the Pākehā way. They tried it for a whole hundred years. They tried it with education, health. It hasn't worked. That is because we have always tried to bend over backwards to try and accommodate the manuhiri. Now the manuhiri think New Zealand is theirs and we are getting marginalised. Māori need their own system to deal with their own problems. That's right across the board. KAU

6.2.4 Assessment questions for Extra-Ordinary Experiences

Below is an outline of the various questions participants would ask someone encountering EOE to understand more about them. Quotes are presented in participant groups as the questions seemed to vary slightly across this dimension. Non-Māori clinician's comments are also included in this section.

6.2.4.1 Clinicians

A number of questions posed by clinicians broadly relate to the content, form and effect of the experience. Some, but not all, clinicians also added they would ask for the person's own understanding of the experience. A couple specifically mentioned questions regarding cultural experiences.

I guess I would ask what are these voices? Are they male, female are they loud? Yeah and I would ask the person I guess to try and get an idea of the content. I would try and get a bit more out of them. I would first and foremost ask are these voices distressing them. Are they command, asking them to hurt themselves and then I'd offer them some medication, I know it's mainstream but yeah CLIN

I would want to know what is the content of the voices they are hearing. CLIN

230

Id probably just say tell me more about it. How is it affecting you in other ways? Is it something that is going to happen today [curse]? Is there something I can do? What are your plans around that? Does it affect other relationships or other things that you need to be doing? Is there any distress related to this belief [makutu]? CLIN

Was it drug use? Could be a part of an illness process. Could be implications of tapu. It all depends on the person really. You don't really see many people with a strong tupuna connection as part of an illness process. It could be a real spiritual thing; it doesn't need to be illness. CLIN

I would say, what does it sound like? This is a random order rather than in the order I would ask. I would ask does it have an identity. Is it male or female? Is it someone you know or don't know? Is there something familiar about it? Is the language in English or Māori or any other language. I guess the tone of the voice, is it angry critical that sort of thing. The kind of situation the person hears the voice. Do you hear it in particular circumstances. Is it when you are using drugs? CLIN-non-Māori

I often ask how the person how the voice differs from what they call a thought. So if they are hearing a voice it is somehow different to what they call a thought. So in what ways is it different?...I would ask if they think anyone else can hear it. I would ask what their understanding of the voices is. I would ask the person how they explain this particular experience. CLIN-non-Māori

6.2.4.2   Kaumatua

Kuia and Kaumatua asked content and belief driven questions but they also appeared to ask more aetiological or diagnostically driven questions in terms of determining whether they are working with a cultural experience or mental illness.

I would be looking at the content of what they are talking about, who they are talking about. They sometimes talk about visiting places so maybe they have takahi [disrespect] somewhere that they shouldn't have been. I don't think health professionals know what to ask they ask questions primarily based on what they have learnt as students. KAU

Okay so this persons name is john, okay he has a moko face tell me what shape is the moko? If they identify a tattooed face then you have to identify where the spirals are and what they look like. There are meanings behind the tattoos ay, and it is a way of trying to identify which whakapapa they come from if in fact they can identify it. KAU/MAN

Can you identify the person? If it is a dead person for example, I think it is proper then that we are having a kaue mate [funeral]. To go back and tangi again, take it right back to that source, we don't know what happened or what this person may have done at that time but because it kind of sits on our spirituality it comes out, eventually it will pop out. And maybe that is a time when it does. CSW/KAU

I tend to understand questions like is there some unresolved issue in their life, or is there something happening in their life that they don't understand. I'd try and get a grasp of what are these voices trying to say to them. KAU

I'd ask do you know who the person is. Can you see them clearly? I'd ask what are they doing. I would ask is there something in your life at the moment that is happening for you that you need to explore and look into. I'd ask is there any body language they can recognise as to what they are seeing. KAU

I would ask questions like did you have a dream? And who was in your dream? what colours that you can remember in the dream. That's only to help the interpretation and are they reoccurring? Is it just a thought? Because if it's a thought it's strictly through intuitions and so what else do your intuitions accompany the thought of makutu? There are other things in your intuitions. What else is there that accompanies that thought. KAU/MAN

6.2.4.3 Tangata whaiora

Tangata whaiora placed additional emphasis on the individual's personal beliefs and cultural, spiritual and psychosocial background in terms of questioning. Some used their own

experiences to try and understand a particular presentation. Others stated they would not ask anything simply listen or just try to be with the person.

I would probably want to know their background and what sort of traumatic experiences they have been through in the past. I don't think I would worry about getting a doctor. TW mother

Why do they think that? Have they done something to someone? Have they been somewhere they shouldn't have been? Again it's like changing your whole mind set. TW

Well basically do you recognise who it is? It is not having that doubt first; I have already experienced this so I have an understanding. First I would want to know do they recognise who it is. What are they going through at that time that it has happened, what is it doing to them are they afraid of it? Are they glad of it? A whole lot of things around that. I would not poo poo it. TW

I wouldn't question that but we'd just talk about they way they see it. TW

I'd first ask them do you know who it is. If they don't know that's okay, I'd just probably ask them what kind of questions are they being asked [by the voices]. Because I know all the questions I was asked and I know everything that I said back. TW

I would ask them what they think is going on for them and I would listen to that and go with that. I wouldn't want to put anything else on top of that. TW

I would have to go with my instincts. I would probably go and sit very quietly next to a person. But then that might freak them out even more, I would just trust my instincts. Most probably I would sit very quiet with them. TW

6.2.4.4   Cultural support workers

Cultural support workers referred to questions that determined the effect of the experience and support that might be required,

I think personally to be able to give them an opportunity, an environment where they can let it out. Non-threatening, I don't know, maybe it's a safe route with someone they can trust. And we can question their voices, just a place where they can share their story or share their voice, tell you what they're hearing, tell you what they're seeing without being screened and assessed and put another name tag on them. Oh manic depressive, manic paranoid schizophrenic, without being labelled I think that confession of the soul or being able to speak, where it's awhi'd and not judged. CSW

What are the voices saying? Is the whanau there? ...Has there been any abuse? We go through the whole initial assessment, drug and alcohol issues because you know all this can impact on what the take is. CSW

I'd want to know what happened, what brought them here now? What current situation they are in? What stress they are under? When they are sleeping? Because I think not sleeping affects this kind of experience. And I would want to know something about what has happened in the past and the history of this experience. When it first occurred, what the context was and how they're dealing with it. What makes it better or worse? I would start to have a conversation about how much control they have over it and help them to hopefully recognise or find ways of getting more control. CSW

What are they saying? What are these voices saying to them? Are they good voices? Are they one of those one's where they talk through the TV? So I say I cannot hear or see what you are so help me share with me. I let them know that I am only wanting to help them but I cannot help them if they don't help me try to understand what they are going through. CSW

6.2.4.5 Students

Most students asked content driven questions. Some asked about individual's beliefs about their experiences.

It would depend what sort of role I am in with that person. If it was a friend I wouldn't be asking clinically driven type questions. I would probably think it was quite awesome and I would say, oh do you know who the people are? Who are you hearing? Is it one person? Who do you think it is? What

are their beliefs around what the voices are, are they distressing to them? I guess some of those questions are clinically driven but I wouldn't think oh my gosh, I'm going to admit you to a psych ward or something like that. CLIN/STU

Who do you think it was? That would be my first question. Did you feel threatened at the time? Did you stay in the room? Did you communicate with this person? What did you feel? Were you able to stay in the room to get more information? STU

I don't know, again I would question them and get their understanding of what it is they're hearing and get their response to what it is they are hearing. On one hand you could say they have some sort of mental disorder or on the other hand there could be something else going on. Again, I don't know I come back to that belief that there is a spiritual world. STU

Unless everyone was upset or particularly bothered I don't think I would [ask questions]. STU

This section is dedicated to comments regarding current pathways of healing and how these may be enhanced when working with Māori who have become 'unwell'. The following section presents participants recommendation on how the higher rates of Māori becoming unwell or needing mental health services might be reduced.

6.3   MAKING SENSE OF, AND WHAT CAN WE DO, ABOUT THE STATISTICS

This final section deals with the last two categories together: making sense of the statistics and what can we do about them. All participants were asked the question of why they believe the disparities exist between Māori and non-Māori in terms of hospital admissions for psychosis. Forty-nine participants referred to the effects of colonisation (urbanisation, assimilation, racism and discrimination) and associated issues around misdiagnosis as explanations. Further to this, participants we asked for their recommendations on how current disparities can be addressed. The major recommendations made were in regards to various levels of prevention.

Table 11: Themes and sub-themes for making sense of the statistics and what can we do

Theme	Sub-themes	Number of participants coded
Making sense of the statistics	Urbanisation Assimilation, Racism and discrimination Misdiagnosis	49
What can we do about the statistics?	Primary prevention Secondary prevention Tertiary prevention	35

6.3.1   Making sense of the statistics

6.3.1.1   Urbanisation

Living in urban areas away from whanau support and marae was considered a major explanatory factor for current disparities in statistics for the rates of admissions and readmissions to inpatient units for psychotic disorders between Māori and non-Māori.

At the moment for example I think there is something wrong with our family structures in Māori. Where is the family structure and standards of health that I grew up with? It's not easy because we're so

236

spread out across the country and around the world. I think this has to do with what is affecting Māori and PI [Pacific Islanders]. KAU

I think that iwi orientation thing is a hard thing to lose and the mauiui [sickness] seems to happen when they do this independent thing...I think some of my whanau you know, I have to get in there soon and stop them from cracking up. It is living down here in Auckland and not being back home around each other that does it. KAU

Some referred to urbanisation as a specific political strategy to sever whanau links. This was considered to impact negatively on Māori mental health.

I remember the days in the 1950's and 60's when we had so many houses around our marae, today there is not one house there. That is because of the effects of the 1953 Town and Country Planning Act. I didn't know about it at that time. But when our people went to get a mortgage for their house or a loan through state advances, now called Housing New Zealand...they say oh yeah you can have it, but you've got to move to town. That's how they got us off the marae at XXX...Now we don't have that connection, we are all so far away from each other and have no support, what is that going to do to your mental health? KAU

Whanau were all removed socially and genetically. Top social engineering, cutting our funding up home, all rural areas so we can become dependant on a welfare system. The impact of colonisation. Taken away from the whenua, the kai. CSW

They are most likely second or third generation living in state housing in towns, benefit families. I am not surprised that it is higher [Māori admission rates] because Māori have got all of these social issues going on. STU

One young participant described her sense of loss at moving to the city from a rural area in which she was raised.

It's like it's a family [the school] it's really hard to understand if your not there. But like you walk down the street [in rural home town] and they're like, how's your dad? You can't do anything wrong because everyone will know. And you move away it's like you've left your whole family behind even

though you're not related. And you see them five years later and you just get that feeling like you only saw them yesterday. In our school there were a lot of people like me and they would just get taken down to the pa and koro would come out and talk to you about it [hearing things and seeing things others cannot]. Up here they laugh at you or call you names it is very nasty. TW

Clinicians also believed that rates of hospitalisation were related to urbanisation of Māori.

I think it is because of the area we are in also, in Auckland. I think some people may still feel a connection with where they come from but they are not there because they are in the urban area so there is that disconnection. STU/CLIN

A lot of them just don't know who they are because they have been brought up away from their whanau, hapu, iwi... In my books the major ill is loss of identity not schizophrenia. CLIN

Some believed that not only those Māori who moved to the city were adversely affected but also those left at home,

I would say here in the far north, the Māori community seem to be more involved in drug misuse and abuse... It's just that the good role models the one's who keep things in order have gone and now the younger one's don't have anything to look up to. KAU

You should have seen this place when I was a child. There were no beaten up old cars on the side of the road. You never sat down in front of the television after school. We all worked, we all respected our elders and what they told us to do, we didn't need police, the rangatahi would listen to the kaumatua then. There used to be children everywhere, now the school has closed down. We all used to be dairy farmers with hundreds of cows, the new dairy board regulations brought an end to that [too expensive to run farms], now the land just sits there. Then we all had to move away to find a living, support the whanau. For a lot of us back then the city was a way of getting away from it all. But this meant we didn't have the leaders back home we used to. Now the kids don't listen, they have the odds stacked against them before they begin. KAU

The only way they will get it is if they go back, but, they've got to leave home because the opportunity is here, work is here [Auckland]. There is nothing up there anymore. KAU

6.3.1.2   Assimilation, Racism and Discrimination

Another effect of colonisation discussed was the process of assimilation that is fuelled by both racism and discrimination. These issues were considered explanations for current disparities in statistics between Māori and non-Māori.

I think it's ripped us off. I'm thinking back to time maybe precolonisation. I am not saying that life for Māori people was sweet as then but we had a better understanding of the process of life and death and change and then when the Pākehā came over the years did what they thought was right by us, what the Pākehā didn't possess was the ability to integrate the entirety of life which includes the things in the spiritual realm. The gods and goddess and everything beyond. Somewhere along the line we were made to feel, I think we were abused, I mean the Pākehā had ways, Christianity being probably the biggest way, and then the law, Pākehā law, of telling us as Māori that we didn't have it right, that we needed to be civilised people and that the white way is the right way. This is how we could become worthy people. TW

Western ways of being often eradicates the human spirit. It doesn't allow feeling, expressions to reach their potential. Mainly because, in the case of Māori, colonisation, assimilation has eroded the expressions of being human and, in the Māori world, if you like the tapa wha model Western medicine hasn't allowed that. TW/CSW

Probably abuses, trauma [causes of high rates of schizophrenia] like telling us that we are shit, you start believing that stuff you know. From suppression of who we are. The Europeans have taken our culture away. Trying to keep up with the modern world really, trying to cope with everything. TW

I would like to say trust your own instincts but I think as a result of colonisation that is something that has been taken away from us, the ability to trust our instincts. Many of us have had to relearn how to trust our instincts. There are still many of us that believe the white way is the right way forward because that is what we have been told from a very young age. TW

Today in New Zealand we have had to adjust to the Pākehā way. I just thank god, I thank atua that we still have access to Māori rights. I tell you what if this was a Pākehā mental health unit I wouldn't come here. I come here because it is Māori. TW

I thinks it's because of our extra-ordinary hospitality and manaakitanga because we always seem to put others ahead of ourselves. Even when you look at the Treaty of Waitangi and get into it, you find that we are actually saying, you fellas can have this to use, we've got enough, we give you a little bit and then bam, they opened the door. That's the generosity of our people. KAU/MAN

The whole history of our people, that's where we screwed up last century. Māori tried to fit in to the Pākehā system. They tried to go the Pākehā way. They tried it for a whole hundred years. They tried it with education, health. It hasn't worked. That is because we have always tried to bend over backwards to try and accommodate the manuhiri [visitors]. Now the manuhiri think New Zealand is theirs and we are getting marginalised. KAU

Colonisation plays a part because it is still happening now the effects of that, but you know all of those historical things come to play a part. Loss of self esteem, self concept, going into a typically white education system not geared for Māori, not teaching correct Māori history, getting the wrong picture from the beginning...It goes across all borders really, health, education, there has just been great disparities in those areas for a long, long time. Just keeping the very best from our people and not treating us equally. CLIN

Probably also just the collective history of Māori being oppressed and colonised in a certain sort of way. I know my grandfather was one of those who was forbade speaking Māori at school. TW

Two participants discussed a belief that the mana of Māori as a whole had been diminished as a result of colonisation. It has already been discussed in Chapter Three that diminished mana can lead to illness.

Being transcends race, creed anything. It allows people to be human beings. Which to me tapu. Everyone has the right, the potential to be who they are. Because this is not acknowledged the tapu is broken, because they tapu is broken we haven't got the mana to be who we are. TW/CSW

As our society becomes more liberal, maybe there is things in our older ways of being that Māori are beginning to transgress the original cultural norms and even though we are beginning to develop as a

society, I wonder if we are beginning to change some cultural norms and as a people we are transgressing tapu. I don't know it's just an idea. CLIN

The enforcement of foreign paradigms and discrimination towards Māori constructions was considered present within mental health

I think that for too long Māori ways of doing things, I guess it stems right back to the Tohunga Suppression Act maybe, where Māori were not able to practice in their own way. Can it become too clinical? Too drug oriented? I know you have to look at the bigger picture but in my mind I cant quite put my finger on it because it's [gap in statistics] a combination of a few things, history, the effects of colonisation, the whole picture. CLIN-Māori

There is a word hegemony that I learnt at college. Dominant culture rules ay. And what I find with the medical model is, all those with medical model training the dominant culture rules. CSW/MAN

Often we are not listened to in a way that respects our opinion of what is going on. You are scared sometimes to say something just in case they think you are crazy too. They [psychiatrists] talk over you and above you or at you, not with you, they don't often ask, what is your take? They tell you what they think because they are supposed to be the experts. CSW

6.3.1.3   Misdiagnosis

Misdiagnosis was seen as another possible explanation for the disparities in statistics between Māori and non Māori for the diagnosis of schizophrenia.

I think people are misinterpreting the symptoms obviously and giving them this diagnosis as soon as they hear something to do with hearing voices then they automatically give them a diagnosis of schizophrenia. CLIN

Well, the profession of psychiatry which makes such diagnoses. This is a good example of what racism is, the power of people. Because Māori experiences don't fit neatly into this profession then we, they get dumped into schizophrenia. KAU

It may be that institutions where their Māori patients are likely to be diagnosed with schizophrenia have a culture of assessment and diagnosis which is biased towards viewing Māori patients who are acutely unwell as having a primary psychotic illness rather than an alternative diagnosis. CLIN

6.3.2   What can we do about the statistics?

Various levels of prevention were discussed by 35 participants. The general themes that emerged were:

- Primary prevention: consisting of educating all Māori from a young age about cultural constructions cultural practices

- Secondary prevention: Helping at risk groups by assisting young Māori and their families to identify extra-ordinary experiences and seek appropriate support early.

- Tertiary prevention: Support for individuals and families already utilising mental health services to prevent relapse.

6.3.2.1   Primary prevention

Teaching Māori tamariki (children) about cultural constructions of EOE and pathways of healing from a young age would be a protective factor for mental illness. Strengthening identity via learning tikanga, whakapapa and Māori accounts of history were discussed within this context.

I gave a boy a book on Whina Cooper who was from the same area as me. He read it in a week and said, I need to go back there. We need an early intervention, of course we are going to know and support one another…How can you put these kids down when they have never been trained. To me, these interventions don't happen in the classroom they're life skills.   CSW

Education. I think our people need to start looking at what is happening and do something about our tamariki now. Teach them now because otherwise our people will be lost, there won't be many of us out there. They have started that now with the reo. But we need to go back, start growing our own kai. It's a different life style growing up in the city; they have just missed out on so much. CSW/MAN

Those of us left with the knowledge need to teach our young one's tikanga, not just the reo, the tikanga that gives the words their substance and meaning. KAU

I sort of strongly feel that if our people knew where they came from they would have a sense of identity and a sense of, because of many things, lack of access to things Māori especially in the cities. It is getting better, but you know the confidence to be able to access resources. I do feel if people knew where they came from, go back to their whakapapa and weed out where their tupuna are and their leaders they will probably find that each of us come from very strong warrior people and leaders. Find the good stories, you get your bad with your good as well. But it has to start from babies and be brought up with that I think Māori will begin to move ahead. CLIN

It is not teaching correct Māori history, getting the wrong picture from the beginning. I think if Māori were taught the true history then we would have come out feeling a lot better about ourselves. KAU

It is because knowledge is understanding, when you get that you can clear it. Education helps to heal because you understand, you read through stories and realise you're not the only one who is going through that [hearing voices], a lot of people are going through that... Yeah education I'd say would be the answer to it all. KAU

Better education [about EOE]. For teachers as well. Right from early child hood, primary, intermediate, college. Some of our kids are missed at primary intermediate then it's hard yaka. We also need people out there promoting awareness. CSW

One person recommended that the best form of primary prevention is to begin with education regarding mental health awareness within one's own whanau.

I just think that our people need to wake up. Stop pretending that the issue of mental illness in the community doesn't exist. Get real, it's out there. Whanau need to be, we just have to ask ourselves, what are we doing on an individual basis to ensure that every single person in this whare [house], we are addressing our mental health needs. Not addressing, preventing, prevention there should be more money in that. CSW/MAN

6.3.2.2 Secondary prevention

Early intervention in the form of screening by asking if rangatahi encountered EOE as well as education about who and how to access help was considered important.

I would like to see more education around intervention. Go to schools, we are trying to do that in schools at the moment. MAN/KAU

If you are hearing voices I believe educate at a very young age to go and see someone early. I would like to see as part of general health questions asking our rangatahi are you experiencing these things? MAN/KAU

If they do go to their parents, oh go away, you're mental and they go into all their little groups to try and help each other. We need to teach them who they can turn to just in case it does happen, don't wait until it's too late. KAU

In our school there were a lot of people like me and they would just get taken down to the pa and koro would come out and talk to you about it [hearing voices and seeing things]. TW

Utilising individuals who have encountered EOE and the mental health system themselves to support young people encountering EOE was also recommended,

I think we need more people like myself who have been through the system and who have been diagnosed. We need more people who are able to educate and take the lead about being human in this world. TW/CSW

They can teach the rangatahi [youth] their experience, be open about it ay. One of them said to me, it is people like you we need, people who understand. When they have hallucinations or something, they've got no-one to turn to...who really understands them. TW

6.3.2.3 Tertiary prevention

When encountering the mental health system, it was recommended that individuals and families be educated about such things as medication, the Mental Health Act and diagnoses. It was

believed this would assist in reducing the risk of relapse. The following is one (small) part of improving services to address disparities in readmission rates. Other recommendations have already been made in section 6.2 such as increased collaboration between Māori and Mainstream pathways, increasing access to Kaupapa Māori Services and having less reliance on medication as the sole line of treatment.

A lot of it is that I think families need education anyway. I was one of those not being aware of what goes on in the system, what hospitalisation and the MHA means. Half the families aren't aware or informed exactly what they are going through or how to go about it. Clients need to know they have got rights. CSW/TW

The family need to be involved in all aspects of the mental health care, it helps tangata whaiora to understand they've got the support from the family there as well. So quite a lot of it is family education, assisting the client to identify when they are starting to become unwell, identify early warning signs which they don't always pick up themselves. The family certainly needs to be involved and educated as well. CLIN/MAN

I think it's important that medication is there because sometimes that is all. But it's how people are prescribing it, Māori people don't want to take it ay. It someone imposing on them most of the time. There's not enough work done around getting people to accept that this might actually be of benefit to them. The whole thing, when people become unwell everyone is like medication and it's always seen as a bad thing, not a good thing. But if you spend some time on education, if they are explained in the right way and reframed for Māori it could be really useful. CSW/MAN

6.3.2.3.1.1 Clinical training programmes

Developing the Māori mental health workforce to work with Māori encountering EOE was another way in which services could be improved. This was considered a way to address the rates of Māori admissions are readmissions.

Why doesn't the government go through all the Māori communities throughout Aotearoa and go into the colleges and find students who want to become doctors and psychiatrists and pay for them. Fund

them from a young age in college who want to be Māori psychiatrists doctors and so on and pay for them to be trained to complete their training. Instead of importing overseas other people to work with our people. CSW/MAN

Upskilling non Māori clinicians to increase cultural competency when working with Māori as well as providing education about resources available within the Māori community was seen as a complementary and parallel process.

They can only go by their book [DSM] and what their knowledge is. So if we're not in the book as Māori, if Māoridom is not in there and the spiritual side, well they can't help. So they just do the best with the information they have supplied to them or whatever they've learnt. It goes right back to training programmes and school and how we educate our people. TW

The European thinking though is that anyone who hasn't done 20 years of study cannot perform to a level of expertise as maybe others, but we find for us, some of them are born to it. Not only do they carry the mana of their own physical being but also the mana of their tupuna's before them because some of them come from a line of them. So you get 400 500 years in some cases of this tohungaism but they cant see it. So we need to educate our agencies to try and believe that we have a way of dealing with the mental health of our own. The manner may be different but if we are going to work together they have to let us. We have to look at different options. KAU/MAN

I often think that Western medicine should allow Māori to take the lead and open up the spiritual world to them. TW

An example of educating about Māori perspectives within mainstream institutions was provided by a kaumatua.

Makutu in actual fact, each year I go and do a lecture at the school of medicine. A lot of doctors now are starting to recognise that there is such thing as mate Māori and makutu. Now they start looking around for people like me to do it. They are starting to recognise that there is something not right, which is a good thing. KAU

246

7   DISCUSSION

The discussion is presented in six major sections. First, a summary of the major findings from each of the four categories in the results will be presented. These findings will then be discussed in relation to national and international literature. I will then attempt to outline the theoretical implications of the findings in terms of Personal Construct Theory (PCT) and Kaupapa Māori Theory (KMT). Next, the clinical implications of the findings will be summarised. Some recommendations for future research will then be made and some overall conclusions will be shared. This discussion is prefaced by recognition of the limitations and strengths of the current research and some additional issues specific to conducting Kaupapa Māori research.

7.1   ISSUES

Based on the Kaupapa Māori paradigm used for this research, a number of issues were encountered that required understanding and flexibility. The question of what information to include and/or exclude was a central issue. I was advised before embarking on this research that some information may be very tapu and caution would need to be exerted around how I presented it, if at all. I sought advice on occasions where it was ambiguous to me whether information should be included. However, there were some occasions where it was blatantly obvious. For example, when specific families were discussed regarding their histories of encounters with mate Māori or makutu, I knew this information was too personal and should not be included due to confidentiality. Therefore, some narratives were omitted as they would be easily recognisable even when names of people and places were suppressed. On another occasion, when transcribing an interview, a whole section of a tape was mostly inaudible (with either side of this section being perfectly audible). This section discussed the participant's understanding of makutu. Even though I could recall much of what the participant had said from my notes, I decided this was a sign that the information was intended to be left between the participant and myself. My choice of interpretation was informed by the fact that the tohunga I had interviewed told me at the end of our discussion that I should not be surprised if sections of

the tape are inaudible as our discussion was tapu. Looking for these signs and understanding them was a significant part of my learning throughout this research.

Another issue encountered along the way was that of consent. Verbal consent for Māori is binding. Upon reflection, I did not like how the signing of the consent form framed the interview. A number of participants were apprehensive to sign and this process brought an air of caution, mistrust and scepticism into the room. I tried to normalise their concern by adding that others had been apprehensive about this process. I then explained what the signing meant in terms of participation and their right to withdraw. I also acknowledged that this was a very Pākehā way of obtaining consent. I explained that my research was being conducted within a Pākehā institution and therefore certain processes needed to be followed. Consent is an issue that needs to be addressed in terms of Māori ethics. For example, ethical boards should assess whether verbal consent is sufficient if it is taped. Maui Hudson (2004), A Kaupapa Māori researcher, has attempted to address ethical issues that may be unique for Māori. In terms of consent, he also raised the issue of individual consent, calling for ways in which communities can provide collective consent.

7.2   LIMITATIONS

7.2.1   Sample characteristics

The participants interviewed for this research are not representative of the entire Māori population. Voluntary participation and the recruitment methods used (advertising within Māori media and spaces) may have resulted in some sample bias. For example, participants "sympathetic" towards cultural and/or spiritual constructions of EOE may have been more inclined to participate. Despite this limitation, a broad range of understandings were shared that included psychosocial and biological explanations indicating any bias towards Māori spiritual constructions was far from absolute. The views expressed by the participants can be seen as forming *part* of the discourse around Māori constructions of EOE and therefore should be heard and respected.

The level of demographic data gathered from Māori participants in terms of cultural identity was also limited. Narratives and personal information shared during interviews revealed a range of

248

personal levels of identification as Māori as well as various levels of access to cultural resources. While not explored here, it may be that stronger cultural identification and participation in the Māori community results in a greater strength and/or variety of cultural constructs. A number of measures for cultural identity were assessed before conducting interviews however none were used as they were either too long or assumed a stereotypical construction of what it means to be Māori. Future research that attempts to investigate the relationship between cultural identity and Māori constructions of EOE should utilise measures that incorporate an inclusive, rather than exclusive, construction of what it means to be Māori.

Another limitation of the research is that the sample included such a broad range of iwi that constructions unique to particular whanau, hapu or iwi could not be presented. Considering the majority of participants descend from iwi in the Tamaki Makaurau (Auckland) and Tai Tokerau (Northland) regions, the results may be affected by the knowledge that descends from these groups. Future research that focuses on particular whanau, hapu, iwi will help to illuminate the commonalities and uniqueness inherent within and across these groups. It is recommended that members of the whanau, hapu or iwi of interest are used to conduct this research.

In terms of the sample, only five participants were non-Māori and all were clinicians. The sample is far too small to make any clear comparisons between Māori and other groups in New Zealand. It is also likely clinicians "sympathetic" to Māori constructions participated in the research as evidenced by the holistic views shared during interviews. Beavan (2005) has conducted a study of constructions held within the wider New Zealand population for hearing voices. While none of her sample were clinicians, she found non-Māori in New Zealand to also hold broad explanatory models that included a strong theme of spirituality. It is not the aim of this research to argue that spiritual constructions are *only* held by Māori in New Zealand. Rather, the aim of this research was to investigate a range of constructions that are *relevant* to Māori. It is recommended that non-Māori receive similar attention in New Zealand from future research.

7.2.2 Methodological limitations

This research was limited by it's exploratory nature. A broad range of issues were covered that could not be investigated in great depth. Future research might investigate these constructs

further. For example, future research could assess the utility of the constructs outlined here across various groups both Māori and non-Māori. One participant made recommendations for future research that investigates the meaning of the construct pōrangi for Māori living within their communities and tracing the change in the meaning of this construct over time from pre-European contact to contemporary contexts.

The constructions shared by participants were also possibly affected by the way in which the questions were asked. When asking a Māori nurse their understanding of a person who hears voices that are distressing, they may change their response depending on whether they are talking from a perspective of being at work or a member of the Māori community (the former may elicit more psychiatric constructions while the latter more cultural). Some participants explicitly referred to this duality of roles:

Can I give a view totally outside of professional role? Can I give a view of an experience of a mother of a consumer having been through that? TW-mother/MAN

Stepping outside of my role as a nurse is kind of hard sometimes. I guess as well is that you need to get an understanding of whether you know this person. CLIN

It would depend what sort of role I am in with that person. If it was a friend I wouldn't be asking clinically driven type questions...I wouldn't think oh my gosh, I'm going to admit you to a psych ward or something like that. CLIN/STU

In order to address this issue, I asked participants to share their perspectives in terms of their role as a Māori community member. While it is recognised that stepping out of one's role within a clinical setting is inherently difficult, many participants seemed to understand this distinction and felt at ease with talking from their perspective as a community member instead. This differentiation was interesting in that it indicated Māori clinicians may be inhibited from expressing and utilising their beliefs in clinical practice.

In addition, the wording of the question can affect whether participants draw upon their personal experiences or another person's experience. Within this research participants were asked to

provide their understanding of another person's EOE. This precaution was put in place to limit the intrusive nature of the interviews as discussion about personal EOEs may have involved some level of trauma and distress. Despite taking this precaution, many participants also drew upon their own experiences to understand the EOE discussed in interviews.

Conducting all of the interviews in English also represents another limitation. As outlined within Chapter Three, some Māori constructs are difficult to translate into English. A depth of understanding and meaning is inevitably lost in translation. This may be especially so for the kaumatua group as many had Māori as their first language. I have already mentioned that kaumatua chose to speak to me in English as I am not fluent in te reo and such an interview would have required my kaumatua conducting the interview and translating for me. Future researchers, who are fluent in te reo Māori, may choose to conduct interviews within the Māori language to ensure that the depth of information is maintained. However this method has it's own limitations as many Māori have not been brought up learning their language. Therefore, the results of research conducted and written in te reo Māori would only reach a limited audience. Indeed, many of the tangata whaiora I interviewed had a limited grasp of te reo Māori.

Another limitation relates to the fact that the EOE used as prompts within this research were intentionally devoid of context, history, social indicators, personality and other factors associated with people in the real world. The experiences used as prompts in the interviews were presented to participants without context purposefully to enable participants to independently determine the contextual factors they deemed important for understanding the person. The prompt that asked, "What questions would you ask to understand more about the person's experience?" (See Appendix E) was targeted towards gathering contextual information. Further to this, the current project in general did not cover Māori ways of understanding the negative symptoms of schizophrenia such as withdrawal. This is a significant limitation as it is well known that negative symptomology is what many consumers find most difficult to live with. A current project (as yet unpublished), conducted by Hapai te Hauora (a Kaupapa Māori health information service), is investigating Māori constructions of symptoms of depression. This research may help to provide a broader understanding of the constellation of issues tangata whaiora labelled with schizophrenia present with. Future research that uses more in depth

vignettes or real people accessing traditional healing or mental health services is recommended to assess the utility of the constructs shared here within a real world setting.

Finally, knower and known cannot be separated. The author is not independent of the construction process. As well as presenting participants' constructions in their pure form, I attempted to make meaning of another's meaning. In addressing this limitation Kelly (1991) argued,

> If immediate accuracy is what I must preserve at all costs, then I had better stick to the first level of construction [construing one's behaviour]. But if I am to anticipate you, I must take some chances and try to sense what you are up to, (p15).

This is an inherent issue with all qualitative research. My interpretations are inevitably influenced by my own values and experiences. I have already indicated in Chapter Five that my past experience shaped certain biases and assumptions I have about the world. I hold a strong spiritual framework when interpreting EOE. I also assumed that current mainstream psychological training and services are poorly lacking in their understanding of spirituality and that this lack of knowledge could affect Māori presenting with EOE. These assumptions may have influenced my interpretation of the data by selecting those comments that align with my own biases. My own biases may have also attracted certain participants to engage in the research. To address this issue, I purposefully went through the data to find counter-narratives (for example, narratives of mainstream services and treatments working well for Māori) so that I was providing a more balanced report. I also attempted to access Māori from outside of my own networks to ensure I was gaining a broader perspective.

There were a number of other cultural factors that may have limited or enhanced what participants shared with me during the research. My age and gender could have affected what people shared. For example, kaumatua may have withheld some information due to their belief that I was too young.

7.3   STRENGTHS OF STUDY

One of the major strengths of this study is it's Kaupapa Māori underpinning. Being a Māori researcher and sharing to some extent identity, values and beliefs with participants is an integral and important part of this research. For example, constructions may have been shared that might not have been elicited by a non-Māori researcher. As outlined in the methodology section, being a Māori researcher entails relationships and responsibilities that are different from most psychological researchers. The principles and practices of tino rangatiratanga (self-determination) and whakawhanaungatanga (coming together under the Kaupapa of the research), inherent within Kaupapa Māori research, instilled a personal sense of commitment and responsibility back to those I had consulted with and the participants I was yet to interview. This represents a major strength of the research, as I believe it increases the validity of the results by ensuring community members themselves helped to shape the research questions.   Further to this, the community was involved in the research interpretations via participant feedback and the rangahau whanau.

Another strength of this research is the kaupapa of aiming for balance between multiple ways of constructing the world. A major concern for Māori when engaging in this dialogue is the exploitation of our knowledge. As is the case with most research conducted in Māori health, a balance must be sought between the issue of providing information that is going to help our whanau members using mental health services and risking the exploitation, misuse and/or misinterpretation of our cultural intellectual property. With the guidance of the rangahau whanau, this research used the benchmark of positive Māori development to make moral, ethical and academic decisions throughout the process.

> Two issues that iwi and Māori providers have raised from their side of a partnership relationship are: how far do they go in terms of explaining what they do in language that the crown will understand and how do they protect their intellectual property if and when they do successfully explain the work that they do? Both issues need to be addressed within the context of a partnership relationship that upholds and supports Māori development, (IRI, 2002).

7.4 SUMMARY OF MAJOR FINDINGS

Outlined below are the major findings of this research, derived from comments loading onto the four categories developed from participant interviews. This summary is not exhaustive and has been developed in consultation with the rangahau whanau regarding the salient findings.

7.4.1 Making sense of EOE and schizophrenia

- Māori are a heterogeneous group when understanding EOE. Participants held numerous and various explanatory models with a preference for cultural (especially spiritual) and psychosocial explanations.

- Māori constructions are not general concepts, but are well-defined and lead to specific and practical ways of understanding EOE.

- EOE are *real* experiences that many Māori accepted as common everyday experiences. Māori have *real* relationships with the voices and visions they encounter.

- Within a cultural framework, EOE indicate either a Māori illness experience (mate Māori) or a gift (matakite). Making sense of these experiences requires suitably qualified individuals from the Māori community, namely other matakite, tohunga or experienced kaumatua/kuia.

- Whakapapa plays a significant role in understanding EOE. Historical events dating back several generations have much more relevance than current Western psychiatric notions of relevant background information (usually one generation removed). Historical events can affect the development, course and content of EOE.

- Contact from tupuna can occur in a number of forms, including hearing voices and visions. These experiences often occur for specific reasons; either to help / warn an individual during difficult times, to pass on knowledge (to descendants) or to get something done in the physical world.

- Trauma (physical, verbal sexual) and substance abuse may contribute to the development of EOE in contemporary contexts, especially for youth. These factors also directly affect the wairua of an individual.

- A major boundary between Pākehā illness and Māori cultural experience (negative and/or positive) may lie within the experiencer (in terms of their personal understanding) rather than the experience itself. This is also influenced by the constructions shared by those around them (whanau, friends, helping professions).

- Clinical constructions (derived from the DSM-IV and biomedical understandings) may affect EOE in a negative manner by internalising the problem and being associated with expectations of a chronic course. Māori cultural constructions may contribute to more positive outcomes by contextualising the experience (externalising the problem) and developing expectations of a remitting course and/or recovery.

- Schizophrenia as a construct held little utility or relevance for most Māori participants even those who have been ascribed with, and work with, the label.

- Māori may be reluctant or cautious about sharing their cultural constructions of EOE within mainstream mental health settings lest they be misunderstood and labelled mentally ill.

7.4.2 Pathways of healing

7.4.2.1 Mainstream pathways

- The diagnosis of schizophrenia and the process of diagnosis is a cultural phenomenon specific to Western psychiatry that may not be relevant or applicable to Māori.

- The use of the Mental Health Act can limit clinicians', whanau and tangata whaioras' choices in terms of treatment and restrict options to medical interventions.

- Medical treatment should not be the only or primary line of treatment. Medication can lead to limited and, at times, damaging outcomes.

- Māori may experience more negative side effects and be differentially treated within mainstream settings.

- Trialling multiple medications can make tangata whaiora feel like "guinea pigs."

- Medical treatment may be useful to reduce distress, increase an individual's ability to cope with everyday life, manage safety and enable the person to engage in other therapeutic activities more effectively.

7.4.2.2 Māori pathways

- Māori pathways incorporate underlying values of acceptance, support and hope and are not time limited (for example, practitioners of Māori pathways will spend all night with an individual to develop a full understanding of their experience).

- "Taking them home" recognises the role of whanau and the wider community and marae in the process of recovery.

- Tohunga, kaumatua and Māori ministers play key roles in Māori pathways to healing. Karakia, rongoa and mirimiri were discussed as key tools in the expertise of these individuals.

- For Māori pathways to succeed, a number of barriers need to be addressed such as stigma in our communities, limited resources, access issues and limited numbers of qualified practitioners.

7.4.2.3 The cultural-clinical interface

- Successful integration of Māori and mainstream pathways requires meaningful participation of Māori staff in the assessment and treatment processes.

- The use of space and time requires adjustment to incorporate tikanga.

- Barriers to successful collaboration include the unequal distribution of power between medical and cultural constructions where the latter are often ignored, marginalised or pathologised within mainstream settings.

- Māori clinicians play an integral role in the navigation of the cultural-clinical interface and face significant barriers (in terms of training and leadership) to resolve the conflicting identities of being Māori *and* a clinician.

- Increasing the cultural competency of non-Māori clinicians is a major task at the cultural-clinical interface.

- A small group believed Māori and Mainstream pathways are so incompatible they should be kept separate.

- A paradigm shift is required where Mainstream pathways are integrated into Māori, rather than the other way around, for the cultural-clinical interface to be successful (see figure 2).

- Both cultural and clinical assessment questions were asked when assessing Māori encountering EOE (see table 13).

7.4.3 Making sense of, and what can we do about, the statistics?

- Historical and current sociocultural factors such as colonisation, urbanisation, assimilation, racism and discrimination have contributed to current disparities in Māori admissions and readmissions to inpatient units for psychotic disorders.

- Factors such as racism and discrimination within mental health services and general ignorance of Māori ways of understanding EOE may contribute to current disparities by generating a bias towards diagnosing Māori with psychotic disorders.

- Prevention at primary, secondary and tertiary levels were considered key initiatives required to target current disparities in statistics. Primary prevention targets all groups and aims to increase positive cultural identities; Secondary prevention targets at risk

groups in order to increase awareness of cultural constructions of EOE; and tertiary prevention was recommended in the form of education and support for individuals and whanau already diagnosed with schizophrenia to prevent relapse.

7.5   RELATIONSHIP TO PREVIOUS FINDINGS

It has already been mentioned within Chapter Three that there are very few studies that have specifically researched Māori and schizophrenia. Therefore, the wider research on Māori and indigenous mental health has been used to make connections to previous findings.

7.5.1   Resilience of Māori constructions

The current findings are consistent with previous research that has identified the resilience of Māori spiritual beliefs relevant to the diagnosis and understanding of mental illness (Beaglehole & Beaglehole, 1946; Cherrington, 1994; Lyndon, 1983). This is despite various political, social and legal events that have specifically tried to suppress these beliefs (Lyndon, 1983). This finding is also consistent with the resilience of Pacific constructions of mental health in Samoa and New Zealand (Tamasese et al., 1997). Lyndon (1983) predicted, almost twenty years ago, that Māori constructions regarding tapu, mate Māori and makutu would continue to be used to understand mental illness in the future as she observed these beliefs were already being passed on to the next generation of young Māori. She also believed that increased acceptance of Māori constructions through the period of Māori development in health would serve to strengthen these beliefs (Durie, 1999). My research has found support for this prediction as many of the participants I interviewed, who had been in contact with mental health services for long periods of time, still retained strong cultural constructions of their experiences and work. However, it was also apparent that many participants had their constructions ignored, marginalised or pathologised within mainstream settings. This indicates that in some instances, there has not been a significant shift in the system in terms of acceptance of Māori constructions. This may be especially the case for the diagnosis of schizophrenia, as it remains the most medicalised mental disorder.

The apprehension of participants to discuss their beliefs and practices with non-Māori within clinical settings has been found in previous research with Māori (Beaglehole, 1939; Gluckman, 1962; Lapsley et al., 2002; Lyndon, 1983) and in various populations around the world (Randall,

1990; Tamasese et al., 1997). Participants here commented they would tell the psychiatrist only what they want to hear to ensure they either get out of an inpatient unit or to prevent them from being prescribed additional medications. Remaining silent, as it was discussed in this research, did not indicate passive conformity (as it may be perceived from the outside) but represents an active effort to survive and protect oneself. This finding has significant implications for the distribution of power in current mental health settings where medical constructions are privileged at the expense of Māori constructions. This unequal distribution of power has lead some tangata whaiora to tell clinicians what they want to hear rather than representing their actual experiences and beliefs.

It should be noted that it is not only Māori who remain silent. Consumers of mental health services in general often feel inhibited and frightened to share their understandings of their experiences with mental health professionals. Suzie Crooks (1999, p.11), the co-ordinator of the Light House, a consumer run resource centre, recalled her active decision to remain silent:

> In the end I just decided that I would behave myself like a good little child and lie to them and con them. I got out [of the inpatient unit] within a fortnight of making that decision. That proved to me that they weren't interested in my wellbeing – they were interested in fitting me into a medical model that I didn't support.

Despite the oppression of Māori constructions within clinical settings, the results indicated that participants held well-established systems for understanding and treating EOE. Just as the category of schizophrenia spectrum disorders incorporates various illness states and leads to specific pathways for treatment, so does mate Māori. A kaumatua working in a community support worker role commented,

> I would put schizophrenia with the same thing as pōrangi, pohauhau, wairangi all those different states of confusion. My understanding of schizophrenia is like having two or three states of that confusion. Schizophrenia is so big; it's one word but covers a lot of things. The same applies to pōrangi, pohauhaua and wairangi; they cover a lot of things in themselves. But those are Māori words that I know that cover those things, that is mate Māori. KAU/CSW

This research makes a relatively unique contribution by describing characteristics of pōrangi and wairangi (both expressions of mate Māori). While these conditions were cited briefly in previously literature, to the knowledge of the researcher, definitions or explanations from

participants have not been shared in past research. The current results are also important as pōrangi and wairangi have commonly been used in general discourse to stigmatise an individual. However within this research, these constructs were discussed in a spiritual manner and the meanings shared were relatively consistent across a number of participants. Pōrangi and wairangi both related to disintegrative states of consciousness that were referred to as a form of illness. This illness arises from an imbalance between the various aspects of the Māori self (hinengaro, wairua, tinana, whanau).

To facilitate an understanding of the way in which participants described pōrangi, a very brief history of Māori cosmology is essential. Prior to the existence of space and time, there were two atua Ranginui (sky father) and Papatuanuku (Earth mother). At first, they were not separated but held each other in a tight embrace. Their embrace was so tight, no light could enter between them; this space was called te Pō (the darkness). The many children of Rangi and Papa felt very cramped between their mother and father's tight embrace and eventually banded together to separate them. They pushed their father, Rangi, up and their mother, Papa, down. Once this was achieved, time, space and light came into the world. This represented the progression from te Pō (the darkness) to te Ao (the light).

Participants within this research described pōrangi as a regression to the state of te Pō. This is a state of nothingness and lifelessness. Within the state of te Pō one loses a sense of self, time and space. Participants referred to pōrangi on numerous occasions for a variety of experiences including hearing voices, seeing things and behaving in an unusual manner. Dissociation between the aspects of light and dark, day and night were discussed as characteristics of pōrangi. Some participant comments from Chapter Six are reiterated here for clarification,

> Pōrangi is that the poor person is in darkness, his mind is in darkness. If we go back to rangi and papa and his mind is in darkness, he doesn't see any light at all, his world is in darkness. KAU/CSW

> There is a word called pōrangi and it is associated with mental illness. Pōrangi is people who don't know, Pō is the night and rangi is the day. They don't know the difference between day and night. KAU

Participants discussed wairangi as a state of disconnection to the wairua (spiritual dimension of the self). The way in which wairua travelling was discussed by participants resembles that which was documented in early anthropological literature (Best, 1976 [1924]).   Wairangi was predominantly used to describe catatonic type states and withdrawn behaviours. Whakamā is also a state that is used to represent withdrawn behaviours, although it refers to a distinct cultural experience as whakama is commonly in reaction to conditions of powerlessness and unfamiliarity (Metge & Kinloch, 1978). Kaumatua proposed antipsychotic medications can induce certain forms of wairangi by disconnecting the individual from their wairua,

> When they have got something wrong with the wairua you find that the wairua is actually off balance and you've got to bring it back through the karakia to get it right again. Then all the korero and whakaaro will start to change. Sometimes with too much Western drugs it is very hard to bring back [This participant was referring to psychiatric drugs as well as illicit drugs]. KAU

This research may have touched on a distinction between the two states of pōrangi and wairangi. These differences can be articulated with the use of Durie's whare tapa wha model (wairua – spirit, hinengaro- mind, tinana- body and whanau- family). Pōrangi relates to the hinengaro being in darkness or out of balance with the rest of the self whereas wairangi occurs when the wairua is out of balance. It should be acknowledged however that these aspects of the self are connected and cannot be treated separately. Confusion, distress and dissociation both intra-personally and inter-personally were described as characteristics of both states. It is possible that these states relate to those findings of Geekie's (2006) recent study regarding the subjective experience of psychosis.   He described fragmentation as a "breaking up of both intra- and inter-personal aspects of the experience" (p.301). Drawing from his participants' descriptions of their experience he described fragmentation as:

> Include[ing] a fracturing of the person's emotional and cognitive worlds, when different parts of the self do not seem to be operating in concert, giving rise to a sense of self that feels as if it lacks coherence in here and now and over time. In the interpersonal and material areas of life, fragmentation refers to feeling somewhat disconnected from other people (with an associated sense of isolation) and detached from the physical world (p. 301).

Overall, these findings indicate that Māori possess systemic and well established ways of understanding illnesses that may be labelled psychotic by the medical model. The states of

pōrangi and wairangi are unique in that they are related to a Māori construction of the self as bound with the spiritual, physical, mental and social dimensions. Some theorists argue that differences in the manifestations of psychosis in various cultures are a function of the differences in the construction of the self (Fabrega, 1989a;, 1989b). Other theorists (Castillo 2003; Lin & Kleinmann, 1988) explain the better prognosis for non-Western cultures as a function of a culture that perceives the self as bound (socio-centric and connected to others), as opposed to independent (egocentric and disconnected from others). This in turn leads to increased integration with family during the course of the illness. The impact of the constructions of the Māori self on the expression and outcome of psychosis warrants further investigation. One participant indicated that Māori are cocio-centric and that this serves a protective function for the outcome of illness states:

> I think if they were labelled with that schizophrenia our people were much better at managing it because there was ongoing support tautoko, awhi, manaakitanga, tuakana/teina. I don't think it became something where they were left out there on a limb. I think a lot of psychoses never came to the [severity], because of tautoko and tuakana /teina. CSW

A number of participants also held beliefs that those encountering EOE or labelled with schizophrenia, may actually be matakite (gifted). Illness states were considered to be a result of not having the proper guidance to understand one's gift. This finding resembles the 'shamanistic' crisis states that have been documented in many cultures (Allen, 2002; Noll, 1983; Randall, 1990).

The process of development for the Okinawa yuta begins with the illness type behaviours (which often involve much suffering and social exclusion) and the subsequent recognition (often by another yuta) that they are possibly gifted (Allen, 2002). Once the yuta has been recognised and accepts the gift, the illness can spontaneously resolve. Rather than returning to a pre-illness state, after acceptance of one's gift, "re-socialisation" takes place where the yuta takes on a new set of social roles and a new identity.

Indeed, the participants within this research who discussed their journey towards becoming a healer referred to a similar process. They recalled initial resistance in accepting the 'matakite' role and a primary state of illness that continued if their gift was not accepted or recognised. Some also shared stories of their "shamanistic illness" being diagnosed as schizophrenic within

mainstream settings. However, with help from others in identifying their gift, the individual then incorporated a new identity and a new set of social roles and cultural norms involved with being a matakite.

Participants also perceived EOE to be *real* experiences. The voices or visions often had a perceived identity with which the individual had a meaningful relationship. This finding is consistent with that of Lyndon's over twenty years ago. The experiences described here were akin to other social interactions participants had with living members of their family. This has implications for the ways in which these experiences are treated in clinical assessments when gathering information on social relationships. For some Māori, EOE may constitute a legitimate form of social interaction. These findings were consistent with findings from Beavan's (2007) descriptions of the essential structure of hearing voices. She found voices had characterised identities, experiencers had a relationship with their voices and there was a "realness" to the experience.

7.5.2   Multiple explanatory models of extra-ordinary experiences

While mainstream mental health settings still have a long way to go in terms of giving voice to multiple perspectives, participants in this research were already doing so. Various New Zealand and international studies have found individuals experiencing psychotic symptoms held various explanatory models for their experience including spiritual, psychological and biomedical constructions (Angermeyer & Klusmann, 1988; Das et al., 2001; Geekie, 2006; C. Grof & Grof, 1990; Joel et al., 2003; Lapsley et al., 2002; Sanders, 2006).

It was also apparent that clinicians and tangata whaiora held cultural constructions alongside biomedical and/or psychological constructions more often than individuals who did not have contact with mental health services. It was not evident that those in contact with mental health services held less cultural constructions; rather they held these alongside those that are predominant in mental health settings (psychological and biological). This supports previous research that has found contact with mental health services to be associated with biological and psychological constructions (Beavan, 2006).

The ability of Māori participants to hold cultural, psychological and biological constructions may be explained by the Māori concept of 'self' as comprising of spiritual, physical, mental and social dimensions. If all dimensions contribute to well-being, it is not surprising that all can be used as explanations for EOE. However, certain constructions may be given more precedence than others. Judging by the number of participants that loaded onto each theme, it was evident that cultural constructions were most commonly endorsed, followed by psychosocial and biomedical constructions (such as trauma, drug abuse and chemical brain imbalances). This is consistent with the frequency and depth of explanatory models found with indigenous people in India (Das et al., 2001; Joel et al., 2003). The greater frequency of psychosocial over biomedical explanations is also consistent with research within the general population in New Zealand (Read & Harre, 2001) and internationally (Read, Haslam, Sayce & Davies, 2006)

Psychological and cultural explanations, as opposed to biomedical constructions, have been found elsewhere to reduce stigma and possibly contribute to more positive outcomes (Castillo, 2003; Read & Harre, 2001). This may be why participants within this research believed Māori constructions had a positive effect on the content, course and outcome of their experience. Alternatively, participants indicated the term schizophrenia and it's associated biomedical constructions lead to more negative content and affect, increased stigma and poorer outcomes. This is also consistent with previous research findings both in New Zealand and internationally (Beavan, 2006; Read & Harre, 2001; Sanders, 2006; Satorious et al., 1987).

It is important to highlight that drugs were considered a significant explanatory factor for the development of EOE. One kaumatua's opinion was that the removal of drugs from the equation would remove disparities in psychotic illnesses between Māori and non-Māori. This concern is consistent with statistics that reveal increased rates of admission for drug related psychoses for Māori and increased rates of substance abuse in Māori communities (Te Puni Kokiri, 1993a;, 1996; Te Runanga o Te Rarawa, 1995).

It must be recognised that the issue of drug abuse for Māori exists within a wider context. Removing drug abuse from the equation is akin to removing the bandage from a wound without healing the wound itself. Drugs have been cited as a coping strategy and "learned lifestyle" in

many indigenous populations when faced with historical traumas and the current social and economic deprivation associated with being colonised (Cook, 2005; Durie, 2001; Walters, 2002). Until these systemic issues are addressed, drug abuse will continue to be a problem for Māori.

Even though some participants held biomedical understandings for individual EOE, most participants rejected the diagnosis of schizophrenia. This included tangata whaiora and clinicians who either work with or have been ascribed with the label. This finding is consistent with Lapsley, Nikora and Black's (2002) research where both Māori and non-Māori rejected the diagnosis of schizophrenia during their recovery. In fact, rejection of the diagnosis was a step towards recovery. Another reason proffered for the rejection of the diagnosis within this research was the "catch all" nature of the construct that rendered it unreliable and invalid. This finding is consistent with numerous critical works now available that indicate schizophrenia is not a scientifically valid construct (Bentall, 1986;, 2003; Read, 2004b). Schizophrenia was also believed to be a means to medicalising wider sociocultural and political issues for Māori. This will be discussed further in section 7.5.8.

7.5.3   Boundaries between cultural experience and Pākehā illness

It was apparent that two forms of boundaries were placed upon EOE discussed in the interviews. The first was a boundary between what would be considered mate Māori or matakite. The second was the boundary placed between a cultural experience (mate Māori and matakite) and a Pākehā illness.

The current findings are consistent with other research that has found EOE to be interpreted as either a welcome blessing or an unwanted curse (Beavan, 2006). Many participants believed EOE were either predominantly negative (mate Māori or Pākehā illness) or predominantly positive (matakite). Mate Māori was referred to by more participants than matakite (41:19). The fact that Māori discussed various illness states challenges stereotypical views of cultural constructions as only positive and mysticised experiences. Māori can also understand EOE as an illness; however these experiences are interpreted through a cultural framework.

This research asked participants what factors would determine the boundary between a Māori illness and a Pākehā mental illness (if such a boundary exists). While the identified boundaries varied, I have tried to represent them in Table 12. The boundaries presented within this table represent the common distinctions that were made between matakite, Mate Māori and Pākehā illnesses. These boundaries were placed on both intra- and interpersonal levels:

Table 12: Summary of the boundaries between Pākehā illness, Mate Māori and matakite taken from participant quotes

Pākehā illness	Mate Māori	Matakite
No control	No control	Control
Involuntary	Involuntary	Voluntary
Negative	Negative	Positive
Disintegrated	Disintegrated	Integrated
Socially invalidated	Socially validated	Socially validated
Breach of social rules	Breach of social/spiritual rules	Guided or explained by others
Recent onset	Recent or sudden onset	Onset in childhood
No evidence of mate Māori or matakite in whakapapa	Evident in whakapapa (makutu)	Evident in whakapapa
Pākehā content	Māori content	Māori content
Age (being younger)	Any age	Any age
Drug use	No drug use	No drug use
No access to cultural resources	Access to cultural resources	Access to cultural resources

It is evident in Table 12 that there are enough similarities in phenomenology between Māori and Pākehā illnesses for them to be easily confused. Some of the major distinctions were access to cultural resources, having evidence of mate Māori in one's whakapapa and the experience being

socially validated as mate Māori by others. Again, this boundary indicates that the differences lay within individual and cultural belief systems rather than in the characteristics of the experience. This finding is consistent with Jackson's (1997) research regarding spiritual and psychotic experiences. This finding is also consistent with the principles of PCT, that propose our words and meanings can shape our experiences (discussed further in section 7.7)

While the phenomenology of mate Māori and Pākehā illnesses were considered to be similar, participants described matakite experiences as distinctly different on a number of levels. The distinguishing characteristics were the level of integration and control over the experience. This is consistent with findings from Noll's (1983) phenomenological research that compared shamanistic and schizophrenic states. The schizophrenic metaphor to explain shamans has been deemed untenable. Walsh's (1995) research also found consistent differences between shamanistic and psychotic states based on factors such as control, concentration, affect and content of the experience.

Based on these descriptions, it would seem unlikely that matakite would be misinterpreted as experiencing mate Māori or a Pākehā illness within either a Māori or Pākehā setting. However, the crisis state for matakite in the absence of guidance regarding how to control and integrate their experience may resemble an illness state that can be misdiagnosed as a mental illness (outlined in section 7.5.1). Some narratives shared here indicated that matakite had been diagnosed as schizophrenic only to later received guidance from tohunga or kaumatua/kuia on how to integrate their experience. Shamans have also been known to be misdiagnosed as schizophrenic in Okinawa (Randall, 1990). This warrants further research on the initiation crisis for Māori matakite and the possibility that they are being misdiagnosed in mainstream settings.

7.5.4   Experiences of mainstream treatment

7.5.4.1   Medication

The majority of the discussion in terms of mainstream treatment centered upon medication. This is not surprising given New Zealand statistics regarding the high numbers of consumers receiving antipsychotic medication (RANZP, 2005). The experience of delivering and receiving this form of treatment was generally negative. Medications were experienced by participants as harmful,

damaging and leading to limited outcomes. This research supports previous literature written by New Zealand service users regarding their experiences of medication (Leibrich, 1990). The current findings also align to other research that has recorded service users' subjective experiences of taking medication (Beavan, 2006; Geekie, 2006; Lapsley et al., 2002; Redko, 2000; Sanders, 2006). In general, participants here did not like the negative side effects of medication, they felt coerced into taking the medication, didn't like taking multiple medications and recalled it as the first, and often the only, form of treatment on offer.

A smaller group of participants referred to the utility of medication for reducing distress and facilitating engagement in other therapeutic interventions. This is also consistent with other subjective accounts (Crooks, 1999; The British Psychological Society, 2000). When being prescribed medications, participants wanted to be more informed about the mechanisms of medication and their effects and regularly asked about their subjective experience. This directly relates to recommendations made by the RANZP (2005) for the prescriptions of antipsychotics. They include: individuals being provided with sufficient information about medications, discussing beliefs and values regarding medical treatments and monitoring subjective experiences of treatment.

The finding that some participants felt Māori were differentially treated with medications compared to non-Māori supports recent research in both New Zealand (Humberstone et al., 2004) and internationally (Segal et al., 1996). This issue needs urgent attention as Māori have to right to be treated equally. Differential treatments breach professional ethics, the rights of Māori under Te Tiriti o Waitangi and human rights in general (O'Hagan, 2006). Differential treatments are of a greater concern if we consider antipsychotic medications increase the risk of diabetes and heart diseases. Māori are at greater risk of developing both conditions (4.5 times mortality for diabetes and about 2 times for heart disease)(Durie, 2001).

Some participants also questioned the economic motivations for providing medication as the first and only line of treatment. One participant believed psychiatric medications were supporting a burgeoning drug industry and keeping psychiatrists in a job. Participants viewed medications as a means to making tangata whaiora reliant on the system and coming back for more. Similar

concerns have been expressed within the profession of psychiatry. It is worth restating the comment made by the president of the American Psychiatric Association in 2005,

> As we address these Big Pharma issues, we must examine the fact that as a profession, we have allowed the bio-psycho-social model to become the bio-bio-bio model...If we are seen as mere pill pushers and employees of the pharmaceutical industry, our credibility as a profession is compromised (Sharfstein, 2005).

7.5.4.2 Hospitalisation and compulsory treatment

Hospitalisation and the MHA were inextricably linked to medications for many participants. Further to this, experiences of hospitalisation and compulsory treatment were generally negative. Participants felt they had lost control, had no freedom and at times found the experience to be traumatic. Some clinicians felt they had little control over treatment options when clients were being treated under the MHA. Participants reported not remembering their hospitalisation either because they were on such high doses of drugs or had "blocked out" the experience due to it's traumatic nature. Again, the narratives shared here align to subjective experiences reported in the literature (Lapsley et al., 2002; Leibrich, 1990; O'Hagan, 1986). Crooks (1990) described the traumatic nature of hospitalisation when she recalled,

> I've had all sorts of experiences, I've worked in the sex industry, I've been raped. Nothing compared with the horror of this psychiatric unit. It was the most traumatic experience I've ever had.

These experiences have significant implications for human rights (Mental Health Commision, 2006; O'Hagan, 2006). Mary O'Hagan (2006) indicated that compulsory treatment is often used in a manner that is not in line with it's mandate (e.g. for social control rather than ensuring safety). She argued that being a mental health consumer does not mean renouncing one's right to be treated in a humane manner. A number of participants expressed their preference for alternatives to hospitalisation. They referred to the need for a place they can go to that is safe and calming and incorporates wairua without the need for medication. These requests align to those cited by consumers in the growing body of recovery focused literature (Agar, 2006; MIND, 2000; O'Hagan, 1999).

An interesting, although not surprising, finding was that psychological interventions were not really discussed in any depth. This is likely a result of participants not receiving this form of support. Indeed a current Mental Health Commissioner indicated that psychological support is poorly lacking in the treatment of severe mental illnesses in New Zealand (O'Hagan, 2006). The long periods of contact participants had with mental health services may partly explain why they had limited access to psychological support. Their first contact with mental health services would have been during a time when psychological treatments were used even less than they are now. Even today, the majority of psychological interventions are provided for those experiencing their first episode of psychosis (Mental Health Commission, 1999). These interventions overlook people who have had longer periods of contact with mental health services. Future research should assess access to multimodal treatments, especially for those who have had long-term contact with mental health services.

7.5.5 Experiences of Māori pathways

Māori pathways of healing are distinct from Mainstream approaches in a number of ways. The greatest difference is in the recognition of wairua when trying to make sense of and heal from distressing EOE. Participants felt they were better understood, and experienced longer-term positive outcomes, as a result of having access to Māori pathways to healing. This research is consistent with other studies in New Zealand that have called for the inclusion of spirituality in mental health service delivery in order to align more closely to positive outcomes for Māori (Ihimaera, 2004; Kingi, 2002; Lapsley et al., 2002; Taitimu, 2002).

This research did not endeavour to develop a new model or way of working with Māori encountering EOE. There is no need to reinvent the wheel as a number of Māori models and therapeutic paradigms already exist. Overall, Māori pathways of healing, as they were expressed here, are consistent with Mason Durie's (2001) model of identity development (see Table 2). This model indicates that a secure identity can be developed via access to cultural resources. Paihiritea counselling, a Māori counselling process (Durie, 2001) aims to increase positive and secure identities for Māori by generating awareness of one's culture, facilitating access to cultural resources and guiding encounters though the use of reflexive learning process. Paihiritea

counselling outlines a process that is similar to the narratives shared within this research regarding "taking them home" where connections are made to family, knowledge of one's whakapapa and marae in the process.

The results also indicated that tohunga, kaumatua and kuia play a pivotal role as the practitioners of Māori pathways. Assessment and treatment of mate Māori, or illness states related to matakite, requires specialist knowledges that are as detailed and systemic as Pākehā psychiatric knowledges. This is especially the case for makutu. Several participants indicted they would not enter into assessment or treatment of makutu without a tohunga. This was due to the possibility of negative ramifications of makutu on those who become involved without the correct procedure to protect oneself. These apprehensions align to those found within previous literature (Gluckman, 1962; Lyndon, 1983). Of note is that Māori practitioners (both traditional and clinical) have also encountered many EOE themselves. These findings align to the role of shamans and healers in other cultures where experts are also experiencers (Allen, 2002; Noll, 1983).

Narratives from participants who were healers indicate their practice is still relatively underground. They expressed caution around sharing their practices with Pākehā clinicians. This represents continued inequalities in power between Māori and Mainstream ways of understanding and healing from EOE. Even Māori clinicians found it difficult to bring their cultural beliefs and practices into the workplace.

This research has attempted to incorporate the Kaupapa Māori principle of tino rangatiratanga by challenging hegemonic practices that prioritise certain world views over others. This research advocates for a paradigm shift in mental health where tohunga, suitably qualified kaumatua and kuia (qualified by their work in the community with EOE) and Māori clinicians are recognised as the experts of Māori experiences. Kaumatua, kuia and tohunga are the practitioners of Māori pathways, just as psychiatrists are the practitioners of mainstream pathways. Participants also seemed to value Māori practitioners and approaches over psychiatrists, medications and inpatient units.

Some participants recognised the increased acceptance of Māori pathways within Mainstream settings. For example, one participant delivers lectures on makutu each year in a medical school. This increased acceptance is also evident in the establishment of a number of traditional healing and Kaupapa Māori Services nationally (Smith & Reid, 2000).

Kaupapa Māori services were generally described in a positive light. Tangata whaiora indicated that they felt more at ease in these services stating "it fit like a glove," and "I don't feel under everyone else." The users and employees of the kaupapa Māori services referred to principles of delivery such as: whanau ora, whanaungatanga, tautoko, tuakana/teina and awhi. These align to the core principles of Māori health development outlined by Durie (Te Puni Kokiri, 1993b): 'tino rangatiratanga' (self determination); 'he tangata, he tangata' (prioritising the people and relationships); and 'tatou tatou' (collective wellbeing and responsibilities).

Issues were raised regarding the development and delivery of Kaupapa Māori Services. One participant, who managed a Kaupapa Māori Service, commented that Māori with clinical qualifications often move on, as there are limited resources and finances to keep them employed. Another raised the issue of some Kaupapa Māori Services being a distinctly non-Māori environment. This aligns to concerns raised by Durie (1999) during the initial development of these services where Māori services often rely on governmental funding that require them to align to Pākehā practices. The current findings reiterate issues regarding funding, resources and staffing of Kaupapa Māori Services raised elsewhere (IRI, 2002).

A barrier towards using Kaupapa Māori Services and accessing other Māori pathways is the often cited trend that many tangata whaiora presenting at mental health services are relatively disconnected from their whanau, hapu and iwi (Durie, 2001). While the levels of acculturation for Māori diagnosed with schizophrenia have not formally been researched, consultation with clinicians working in the area and my own limited clinical experience reveals that many do not strongly identify as Māori and have limited access to cultural resources. As a result they may be apprehensive to access Māori services because they do not know te reo and tikanga Māori and are unfamiliar with Māori environments.

Participants within this research also recognised that there are number of barriers to the successful implementation of Māori pathways. These barriers included stigma within our own communities, abuse within Māori whanau (making 'taking them home" a dangerous intervention) and limited resources in our own communities (that can lead to burnout and ineffective services due to limited funding). "Taking them home" cannot be done overnight until these wider issues are addressed. Careful planning and significant resources are required for the development and maintenance of this initiative. Māori communities need an injection of resources such as finance/people/education/facilities to be prepared to welcome tangata whaiora home. In the current situation, the initiative of 'taking them home' would lead to burnout (due to lack of personnel). This could possibly diminish the health of tangata whaiora if communities are not well resourced to develop the journey home. In the absence of planning to establish pathways home, we will continue to hear only the odd narrative of an individual being lucky enough to find someone who was able to instigate this pathway of recovery for him or her. Gaining access to the appropriate form of healing should not be about luck.

Participants also indicated that Māori pathways require recognition of the work that is often done over and above contractual arrangements or Mainstream services. The extra time and resources required to successfully implement Māori pathways are often not recognised within formal funding structures and services. These results support that has already been conducted regarding facilitators to success for Kaupapa Māori Services (IRI, 2002).

7.5.6   Facilitators and barriers to the success of the Cultural/clinical interface

A number of narratives were shared that indicate Māori and mainstream pathways can exist together. This often involved Pākehā clinicians recognising their own values and beliefs and how these may limit their expertise when working with Māori. This finding aligns to the first step required for non-Māori to increase their cultural competency (Brady, 1992; Mcfarlane-Nathan, 1996). Participants here indicated their collaboration with non-Māori colleagues required a dialogue regarding how their pathways can work together. While writing this discussion, I referred back to the participant narratives regarding the cultural-clinical interface and found continued inequalities in power. The narratives outlined in section 6.2.3.5 give the concept of

"power sharing" a different meaning. Power sharing is not about both parties having the same power to determine pathways of recovery but involves the psychiatrist having *all* of the power and, *at their own discretion,* sharing it now and then. Those in cultural positions indicated their psychiatrist was "good" simply because he/she *allowed* Māori pathways to be put in place. It is interesting that I did not pick this up in interviews or even the initial analysis of the data. This may because I also accepted the power of psychiatrists as the status quo. This limited type of power sharing will ultimately limit the effectiveness of healing that occurs at the cultural-clinical interface. As long as Māori have to ask non-Māori for permission to instigate their own pathways of healing with people from their own culture, the cultural-clinical interface will be a cultural-clinical inter-*farce.*

Māori clinicians are extremely important stakeholders in addressing power differentials within mainstream settings. The results suggest we need more of our own people in positions of power in mental health to instigate change from within. However, the literature indicates that the road to becoming a psychiatrist or psychologist is dangerous in terms of making Māori think like Pākehā (Milne, 2005). There remains a limited number of Māori enrolling in clinical training programmes (Levy, 2002). The current findings call for increased access to training programmes and increased support for Māori clinicians in navigating and resolving the, at times, competing identities of being a Māori and a clinician. This is in line with the needs expressed in already existing research (Levy, 2002; Paewai, 1997) and policy outlined by Te Rau Matatini (Ministry of Health, 2005). At present, educational providers are currently faced with a catch 22 position. In order to increase the number of Māori in training programmes, course material needs to incorporate Māori ways of understanding and treating mental illness. However, training programmes need more Māori to become qualified in order to facilitate change in educational paradigms. Levy (2002) called for a combined approach that targets both issues at the same time.

7.5.7   Colonisation as an historical trauma for Māori

For many Māori, colonisation is not a remnant of the distant past but a lived trauma that has served to contribute to current disparities in mental health statistics. Participants referred to the social, psychological and spiritual impact of colonisation on Māori communities. Colonisation

has diminished the tapu and mana of Māori and thereby left them open to a number of negative influences and lifestyles. More specifically mana atua, mana tangata, mana whenua, mana tupuna and mana Māori have been diminished through colonisation (Love, 2004). These descriptions align to the 'soul wounds' and 'historical trauma responses' cited in the international indigenous literature (Brave Heart, 2001; E Duran & Duran, 1995). The explanation of urbanisation as a significant contributing factor has also been cited elsewhere (Durie, 2001; Te Puni Kokiri, 1996). Urbanisation was reported here to sever the access Māori have to beliefs and practices relevant to healing from negative EOE.

Educating Māori within a wider system that represents Māori culture in ways that diminish one's identity, self concept and self esteem was also cited as a reason for current disparities. Being taught "the white way is the right way" was proposed by participants to lead to suppression of the Māori being and spirit. Some have suppressed this in themselves as a strategy for survival. Negative self esteem, low self worth and suppression of one's being can all lead to negative lifestyles that are associated with the development of EOE labelled schizophrenic (Durie, 2001; Walters, 2002). These comments are echoed in the stories of other oppressed groups the world over (Cook, Withy, & Tarallo-Jensen, 2003).

Another explanation preferred by participants for current disparities was the racism and ignorance of those diagnosing Māori. Participants proposed that clinicians might be biased towards diagnosing Māori with schizophrenia. This supports findings in other countries where indigenous and ethnic minority groups are more likely to receive a diagnosis of schizophrenia than their counterparts from dominant groups even when they present with similar or less symptoms (Trieweler, Neighbours, Thompson, Munday & Comex, 2000). Johnstone and Read (2000) have already found that a minority of psychiatrists within New Zealand are racist as evidenced by a view that Māori are genetically more predisposed to mental illness. No participant within this research proposed genetics as an explanation for current disparities. One kaumatua referred to Johnstone and Read's research and the effect of the bias of diagnosticians on current disparities:

Well, the profession of psychiatry which makes such diagnoses. This is a good example of what racism is...Because Māori experiences don't fit neatly into this profession then we, they get dumped into schizophrenia. I know one of our girls doing her phd in psychology, looked at psychiatrists and psychologists. It was looking at the attitudes of those professions to Māori. Kelly brought her thesis to me...It was a little bit of reluctance on her part. She said you will see things in here that may distress you. My answer was, no it won't, there is nothing in those two professions that I haven't already seen...[some of] of those interviewed had attitudes that Māori have a genetic predisposition to mental illness. That is really indicative of the type of training that people are put through and it reinforces for people who already think that way anyway. So if that is part of their training, well how the hell does that carry over. So whenever I see a psychiatrist or psychologist I think...are you one of those where I'm in trouble already? And so that study that replicated one ten years prior came out with the same results, there was no bloody change. Now in answer to your question I'd have to say that the profession has not been brought through with a very wholesome way of seeing the world. And with schizophrenia, well I'm saying to you people that it would be preferable if you don't treat our people and diagnose them because you are going to make the wrong one. KAU

Participants' comments regarding the inexperience of our current mental health workforce support psychiatrists' and psychologists' own feeling that they are ill equipped to work with Māori (Johnstone, 1997).

7.5.7.1   Healing the soul wounds

Participants' recommendations on how to address disparities in statistics support Duran's (2006) process proposed for healing the soul wounds of Native Americans. He indicated that Native Americans have internalised the oppression placed on them by dominant groups,

> Once a group of people have been assaulted in a genocidal fashion, there are psychological ramifications. With the victims complete loss of power comes despair, and the psyche reacts by internalising what appears to e genuine power-the power of the oppressor. The internalising process begins when Native American people internalise the oppressor, which is merely a caricature of the power actually taken from the Native American people (p. 29)

He went further to state that healing arises through liberation discourse. Rather than waiting for the Western world to legitimise Native American thought, Native American communities have started to help themselves by legitimising their own knowledge and allowing healing to emerge within their own communities. This relates to the Frierian notion of conscietisation. Friere (1993) argued that emancipation can only be achieved from within an oppressed group; it cannot be achieved *for* the oppressed by the dominant group. Participants within this research made several comments in this vein. They called for: teaching of revisionist histories by Māori from a

Māori perspective; increasing the access our children have to cultural resources; teaching tikanga to the younger generation before our current generation pass; teaching stories and knowledge regarding EOE encountered by Māori; teaching the Māori language; and teaching Māori health practices. All of these were recommended to be delivered by Māori, for Māori and within Māori settings. Excerpts of some of these comments are reiterated below:

> We have Māori problems that have Māori idiosyncrasies that need to be dealt with in a Māori way. KAU

> I think with Māori the whanau can help pull them through. We need to pull our own people through. CSW

One participant described the internalised oppression of Māori and the need to enter into liberation discourses,

> We let ourselves down; we shoot ourselves in the foot every time. We have so much to offer other people but we don't do it. I think with Māori they can sometimes be, well everybody thinks that so lets just be it. And they don't rise above that thinking you know. They don't rise above it. I have never seen myself like that ever. CLIN

7.6 CLINICAL AND TRAINING IMPLICATIONS

While the preceding discussion contains a number of clinical implications, some general themes were apparent that are highlighted here. Overall, the clinical implications all relate to *centralising* Māori constructions of their experience, giving *control* and power to Māori to make decisions about assessment and treatment processes and providing *choice* to tangata whaiora in terms of pathways for healing.

7.6.1 The three C's: Centralising (Māori constructions) Control (of power in assessment processes) and Choice (of pathways for treatment)

The three C's may serve as a guideline for any initiatives that attempt to recognise Māori constructions of EOE within both cultural and clinical settings. The three C's draw strong parallels to the three 'P's' derived from the Treaty of Waitangi (Partnership, Protection and Participation) (Ministry of Health, 2007). Table 13 outlines how these principles relate to one another as well as the key tasks related to each principle. One aspect cannot be fully achieved

without addressing the other. Therefore, any initiative should assess how all three principles and the associated tasks are being addressed.

Table 13: Clinical implications in relation to Treaty principles

Clinical implications	Treaty principles	Key tasks
Control	Participation	Māori given power to make treatment decisions
Centralising	Protection	Māori constructions and healing recognised as legitimate health practices
Choice	Partnership	Māori provided with choice between aspects of both Māori and Mainstream pathways

In whatever pathway we work we must first access the clients' understandings and *centralise* these constructions within the formulation and treatment. The results here indicate that Māori constructions can affect the course, content and outcome of EOE. Considering wider international evidence that indicates biomedical education can reduce the range and number of indigenous constructions held for experiences commonly labelled psychotic, we must be cautious upon first meetings about giving our own interpretations of other's experiences. Māori require acceptance that their experiences are *real* and services also need to recognise the diversity of explanations that Māori service users may hold for their experience.

The experience of colonisation also needs to be *centralised* as a legitimate and valid aetiological factor for individuals presenting at mental health services. Experiences of racism and discrimination and historical traumas need to be incorporated into current assessment and treatment processes. Duran's (2006) framework for healing the soul wounds may be useful in clinical practice with Māori to address the effect of historical trauma on individual presentations.

In addition, Māori need to *participate* in the process of diagnosis and treatment in mainstream settings and we need greater *control* in decision-making. This finding supports current bicultural

policies within mental health (Mental Health Commision, 1998). The cultural-clinical interface will only be successful if issues regarding power sharing are addressed. This requires a commitment to change and learning and a dialogue that allows for knowledge exchange as opposed to knowledge transfer (Brady, 1992; Schwendler, 1984). For example, participants here called for the constructions of space and time in clinical assessment and treatment to be adjusted to incorporate tikanga. Māori not only wanted greater control within Mainstream pathways but also wanted control over the development and delivery of Kaupapa Māori services that are independent from Mainstream. The results therefore support the increased recognition and development of services for Māori, delivered by Māori in a Māori way (Durie, 1999; IRI, 2002).

In terms of *choice*, participants wanted access to Māori *and* Mainstream pathways. It has already been mentioned that Mainstream pathways were considered useful to address issues of safety and help the individual engage with other forms of treatment. Māori pathways were considered to facilitate healing in the wairua (spirit) and whanau (family), while Mainstream pathways were considered to predominantly focus on the tinana (body) and hinengaro (mind). This aligns to findings from Ihimaera's (2005) study regarding the incorporation of wairua into mental health services. She indicated Māori need: to participate and feel protected when engaging with mental health services; to have options and control over choices; to have advocacy and support; and have access to both culturally and clinically competent staff who address the range of dimensions essential to wellbeing.

Some argue that the cultural-clinical interface will not succeed if we try to fit Māori into mainstream settings. While some projects, such as the bicultural therapy model in prisons and the poutama model of assessment in EIS (see section 3.4.2), aim to integrate Māori into mainstream, others criticise these initiatives for simplifying Māori ways of understanding health. Figure two represents the difficultly of including Māori pathways into mainstream settings as the latter covers a more limited range of factors in terms of recovery. This is akin to trying to fit a larger peg in a smaller hole. The peg inevitably ends up being squashed into a different shape or cut to make it fit. If we turn this around, mainstream pathways are able fit more readily within Māori. In the words of one participant, "if you [Pākehā] want to solve our problem you must move from your neck of the woods our way". Figure two is a very basic representation of the

way in which the cultural-clinical interface may look. The constructions utilised have been derived from participant comments regarding the factors that are addressed by each pathway (see section 6.2). Some of the factors have also been drawn from the Māori models of wellness outlined in Chapter Three. As can be seen by the figure, Māori pathways include, but are not limited to, the dimensions of tinana and hinengaro which are often the domain of Mainstream pathways. Alternatively, participants commented that mainstream pathways often do not address wider dimensions that are essential to Māori wellness such as whakapapa and whenua.

Figure 2: Visual representation of the relationship between Māori and mainstream pathways of healing
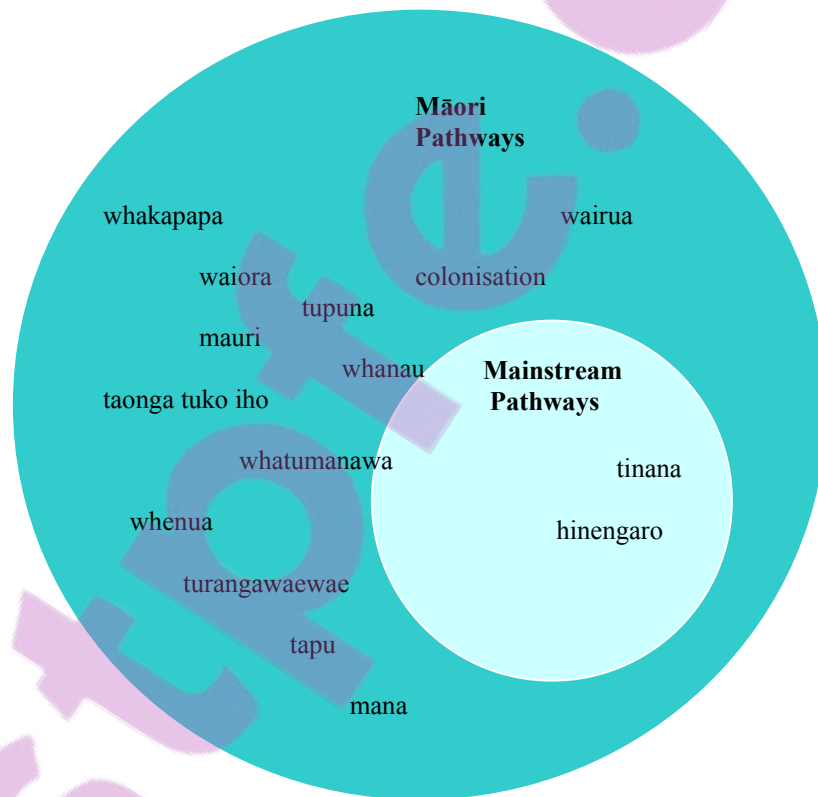
7.6.2 Clinical and cultural descriptions of EOE

Table 14 outlines the way in which Māori understood the major clinical symptom clusters of hallucinations, delusions and disorganised speech or behaviour. This is merely an exercise to

allow the reader to make comparisons between clinical and cultural constructions of EOE. This comparison was not made during interviews but has been drawn from the comments made by participants regarding particular EOE discussed during interviews. Further investigation would be required to understand the nature of the comparisons further.

Table 14: Comparison of clinical symptoms and Māori constructions

Clinical symptomology	Māori constructions
Auditory hallucinations	Mate Māori Matakite Normal everyday experience hearing tupuna Drugs / Trauma response
Delusions of Grandeur	Matakite Tohunga Beliefs in Kaitiaki Beliefs regarding rangitira lines in whakapapa
Delusion of persecution	Makutu Mate Māori as a result of breach of tapu
Paranoid delusion, thought insertion	Drug / trauma response Makutu
Visual Hallucination	Seeing tupuna for various reasons job needs to be done resolve conflict / warn of danger own death or others is near
Other sensory hallucinations	Ability to smell death Feeling the touch of tupuna
Disorganised speech or behaviour Dissociative states	Pōrangi Wairangi

7.6.3   Towards a clinical/cultural assessment for EOE

A summary of the questions that participants asked to understand more about EOE is included in the following pages (these have already been outlined in section 6.2.4). Overall, commonalities and differences were found across groups. As can be seen from section 6.2.4, clinicians were

heavily focused on the content and effect of the experience; students asked about the content and an individual's beliefs about their experience; kaumatua/kuia asked more aetiologically driven questions; cultural support workers were more invested in the effect of the experience; while tangata whaiora predominantly asked about personal beliefs and recommended being *with* the person in a non judgemental environment. While it cannot be assumed these differences are clear-cut or representative, a trend was evident that would warrant further investigation. In general the questions participants asked related to their expertise, training and current work roles. This indicates a need to include a broader range of questions in the assessment of participants to develop an understanding of their experience.

Included in the following tables (15 and 16) are the questions participants asked according to content, form, effect, context, duration, personal understandings of EOE and the level of support the individual has accessed. In addition, participants made recommendations regarding the atmosphere required for assessment to take place. By summarising the variety of questions that individuals from diverse Māori realities would ask (as well as the five Pākehā clinicians), the beginning of a more comprehensive assessment framework is apparent. This framework incorporates both clinically and culturally driven questions. They are in no set order and should not be considered to be a step by step questioning structure. They are not all applicable for a first meeting with a client. The questions are presented in the words of the participants and have not been reworded.

It is not recommended that any one individual is competent in gathering or interpreting the relevant information derived from these questions. Rather it is recommended these questions are utilised within already established cultural assessment procedures (Mental Health Commision, 2001) by both clinical and cultural experts. This will facilitate a dialogue akin to knowledge exchange as opposed to knowledge transfer.

Table 15: Assessment questions for content, effect, personal understanding and context of extra-ordinary experiences

Content	Effect	Personal understanding	Context
Who can you see /hear?	Are they distressing you?	Tell me more about it?	What time of day do you see them? (early in the morning considered a time when kehua or Māori spirits are the most active)
Are they male or female?	Does it interfere with your life?	What are your beliefs about hearing voices?	
Are they loud or soft?			Is it when you are using drugs?
	Are the voices giving good or bad energy?	What is your understanding of the experience?	Do you hear these things in particular circumstances?
Are they asking you to hurt yourself?			
	Is it guiding you?	What is the whanau's understanding of the experience?	Have you taken something from somewhere recently? (spiritual connotations of a breach of tapu)
Is it someone you know or don't know?	Did you feel threatened by the voices?	What is the clinician's understanding?	
			Has someone recently died?
Is the language in English or Māori?	How have you been sleeping?	What is a cultural expert's understanding of the experience?	
Are the voices talking to you, to each other, are you a part of the conversation?	How do the voices make you feel?	How do you know you are cursed?	What has happened to make you think you are cursed?
What are they talking about/saying? Is it angry/critical?		What are your spiritual beliefs?	Have you recently moved into a new house? (possible spiritual connotations previous events)
		Why do you believe in makutu?	
Who do you think cursed you?			Where have you been recently? (spiritual connotations of a breach of tapu)
Have you asked the voices why they are there?		Has someone told you about it (Mate Māori/makutu/tapu and noa)?	
			Is there a history of trauma/abuse?
What do they look like? (assist in determining the whakapapa of the individual)		Have you witnessed it (mate Māori/ Makutu)?	What have been in your dreams recently? Is it reoccurring?
			Have you been somewhere you shouldn't have been?
What is the body language of the person you are seeing?			
			Is there any unresolved conflict between you /

			your whanau and other whanau now or historically?

Table 16: Assessment questions for form, duration, support and atmosphere of extra-ordinary experiences

Form	Duration	Atmosphere	Support
Is it internally or externally experienced? Where are the voices coming from (inside or outside)? Are you hearing and seeing things? In what sense is it a voice?	How long have the experiences been like this? When did it start? Have you experienced this before? Has anyone in your whanau experienced this before?	Don't ask, just be there with the person, allowing them to share their experiences with you. A place to share one's story without fear of being labelled or judged.	Have you got whanau support? Have you been to your minister or priest? Have you been to a kaumatua / kuia or tohunga? What support would you like?

7.7 THEORETICAL IMPLICATIONS

The current research both supported and challenged the principles of Kaupapa Māori and Personal Construct Theory.

This research supported a central tenet of PCT by positing that constructs are not born of the experience but exist before an experience and are placed upon it. Moreover, once placed upon an experience, constructs can colour the course, content and outcome of that experience.

The well known Shakespearean citation, "What is in a name? Surely a rose by any other name would smell just as sweet," refers to the common myth that a name is independent of the subject or "element" being described. According to the postulates of PCT, a rose by any other name would *not* smell as sweet, in fact another name would not only affect the smell but the appearance of the rose altogether. While it is difficult to grasp how a name could change a tangible object in form and content, it was evident that many participants within this research believed that a name could affect human experience in this manner. For example, constructs such as matakite, mate Māori, makutu and tapu were believed to directly affect the way in which the "experience was experienced" based on factors such as distress, control, the negative or positive nature of an experience and the perceived belief that an individual can "recover" from or resolve the experience. The constructions used also directly related to certain treatment pathways. The constructs Māori placed upon EOE were less stigmatised and provided an increased sense of a positive prognosis as opposed to the construct of schizophrenia. As outlined in the quote that follows, this research testifies that the responsibility of the course and content of experiences may lie within the construer rather than inherently within experience:

> Wherein does responsibility lie? Can we ever make facts, even facts that turn out as predicted, responsible for conclusions? I think not. Whatever the world may be, man can come to grips with it only by placing his own interpretations upon what he sees. While his ingenuity in devising suitable constructions may be limited, and many misfortunes therefore come to pass, still it is he, not facts, who hold the key to the ultimate future. This, it seems to me, makes him responsible, and suggests that it is quite inappropriate for him ever to claim that his conclusions have been dictated by any other nature. (Kelly, 1970, p. 14)

Several corollaries of PCT were upheld within this research. Many participants appeared to utilise their own diagnostic manuals that are derived from their personal encounters and knowledge about the world. Participants' responses often began with the words, "I remember when I..." or "when my aunty..." or "what I have been taught about..." This suggests participants' personal histories wrote the manuals of their diagnostic systems (derived from their personal constructs). Often these personal manuals were not in line with the manual popularly used to understand EOE in mental health today, the DSM-IV. Further, some commonalities were inherent between participants' constructions of EO experience (e.g. kaumatua and the constructions of whakapapa) supporting Kelly's notion of a commonality corollary. At the same time the individuality corollary was upheld in that participants shared diverse ways of understanding and treating EOE. For example, participants placed various boundaries between what would be considered a Pākehā illness or cultural experience.

This research challenged the principles outlined within the range corollary of PCT. Kelly (1991) posited, "a construct is convenient for the anticipation of a finite range of events only" (p.11). However, some participants indicated that constructs such as tapu, mana and mauri can be "convenient" for all events. If all things, both animate and inanimate, have a mauri all experiences can affect or be affected by mauri.

The cycle of experience of anticipation, investment, encounter, confirmation or disconfirmation and constructive revision (outlined in section 4.4.2) can also be applied to the research results. When discussing their EOE, many participants described a process of disconfirmation of their own anticipatory constructions when others construed the event as "schizophrenic". Many simply disregarded the construct of schizophrenia as it served to invalidate superordinate constructs related to spirituality. Instead, some participants used, or searched for, their own constructions of EOE in order to be able to consolidate their construct system in a manner that was meaningful for them. The following quote shares the journey of one participant in her search for a way to understand her daughter's experience,

Initially we couldn't understand it...purely from a tuturu Māori perspective the psychiatrist failed miserably to help us understand what was happening...as a whanau we did a search in our whakapapa down both sides...to discover whether anyone in our whanau had been considered pōrangi...it wasn't in our whakapapa...then we searched into the realms of makutu...we looked above and beyond the physical plain...I did not ever accept that there has been a psychiatrist diagnosis of schizophrenia of which is a name I knew nothing about...it was a term for a medicated model. *TW-mother*

7.7.1 Kaupapa Māori Theory

The above quote outlines the central tenet of Kaupapa Māori Theory, that Māori have the right to access their own knowledges to understand their experiences and their world. Two major principles of KMT were upheld within this research. First, this research sought to deconstruct the dominant hegemony that assume universal truths (such as schizophrenia) and oppress indigenous knowledges. More specifically, I turned the research lens back on Western notions of truth and recognised the precise historical changes that legitimised Western psychiatric knowledge and oppressed Māori knowledges.

The psychiatric term 'schizophrenia' was viewed by many participants as a cultural construct developed within a Western medical framework that was being used in a disproportionate manner with Māori both intentionally (due to racism and discrimination) and ignorantly (due to a lack of knowledge). Even at a symptom level, Māori participants did not use psychiatric constructs such as "auditory hallucinations."

Smith positions KMT from a colonised perspective aimed at reclaiming Māori knowledge through the process of tino rangatiratanga. Tino rangatiratanga was 'operationalised' in this research by centralising Māori constructions of EOE and presenting Māori values, beliefs and practices as lived realities (not idealised remnants of a distant past). Many participants commented that they had not consciously and meaningfully shared their understanding of EOE prior to their interview. This included tangata whaiora who had many years of contact with mental health services. One tangata whaiora contacted the researcher after interviewing to share the positive effect the interview had on his recovery process as it was the first time someone had asked him about his own understandings.

The initial apprehension and scepticism that my consultants indicated participants would hold about the research was not found. In general, within public forums, I received mostly support and the odd "constructive criticism" (that were generally coupled with a solution). I received an overwhelming response from Māori and non-Māori who wanted to participate and talk about EOE. I totally understand why some Māori are cautious about conducting research into Māori spirituality although this needs to be balanced with the priorities of other Māori who want a forum to discuss and learn about these issues.

Finally, this research is part of an international movement towards the greater recognitions of indigenous psychologies. A number of the findings here could contribute to the development of a Kaupapa Māori Psychology. This research not only represents Māori ways of thinking but also of behaving and healing. Māori tended to understand EOE from a spiritual foundation. Participants also referred to an understanding of the self as bound their whanau, hapu, iwi, the land and one's ancestors. In addition, a number of metaphors were used to explain EOE. For example, the metaphor of te pō was used to understand behaviours indicative of pōrangi. An example of Kaupapa Māori psychological practice is evident in comments regarding karakia as a tool to deescalate individuals in times of crisis. Marae were also believed to have a calming effect and facilitate healing just by virtue of the space and tikanga that surrounds one's conduct when in this space. This is in line with Durie's (2001) belief that marae encounters can be used to understand more about Māori psychologies. Further to this, Kaupapa Māori psychology is invested in local solutions. Rather than the top down approach of political solutions, this research aimed to represent solutions from within the group (bottom-up) for current disparities in statistics between Māori and non-Māori. These solution have already been outlined in section 7.5.7.1. In general, this research aimed to contribute towards increased recognition of Māori psychological paradigms.

7.8   FUTURE RESEARCH

At the end of participant interviews I asked "what would you like researched in the future in this area?" Participant comments referred to four broad areas of investigation:

- Understanding more about the phenomenology and philosophy of Māori EOE.

- Where do Māori go to get help for EOE and how do various interventions help?

- Addressing access issues to both mainstream and cultural pathways of healing.

- More research on why Māori are overrepresented in the current statistics?

Due to the exploratory nature of the current project, the findings are only tentative and require further elaboration in future research. There is a broad scope of implications for future research that covers individual, service level and sociocultural factors. Only those factors defined by participants as important are outlined below to ensure that the recommendations here are aligned to what participants wanted from future research.

It is recommended that any research conducted in the future is conducted within a Kaupapa Māori framework. It is imperative that future research recognises the needs of Māori communities and represents cultural constructions from within the community. Future research should also aim to cover a range of settings. Research that includes Māori using mental health services in both inpatient and community settings and Māori accessing traditional healing within the wider community will ensure a range of perspectives and pathways are covered. To date, research regarding Māori constructions of schizophrenia has predominantly been limited to clinical settings. To the knowledge of the researcher, Lyndon's research in 1983 represents the only other study conducted in the Māori community regarding Māori constructions related to schizophrenia.

One of the major implications for future research will be researching the generaliseability of the current findings. This study had a limited sample that was likely not representative of the Māori community in general. Larger scale qualitative and/or quantitative studies that cover a broader range of iwi and settings would be useful to assess the relevance of these constructs to the wider Māori community. This research will need to be balanced with the inherent issues of conducting larger scale quantitative research within Māori communities. Some Māori researchers have attempted to outline guiding principles for conducting quantitative research under a Kaupapa Māori paradigm (Barnes, 2003).

Research that aims to investigate the manifestations, course, content and outcomes of various illness states related to mate Māori may also help to reduce misconstructions of these experiences in the future. Further to this, a greater depth of understanding for experiences such as wairangi may help Kaupapa Māori Services to develop their own cultural assessment measures for EOE (if this was desired) in the future. This may assist in making a differential diagnosis and ensuring the most effective forms of treatment are accessed for tangata whaiora.

Concurrent to understanding the nature of these experiences, Māori ways of healing should also be researched in terms of outcomes to understand more about the effectiveness of these pathways. A number of Kaupapa Māori Services and Traditional Healing Services are now working with tangata whaiora with a range of physical, mental and spiritual illnesses. Research that understands more about the effectiveness of these interventions will help to legitimise their practices within wider New Zealand society. One recent project has found that traditional healing, targeted at balancing imbalances between various dimensions of the self, helped clients to address historical trauma, personal trauma and spiritual illnesses (O'Connor, 2007). Future research could build upon the current findings that indicate Māori constructions lead to more positive outcomes. Sanders (2006) has already found that Māori service users with a diagnosis of schizophrenia hold more positive expectations of outcome when compared to their Pākehā counterparts. Such research would build upon international findings with ethnic minority and indigenous peoples where cultural constructions are perceived as having a positive effect on outcomes for schizophrenia (Sartorious et al., 1986; Satorious et al., 1987). Further to this, research should investigate the effect of medical constructions on the ability of individuals to hold cultural constructions about their experience and seek cultural pathways of healing. This research may help to address the poorer outcomes seen in mainstream settings today.

In terms of mainstream pathways, the major areas that could be built upon in future research are the Māori experiences of medication, hospitalisation and compulsory treatment, especially considering these interventions are more commonly used with Māori. Future research could also investigate what Māori want in terms of alternatives to inpatient units for managing acute states. Another area of investigation would be addressing access issues, including:

- What are the barriers and facilitators to accessing mainstream and Māori pathways of healing?

- What would Māori want from mainstream pathways to make them more accessible and applicable to Māori needs?

- What needs to be implemented and/or changed to ensure Māori and mainstream pathways are delivered together?

To address current disparities in statistics future research in New Zealand could replicate studies that have been conducted with indigenous populations overseas. For example, to assess the effect of misdiagnosis, Randall's (1990) study could be replicated by using tohunga to assess Māori inpatients with a diagnosis of schizophrenia. Another project could compare Māori and non-Māori clinicians' diagnoses of Māori patients to assess bias. The effects of historical trauma on the current clinical population of Māori diagnosed with schizophrenia should also be given recognition. Walters (2005) has already aimed to developed ways in which historical trauma can be measured via psychometrics within the Native American population. These may need to be adjusted to be applicable to the New Zealand context. Future research that aims to understand the effects of discrimination and racism on Māori entering mental health services could use methods from an increasing body of international research that recognises these factors as contributing to higher rates of schizophrenia in ethnic minorities (Janssen et al., 2003).

7.9 PLAN FOR DISSEMINATION

At the time of completing this thesis a dissemination hui had already been held at a marae in a Māori mental health service in Auckland and reached a wide audience. The hui was attended by kaumatua and kuia, Māori clinicians, managers of mental health services and Māori researchers. Pākehā psychiatrists, psychologists, occupational therapists and nurses were also in attendance. This was only one step in an overall plan for dissemination outlined below:

- Send the dissemination report to key stakeholders involved in the research including but not limited to participants, community consultants, mental health services, Māori

organisations and governmental departments such as the Ministry of Health and Mental Health Commission.

- Conduct two more public hui in the Northland area to discuss the major findings of the research within the Māori community.

- Continue conversations regarding the results within my own whanau, community and workplace.

The above are in addition to the more traditional modes of dissemination such as publications in scientific journal and presentations at conferences. A number of presentations were made at both national and international conferences throughout the course of this PhD. Further to this, articles are currently being developed for submission to various peer reviewed journals.

7.10 CONCLUSIONS

Within this thesis, schizophrenia is represented as a cultural construct that may not be applicable to people within the culture it was forged, let alone on others. Māori participants were found to hold unique and diverse ways of understanding EOE. The resilience of Māori constructions was evident in the comments regarding tapu, mate Māori and matakite. This did not preclude some participants from also holding biomedical or psychological constructions. However, in terms of diagnosis, participants generally rejected the use of the term schizophrenia for understanding EOE.

Māori were also generally critical of the limited way in which their health was viewed and treated within Mainstream pathways. Those who had accessed Māori pathways indicated this form of healing was more conducive to their recovery by helping them to understand their experience and generally making them feel more accepted. This finding has major implications for current assessment and treatment practices considering statistics that indicate Māori have significantly higher utilisation rates of inpatient units. Further to this, it seemed that access to Māori pathways is currently ad hoc and a number of barriers exist to making these pathways accessible to the wider Māori community.

In general we need to understand more about the who, what, when, where, how and why of Māori pathways of healing. An example of the questions that need to be addressed are: Who gets access to these pathways? What do the pathways entail? When are people accessing these services? Where do they exist? How do they help? *And* why do they help? The "why" relates to the philosophy around Māori constructions and the history of oppression and emancipation of ways in which Māori make sense of and work with EOE.

Final note

While writing my honours dissertation I came across an analogy of the traditional approach to knowledge provided by Māori Marsden. He stated that attaining knowledge and understanding entails a process of three major stages. The first is *māutauranga* when we gather information. The second is *mōhiotanga*, when we begin to learn and *know* the information and the third is *māramatanga*, when we begin to *understand* the information. My own interpretation of this process is that the first stage is akin to rain falling on the ground. The second stage involves a process where the soil begins to soak up the rain. The final stage occurs when the skies clear and sunshine facilitates the sprouting of seeds and new growth. This indicates that when one enters the stage of māramatanga, the results are more than the sum of the parts.

Using this analogy with the current research, history tells us we are at the end of a very long drought. The rain has finally begun to fall with the increased recognition of Māori constructions in mental health, but the land is dry from the long drought and requires a good drenching for the soil to begin to soak up the rain. This stage of irrigation has not yet begun and will only take place when services have enough information, funding and a critical mass of informed people to ensure that Māori constructions are centralised, rather than being labelled the alternative. This will require Māori diagnostic processes and treatment pathways to be well defined, monitored and revised to ensure services are constantly aligned to what Māori service users need. I believe that the day will eventually come when power sharing is achieved within mental health services and Māori pathways are seen as legitimate alongside mainstream pathways. I hope this research has added a little to the rainfall necessary for this goal to be achieved. There remains a very long way to go in achieving this goal, although just as Tane Mahuta (a New Zealand native Kauri tree

over 2000 years old) started with a little rain and sunshine on a small seed, so it is with knowledge and   understanding.

REFERENCES

Agar, K. (2006). *Mental health crisis services: What do service users need when in crisis? A retrospective study.* Unpublished Doctoral thesis, University of Auckland, Auckland.

Alexander, F., & Selesnick, S. (1996). *The history of psychiatric thought and practice from prehistoric times to the present.* New York: Harper & Row.

Allen, M. (2002). *Identity and resistance in Okinawa.* New York: Rowman & Littlefield Publishers.

American Psychiatric Association. (1994). *Diagnostic and statistical manual: 4th edition.* Washington DC: APA.

American Psychiatric Association. (2001). *The practice of ECT: A task force report.* Washington DC: APA.

Amor, V. (2002). Reflections on working in a kaupapa Māori service. In R. Truell & L. Nowland (Eds.), *Reflections on current social work practice.* Palmerston North: Dummok Press.

Angermeyer, M. C., & Klusmann, D. (1988). The causes of functional psychoses as seen by patients and their relatives. *European Archives of Psychiatry and Neurological Sciences, 238*, 47-54.

Angermeyer, M. C., Loffler, W., Muller, P., Schulze, B., & Priebe, S. (2001). Patients and relatives assessment of clozapine treatment. *Psychological Medicine, 31*, 509-517.

Antonuccio, D. (1995). Psychotherapy for depression: No stronger medicine. *American Psychologist*, 450-453.

Bannister, D. (1960). Conceptual structure in thought disordered schizophrenics. *Journal of Mental Science, 106*, 1230-1249.

Barlow, C. (1991). *Tikanga Whakaaro.* Auckland: Oxford University Press.

Barnes, H. (2003). *Quantitative research by and with Māori.* Paper presented at the The social policy research and evaluation conference, Wellington Convention Centre.

Bateson, G. (1973). *Steps to an ecology of mind.* St Albans: Paladin.

Bateson, G. (Ed.). (1962). *Perceval's Narrative.* London: Hogarth Press.

Bateson, G., Jackson, D. D., Haley, J., & Weakland, J. (1956). Toward a theory of schizophrenia. *Behavioural Science, 1*, 251-264.

Bathurst, K. O. (1940). *The hauhau movement: A study in social religious and abnormal psychology.* Unpublished Masters thesis, University of New Zealand.

Beaglehole, E. (1939). Culture and psychosis in New Zealand. *Journal of the Polynesian Society, 48,* 144-155.

Beaglehole, E., & Beaglehole, P. (1946). *Some Modern Māoris.* Auckland: Oxford University Press.

Beaglehole, E., & Ritchie, J. E. (1957). The Rakau Māori Studies. *The Journal of the Polynesian Society, 66,* 132-153.

Beattie, H., & Tikao, T. (1939). *Tiakao Talks: Ka Taoka o te Ao Kohatu. Treasures from the ancient world of the Māori.* Auckland: Penguin Books.

Beavan, V. (2007). *Angels at our tables: New Zealanders experience of hearing voices.* Unpublished Doctor of Philosophy, University of Auckland, Auckland.

Bentall, R. (1986). The scientific validity of the schizophrenia diagnosis: A critical evaluation. In N. Eisenberg & D. Glasgow (Eds.), *Current Issues in Clinical Psychology.* Aldershot: Gower.

Bentall, R. (1990). The syndromes and symptoms of psychosis. In *Reconstructing schizophrenia.* London: Routledge.

Bentall, R. (2003). *Madness Explained.* London: The Penguin Press.

Best, E. (1898). Omens and superstitious beliefs of the Māori. *The Journal of the Polynesian Society, 7,* 119-136.

Best, E. (1924). *The Māori as he was* (2nd Edition, 1952 ed.). Wellington: Dominion Museum.

Best, E. (1954). *Spiritual and mental concepts of the Māori. Being illustrations and animism and animatism.* Wellington: Dominion Museum.

Best, E. (1976 [1924]). *Māori religion and mythology, being an account of the cosmology, anthropogeny, religious beliefs and rites, magic and folk lore of the Māori folk of New Zealand. Part I.* Wellington: Government Printer.

Bhurga, D., Hilwig, M., Hossein, B., Marceau, H., Neehal, J., Leff, J., et al. (1996). First contact incidence rates of schizophrenia in Trinidad and one-year follow up. *The British Journal of Psychiatry, 169,* 587-592.

Bhurga, D., & Jones, P. (2001). Migration and mental illness. *Advances in Psychiatric Treatment, 7,* 216-223.

Bhurga, D., Leff, J., Mallet, R., Der, G., Corrindian, B., & Rudge, S. (1997). Incidence and outcome of schizophrenia in whites, African - Carribeans and Asians in London. *Psychological Medicine, 27*, 791-798.

Bhurga, D., & Littlewood, R. (2001). *Colonialism and psychiatry*. New Dehli: Oxford University Press.

Binney, J., Bassett, J., & Olssen, E. (1990). *The people and the land: An illustrated history of New Zealand 1820-1920*. Wellington: Bridget Williams Books.

Bishop, R. (1996). *Whakawhanaungatanga. Collaborative research stories*. Palmerston North: Dunmore Press.

Bishop, R. (1998). Freeing ourselves from neo-colonial domination in research: A Māori approach to creating knowledge. *Qualitative Studies in Education, 11*(2), 199-219.

Bleuler, E. (1913/1950). *Dementia Praecox: The group of schizophrenias*. New York: International University Press.

Borch-Jacobsen, M. (2001). Making psychiatric history: Madness as *folie a plusieurs*. *History of the human sciences, 14*(2), 19-38.

Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and code development*. Washington: Sage.

Boydell, J., Van Os, J., McKenzie, K., Allardyce, J., Goel, R., Mcreadie, R., et al. (2001). Incidence of schizophrenia in ethnic minorities in London: Ecological study into interactions with the environment. *British Medical Journal, 323*, 1336-1338.

Boyle, M. (1990). The non-discovery of schizophrenia. In R. Bentall (Ed.), *Reconstructing Schizophrenia*. London: Routledge.

Brady, E. (1992). Cross-cultural issues in clinical psychology training programmes. *New Zealand Journal of Psychology, 21*, 56-61.

Brass, G. M. (1999). *Respecting the medicines: Narrating an aboriginal identity*. McGill University, Montreal.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Brave Heart, M. Y. (2001). The circle. *The Circle News, 22*(1), 190.

Brett, C. (2002). Psychotic and mystical states of being: Connections and distinctions. *PPP, 9*(321-341).

Bruxner, G., Biurvill, P., Fazio, S., & Febbo, S. (1997). Aspects of psychiatric admissions of migrants to hospitals in Perth, Western Australia. *Australasian and New Zealand Journal of Psychiatry, 31*(4), 532-542.

Buck, P. (1949). *The coming of the Māori*. Wellington: Whitcombe and Tombs ltd.

Burdett, J., & Geekie, J. (2003). *Philosophical inquiry groups for clients of a first episode psychosis service.* Paper presented at the 14th ISPS Symposium, Melbourne.

Butt, T. W. (2003). The phenomenological context of personal construct psychology. In F. Fransella (Ed.), *International Handbook of personal construct psychology*. London: Wiley.

Button, E. (1985). *Personal construct theory and mental health: Theory, research and practice.* London: Croom Helm.

Carpenter, W. T., & Buchanan, R. W. (1995). Schizophrenia: Introduction and overview. In H. I. Kaplan & B. J. Saddock (Eds.), *Comprehensive Textbook of Psychiatry*. Maryland: Williams and Wilkins.

Carr, J. E. (1985). Ethno-behaviourism and the cultural bound syndromes: The case of *Amok*. In R. C. Simons & C. C. Hughes (Eds.), *The culture bound syndromes. Folk illnesses of psychiatric and anthropological interest*. Dodrecht: D Reidel Publishing Company.

Castillo, R. (2003). Trance, Functional Psychosis and Culture. *Psychiatry, 66*(1), 9-21.

Chandrasena, R. (1987). Schneider's First Rank symptoms: An international and interethnic comparative study. *Acta Psychiatra Scandanavia, 76*, 574-578.

Cherrington, L. (1994). *A Comparison study of the presenting symptoms between Māori and Pākehā patients diagnosed with schizophrenia.* Massey University, Palmerston North.

Claridge, G. (2001). Spiritual experience: Healthy psychoticism? In I. Clarke (Ed.), *Psychosis and Spirituality: Exploring the new frontier*. London: Whurr Publishers Ltd.

Clement, D. C. (1984). Samoan folk knowledge of mental disorders. In A. J. Marsella & G. M. White (Eds.), *Cultural conceptions of mental health and therapy*. Dordrecht: D. Reidel Publishing Company.

Coid, J., Kahtan, N., Gault, S., & Jarman, B. (2000). Ethnic differences in admissions to secure forensic psychiatry services. *The British Journal of Psychiatry, 177*, 241-247.

Colquhoun, R., & Martin, B. (2001). Constructing social action. *Philosophy and social action, 27*(4), 7-23.

Cook, B. (2005). Changes in Kanaka Maoli men's roles and health: Healing the warrior self. *International journal of men's health, Summer*, 1-12.

Cook, B., Withy, K., & Tarallo-Jensen, L. (2003). Cultural trauma, Hawaiian spirituality and contemporary health status. *Californian journal of health promotion, 1*, 10-24.

Cook, B., Withy, K., & Tarallo-Jensen, L. (2003). Cultural trauma, Hawaiian spirituality and contemporary health status. *Californian journal of health promotion, 1*, 10-24.

Copeland, J. (1971). Differences in usage of diagnostic labels amongst psychiatrists in the British Isles. *British Journal of Psychiatry, 118*, 629-640.

Cram, F. (1997). Developing partnerships in research: Pākehā researchers and Māori research, *SITES, 35.*

Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among the five traditions*. Thousand Oaks, California: Sage Publications.

Crooks, S. (1999). It's a privilege, not a disability. In J. Leibrich (Ed.), *A gift of stories*. Christchurch: University of Otago Press.

Culleberg, J. (2006). *Psychoses: An integrative perspective*. East Sussex: Routledge.

Curtis, L. C. (1997). *New directions: International overview of best practices in recovery and rehabilitation services for people with serious mental illness*. Vermont: Centre for Community Change.

Das, S., Saravanan, B., Karunakaran, K. P., & et al. (2001). Effects of a structured educational intervention on explanatory models. *Journal of Psychiatry, 188*, 286-287.

Dean, B. (2000). Signal transmission, rather than reception is the underlying neurochemical abnormality in schizophrenia. *Australasian and New Zealand Journal of Psychiatry, 34*, 560-569.

Dennehy, M. (2005). *Tapu in tradition, history and scholarship*. Unpublished Research portfolio for a Master of Arts, University of Auckland, Auckland.

Department of Social Welfare. (1989). *The national mental health consortium report*. Wellington: Department of Social Welfare.

Devenish, S. (2002). An applied method for undertaking phenomenological explication of interview transcripts. *The Indo Pacific Journal of Phenomenology, 2*(1), 1-20.

Dickerson, F. B. (2000). Cognitive behavioural psychotherapy for schizophrenia: a review of recent empirical studies. *Schizophrenia Research, 43*(2-3), 71-90.

Dragnus, J. G. (1980). Psychological disorders of clinical severity. In H. C. Triandis & J. G. Dragnus (Eds.), *Handbook of cross cultural psychology: Psychopathology* (pp. 99-174). Boston: Allyn and Bacon.

Drug Advisory Committee. (1995). *Cannabis and health in New Zealand*. Wellington: Drug Advisory Committee.

Ducey, C., & Simon, B. (1975). Ancient Greece and Rome. In J. Howells (Ed.), *World history of psychiatry*. New York: Bruner/Mazel.

Duran, E. (2006). *Healing the soul wound, counselling with American Indians and other native peoples*. New York: Teachers College Press.

Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. Albany: State University of New York.

Duran, E., Duran, B., Yellow Horse Brave Heart, M., & Yellow Horse-Davis, S. (1998). Healing the American Indian soul wound. In Y. Danieli (Ed.), *International handbook of multigenerational legacies of trauma* (pp. 341-354). New York: Plenium Press.

Durie, M. (1988). Te aro kawa whakruruhau: cultural safety in health. In Mental Health Foundation of New Zealand (Ed.), *Māori mental health a resource kit*. Auckland: Mental Health Foundation New Zealand.

Durie, M. (1994). *Māori health policy*. Paper presented at the Te Ara Ahu Whakamua: proceedings of the Māori health decade hui, Wellington.

Durie, M. (1996). Māori cultural identity and it's implications for mental health services. *International Journal of Mental Health*, 61-67.

Durie, M. (1998). *Te ora rangahau: concluding remarks*. Paper presented at the Te Oru Rangahau, Massey University, Palmerston North.

Durie, M. (1999). *Whaiora: Māori health development*. Auckland: Oxford University Press.

Durie, M. (2001). *Mauri ora: The dynamics of Māori health*. Auckland: Oxford University Press.

Durie, M. (2004). *Mauri Ora: The Dynamics of Mental Health*. Auckland: Oxford University Press.

Durkheim, E. (1912). *The elementary forms of religious life*. London: Oxford University Press.

Dyall, L. (1997a). Māori. In P. M. Ellis & S. C. D. Collings (Eds.), *Mental health in New Zealand from a public health perspective*. Wellington: Ministry of Health.

Dyall, L. (1997b). Oranga Hinengaro Māori: Māori mental health summit 1997 abridged. In J. Cherrington, C. Coggan, A. Goslyn, J. Hand & J. Raeburn (Eds.), *Mental health: A review of 1997*. Auckland: Mental Health Foundation of New Zealand.

Dyall, L. (1999). Māori outcomes: Expectations of mental health services. In *Social Policy Journal of New Zealand (issue 12)*. Wellington: Social Policy Agency.

Ellason, J., & Ross, C. (1995). Positive and negative symptoms in dissociative disorder and schizophrenia. *Journal of Nervous and Mental Disease, 183*(263-41).

Ely, M., Vinz, R., Downing, M., & Anzul, M. (1997). *On writing qualitative research: living by words.*: Routledge/Farmer.

Estroff, S. E. (2004). Subject/subjective in dispute: The poetics, politics and performance of fist person narratives of people with schizophrenia. In J. Jenkins & M. Barrett (Eds.), *Schizophrenia, Culture and Subjectivity*. New York: Cambridge University Press.

Fabrega, H. (1989a). On the significance of an anthropological approach to schizophrenia. *Psychiatry, 52*, 45-65.

Fabrega, H. (1989b). The self and schizophrenia: A cultural perspective. *Schizophrenia Bulletin, 15*(2), 277-290.

Fanon, F. (1963). *The wretched earth*. New York: Grove Press.

Feinstein, A., & Holloway, F. (2002). Evaluating the use of a psychiatric intensive care unit: Is ethnicity a risk factor for admission. *International Journal of Psychiatry, 48*(1), 9-.

Fernando, S. (1988). *Race and culture in psychiatry*. Great Britain: Billing & Sons Ltd.

Fernando, S. (1995). *Mental Health in a multi-ethnic society: A multidisciplinary handbook*. London: Routledge.

Fitch, M. J. (1938). *The Māori custom of muru.* Unpublished Masters Thesis, University of New Zealand, Canterbury College.

Flick, U. (2002). *An introduction to qualitative research*. London: Sage Publications.

Foucault, M. (1965). *Madness and civilisation*. New York: Random House.

Foulks, E. F. (1985). The transformation of arctic hysteria. In R. C. Simons & C. C. Hughes (Eds.), *The culture bound syndromes. Folk illnesses of psychiatric and anthropological interest*. Dordrecht: D Reidel Publishing Company.

Friere, P. (1993). *Pedagogy of the Oppressed*. London: Penguin Books.

Fromm-Reichmann, F. (1948). Notes on the development of treatment of schizophrenia from a psychoanalytic perspective. *Psychiatry, 11*, 263-273.

Gaines, A. D. (1982). Cultural definitions, behaviour and the person in american psychiatry. In A. J. Marsella & G. M. White (Eds.), *Cultural conceptions of mental health and therapy*. Dordrecht: D.Reidel Publishing Company.

Gardner, W. J. (2006). *Rolleston, William 1831-1903: Dictionary of New Zealand Biography*, from http://www.dnzb.govt.nz/

Geekie, J. (2006). *The experience of psychosis: Fragmentation, invalidation and spirituality*. Unpublished PhD Thesis, University of Auckland, Auckland.

Gibbs, A., Dawson, J., Forsyth, H., Mullen, R., & Te Oru Tonu Tanga. (2004). Māori experience of community treatment orders in Otago, New Zealand. *Australasian and New Zealand Journal of Psychiatry, 38*, 830-835.

Gilgun, J. F. (2005). Qualitative research and family psychology. *Journal of Family Psychology, 19*, 40-50.

Glavish, N. (2000). *Māori concepts of assessing behaviours for mind wellness*. Auckland: Office of Chief Advisor Tikanga, Auckland District Health Board.

Gluckman, L. K. (1962). *Makutu: A study in the ethno-psychiatry of the Māori, past and present*. Unpublished M.D, University of Otago.

Gluckman, L. K. (1977). Clinical experience with Samoans in Auckland, New Zealand. *Australian and New Zealand Journal of Psychiatry, 11*, 101-107.

Goddard, H. (1909). Report of the Royal Commission on the care and control of the feeble minded: A review. *American Journal of Psychiatry, 20*(3), 456-457.

Golafshani, N. (2003). Understanding reliability and validity in Qualitative research. *The Qualitative Report, 8*(4), 597-607.

Goldie, W. H. (1904). *Māori medical lore: notes on the causes and treatment of the sick among the Māori people of New Zealand, as believed and practiced in former times, together with some account of various ancient rites connected with the same*. Wellington: Transactions and Proceedings of the New Zealand Institute.

Goldsbury, S. (2004). *Māori service users experiences with clinical psychologists*. Unpublished Masters, Waikato University, Waikato.

Gottesman, I. I. (1991). *Schizophrenic genesis: The origins of madness*. New York: Freeman.

Gould, R. A., Mueser, K. T., Boulton, E., & al., e. (2001). Cognitive therapy for psychosis in schizophrenia: an effect size analysis. *Schizophrenia Research, 48*, 335-342.

Greenfield, P. M. (1987). Culture as process: Empirical methods for cultural psychology. In J. W. Berry, Y. H. Poortinga & J. Pandey (Eds.), *Handbook of Cross-Cultural Psychology: Theory and Method*. MA: Allyn & Bacon.

Grof, C., & Grof, S. (1990). *The stormy search for the self: A guide to personal growth through transformational crisis*. New York: Jeremy P Tarcher.

Grof, S., & Grof, C. (1989). *Spiritual emergency: When personal transformation becomes a crisis*. Los Angeles: Tarcher.

Gudeon, C. M. G. (1921). The tohunga Māori. *The Journal of the Polynesian Society, 30*, 162-184.

Gussow, Z. (1985). Pibloktoq (hysteria) Among the polar Eskimo: An ethno psychiatric study. In R. C. Simons & C. C. Hughes (Eds.), *The culture bound syndromes: Folk illnesses of psychiatric and anthropological interest*. Dodrecht: D Reidal Publishing Company.

Harris, R., Tobias, M., Jeffreys, M., Waldergrave, K., Karlsen, S., & Nazroo, J. (2006). The relationship between experience of racial discrimination and health in New Zealand. *Social Science and Medicine, 63*(6), 1424-1441.

Harrison, G. (1990). Searching for the causes of schizophrenia: The role of migrant studies. *Schizophrenia Bulletin, 16*(4), 663-671.

Hassen, C., Lambert, M., Mass, R., & Krausz, M. (1998). Impact of ethnicity on the prevalence of psychiatric disorders among migrants in Germany. *Ethnicity and health, 3*(3), 159-165.

Hassen, C., Yagdiran, O., Mass, R., & Krausz, M. (2000). Potential for misdiagnosis among Turkish migrants with psychotic disorders: A clinical controlled study in Germany. *Acta Psychiatra Scandanavia, 101*(2), 125-128.

Henare, M. (2003). *The changing images of nineteenth century Māori society - From tribes to nation*. Unpublished Doctor of Philosophy, Victoria University, Wellington.

Herbert, A. & Morrison, L. (2007). Practice of psychology in Aotearoa a Māori perspective in Evans, I., Rucklidge, J. & O'Driscoll, M. (Eds). *Professional Practice of Psychology in Aotearoa New Zealand.*

Herron, W. (1992). A Comparison of 16 systems to diagnose schizophrenia. *Journal of Clinical Psychology, 48*(711-21).

Hickling, F. W., McKenzie, K., Mullen, R., & Murray, R. (1999). A Jamaican psychiatrist evaluates diagnosis at a London psychiatric hospital. *The British Journal of Psychiatry, 175*(9), 283-285.

Hickling, F. W., & Rodgers-Johnson, P. (1995). The incidence of first contact schizophrenia in Jamaica. *British Journal of Psychiatry, 167*(2), 193-196.

Hirini, P., & Maxwell-Crawford. (2002). *Te Rau Matatini: Māori mental health workforce development.* Paper presented at the Proceedings of the National Māori Graduates of Psychology Symposium, Waikato University.

Hogarty, G., Anderson, C. M., Reiss, D. J., Kornblith, S. J., Greenwald, D. P., Ulrich, R. F., et al. (1991). Family education, social skills training and maintenance chemotherapy in the aftercare of schizophrenia. *Archives of General Psychiatry, 48*(340-347).

Holloway, I., & Todres, L. (2003). The status of method: Flexibility consistency and coherence. *Qualitative research, 3*, 345-357.

Hopa, N. (1998). Makutu, whaiwhaia, whakanganewha, mate Māori: syncretism and "Māori sickness". *Stimulus: The New Zealand Journal of Christian thought and practice, 6*(2), 72-75.

Houkamau, C., & Rickard, S. (2001). Diagnostic issues and Māori. *The Bulletin, 99.*

House of Commons Select Committee. (1837). Official report to the select committee on aborigines. In J. H. Bodley (Ed.), *(1998). Tribal Peoples and development issues: A global overview* (pp. 63-69). Mountain View CA: Mayfield.

Hoyt, M., F. (2002). How I embody and narrative constructive approach. *Journal of Constructivist Psychology, 15*, 279-289.

Hudson, M. (2004). *Māori and ethical review in health research.* Unpublished Masters in Health Science, Auckland University of Technology, Auckland.

Human Rights and Equal Opportunities Commission. *Bringing them home: Community Guide*
Human Rights and Equal Opportunities Commission. (1997). *Bringing them home: report of the national inquiry into the separation of Aboriginal and Torres Straight Islanders from their families.* Sydney: Human Rights and Equal Opportunities Commission.

Humberstone, V., Wheeler, A., & Lambert, T. (2004). Outpatient antipsychotic usage in outpatients in three community mental health centres in New Zealand. *Australasian and New Zealand Journal of Psychiatry, 38*, 240-245.

Hunter, E. (2001). *Social origins of distress: The deep sleep of forgetfulness: Reflecting on disremembering.* Paper presented at the mental health of indigenous peoples, Montreal, Quebec.

Hutchinson, G., Takei, N., Gilvarry, C., Sham, P., Bhurga, D., Mallet, R., et al. (1996). Morbid risk of schizophrenia in first-degree relatives of white and African-Caribbean patients with psychosis. *The British Journal of Psychiatry, 169*(6), 776-780.

Huygens, I. (1999). An accountability model for Pākehā practitioners. In N. Robertson (Ed.), *Māori and psychology: research and practice- The proceedings of a symposium sponsored by the Māori and Psychology Research Unit*. Hamilton: Māori and Psychology Research Unit.

Ihimaera, L. (2004). *He ara ki te ao Marama: Pathway to understanding the facilitation of taha wairu in mental health services.* Unpublished Masters thesis, Massey University, Palmerston North.

IRI. (2002). *Iwi and Māori provider success. A research report of interviews with successful iwi and Māori providers and governmental agencies.* Wellington: Te Puni Kokiri.

Irwin, K. (1994). *Māori research methods and processes: An exploration.* Paper presented at the NZARE/AARE Annual Conference, Geelong, Australia.

Jablensky, A., Sartorious, N., Ernberg, G., Anker, M., Korten, A., Cooper, J. E., et al. (1992). Schizophrenia: Manifestations, incidence and course in different cultures. A World Health Organisation ten country study. *Psychological Medicine, (supp 20).*

Jackson, H. (1990). Biological markers of schizophrenia? In R. Bentall (Ed.), *Reconstructing Schizophrenia*. London: Routledge.

Jackson, M. (1997). Benign Schizotypy? The case of spiritual experience. In *Schizotypy: Implications for illness and health*. Oxford: Oxford University Press.

Jackson, M. (2001). Psychotic and spiritual experience: A case study comparison. In I. Clarke (Ed.), *Psychosis and spirituality: Exploring the new frontier*. London: Whurr Publishers.

Jackson, M., & Fulford, K. W. M. (1997). Spiritual experience and psychopathology. *Philosophy, Psychiatry & Psychology, 4*, 41-65.

Jahnke, H., & Taiapa, J. (1999). Māori research. In C. Davidson & M. Tolich (Eds.), *Social Science Research in New Zealand: Many Paths to Understanding* (pp. 39-50). Auckland: Longman.

James, W. (1902). *The varieties of religious experience*. New York: Longmans, Green & Co.

Janssen, I., Hanssen, M., Bak, M., Bijl, R., De Graaf, R., Vollebergh, W., et al. (2003). Discrimination and delusional ideation. *The British Journal of Psychiatry, 182*, 71-76.

Janssen, I., Krabbendam, L., Bak, M., Hanssen, M., Vollebergh, W., De Graaf, R., et al. (2004). Childhood abuse as a risk factor for psychotic experiences. *Acta Psychiatra Scandanavia, 109*(38-45).

Jenkins, J. (1988). Ethnopsychiatric interpretations of schizophrenic illness: The problem of nervois within Mexican American families. *Culture, Medicine and Psychiatry, 12*, 301-329.

Jilek, W. (1998). Transcultural psychiatry - Qou Vadis? *Transcultural Psychiatry Newsletter, XVI*(1), 1-14.

Joel, D., Sathyaseelan, M., Jayakaran, R., & et al. (2003). Explanatory models of psychosis among community health workers in South India. *Acta Psychiatra Scandanavia, 108*, 66-69.

Johansen, J. P. (1958). *Studies in Māori rites and myths*. Kobenhavn: Ejnar Munskgraad.

Johansson, L. M., Sundquist, J., Johansson, S. E., & Bergman, B. (1998). Immigration, moving house and psychiatric admissions. *Acta Psychiatra Scandanavia, 98*(2), 105-111.

John, C. W. (1903). *The oldest code of laws in the world: The code of laws promulgated by the Haummrabi, King of Babylon, BC 2285-2242*. Edinburgh.

Johnstone, K. (1997). *Māori mental health: A survey of psychologists and psychiatrists opinions*. Unpublished Masters, Auckland.

Johnstone, K., & Read, J. (2000). Psychiatrists recommendations for improving bicultural training and Māori mental health services: A New Zealand survey. *Australasian and New Zealand Journal of Psychiatry, 34*, 135-145.

Jones, R. (2000). *Rongoa Māori and primary health care*. University of Auckland, Auckland.

Joseph, J. (2004). Schizophrenia and heredity: Why the emperor has no genes. In J. Read, L. Mosher & R. Bentall (Eds.), *Models of Madness*. East Sussex: Brunner-Routledge.

Jung, C. G. (1936). The psychology of dementia praecox. In *Nervous and Mental Disease Monograph Series No.3*. Washington, DC: Nervous and Mental Disease Publishing Company.

Kelly, G. (1969). The autobiography of a theory. In B. A. Maher (Ed.), *Clinical Psychology and personality: The selected papers of George Kelly* (pp. 147-162). New York: Krieger.

Kelly, G. (1970). A brief introduction to Personal Construct Theory. In D. Bannister (Ed.), *Perspectives in Personal Construct Theory*. London: Academic Press.

Kelly, G. (1991). *The psychology of personal constructs. Volume One: Theory and Personality*. London: Routledge.

Kemp, S. (1985). Modern myth and medieval madness: Views of mental illness in the European middle ages and renaissance. *New Zealand Journal of psychology, 14*(1), 1-8.

Kepa, M. (2004). *Cultural fragments: Concerning Māori research developments*: Ngā Pae o te Māramatanga: The Institute of Research Excellence for Māori Development and Advancement.

King, L. J. (1999). A brief history of psychiatry: Millenia past and present. *Annals of clinical psychiatry, 11*(1), 3-12.

Kingi, T. K. R. (2002). *Hua oranga: Best outcomes for Māori.* Wellington: Te Pumanawa Hauora Māori Research Unit, Massey University.

Kingi, T. K. R. (2005). *Cultural interventions and treatment of Māori mental health consumers.* Wellington: Te Mata o te Tau Academy for Māori Research and Scholarship.

Kingi, T. K. R., & Durie, M. (2001). *Hua Oranga: A Māori measure of mental health outcome.* Paper presented at the Mental health outcomes research in Aotearoa. Mental health research and development strategy: Proceedings of the September 2000 conference and other developments in mental health outcomes research, Auckland.

Kirmayer, L. J., Brass, G. M., & Tait, C. L. (2001). The mental health of aboriginal peoples. In L. J. Kirmayer, M. E. Macdonald & G. M. Brass (Eds.), *The mental health of indigenous peoples.* Montreal: McGill University.

Kirmayer, L. J., Macdonald, M. E., & Brass, G. M. (2001). *The mental health of indigenous peoples.* Montreal: McGill University: Division of Social and Transcultural Psychiatry.

Klein, M. (1930). The psychotherapy of psychoses. *British Journal of Medical Psychology, 10*, 242-244.

Kleinman, A. (1973). Toward a comparative study of medical systems. *Science, Medicine and Man, 1*, 55-65.

Kleinman, A. (1980). *Patients and healers within the context of culture.* Los Angeles: University of California Press.

Kraepelin, E. (1919). *Dementia Praecox and Paraphrenia.* Edinburgh: E & S Livingstone.

Laing, R. D., & Esteron, A. (1970). *Sanity, madness and the family.* New York: Basic Books.
Lapsley, H., Nikora, L. W., & Black, R. (2002). *Kia Mauri Tau! Narratives of recovery from disabling mental health problems.* Wellington: Mental Health Commission.

Lauber, C., Nordt, C., Falcato, L., & Rossler, W. (2004). Factors influencing social distance toward people with mental illness. *Community mental health journal, 40*(3), 265.

Lawson-te Aho, K. (1996). *Service evaluation of Te Whare Whakapikiora o te Rangimarie: A Māori traditional healing service.* Wellington: Te Aho Associates.

Lefley, H. P. (1994). An overview of family-professional relationships. In D. T. Marsh (Ed.), *New directions in the psychological treatment of mental illness* (pp. 166-185). Westport: Praeger.

Leibrich, J. (1990). *A gift of stories: Discovering how to deal with mental illness.* Christchurch: University of Otago Press.

Levy, M. (2002). *Barriers and incentives to Māori participation in the profession of psychology. A report for the New Zealand Psychologists Board.* Hamilton: Māori and Psychology Research Unit.

Lewentin, R. C., Rose, S., & Kamin, L. J. (1984). *Not in our genes: Biology, Ideology and Human Nature.* New York: Pantheon.

Lewis, G., Croft-Jeffreys, C., & David, A. (1990). Are British psychiatrists racist? *British Journal of Psychiatry, 157*, 410-415.

Liddle, P. F. (1987). The symptoms of chronic schizophrenia: A re-examination of the positive-negative dichotomy. *British Journal of Psychiatry, 151*, 145-151.

Lin, K. M., & Kleinman, A. M. (1988). Psychopathology and clinical course of schizophrenia: A cross cultural perspective. *Schizophrenia Bulletin, 14*(4), 555-567.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry.* Beverly Hills, CA: Sage.

Little Bear, L. (2005). *Indian Science and Western Physics.* Paper presented at the Indigenous Knowledges Conference, Wellington.

Littlewood, R., & Bhurga, D. (2001). *Colonialism and psychiatry.* London: Oxford University Press.

Lopez, S. R., & Guarnaccia, P. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology, annual*, 571-607.

Love, C. (2004). *Extensions on Te Wheke, Working Paper*: The Open Polytechnic of New Zealand.

Lukoff, D. The diagnosis of mystical experiences with psychotic freatures, *Journal of Transpersonal Psychology,* 17(2), 155-181.

Lukoff, D., & Turner, R. (1998). From spiritual emergency to spiritual problem: The transpersonal roots of the new DSM-IV category. *Journal of Humanistic Psychology, 38*(2), 21-50.

Lyndon, C. (1983). *Beliefs in tapu, mate Māori and makutu and the relevance of these beliefs to the diagnosis of mental illness amongst the Māori.* Unpublished Masters, University of Auckland, New Zealand, Auckland.

Macpherson, C., & Macpherson, L. (1990). *Samoan medical belief and practice.* Auckland: Auckland University Press.

Mankowski, E., & Rappaport, J. (2000). Narrative concepts and analysis in spiritually- based communities. *Journal of Community Psychology, 28*(5), 479-493.

Manna, L. (2002). *Biculturalism in practice, 'Te pounamu': Integration of a Māori model with traditional clinical assessment processes.* Paper presented at the National Māori Graduates of Psychology Symposium, Waikato.

Marek, M., & Bratton, M. (2002). Mystical states or mystical life? Buddhist, Christian and Hindu perspectives. *PPP, 9*(4), 349-351.

Marsden, M. (1986). *Māori illness and healing.* Paper presented at the Seminar on mental health - A case reform, Auckland.

Marsden, M. (1992). God, Man and the Universe: A Māori view. In M. King (Ed.), *Te Ao Hurihuri: The world moves on. Aspects of Māoritanga* (pp. 117-137). Auckland: Octopus.

Marsden, M. (2003). *The woven universe: Selected writings of rev. Māori Marsden*. Otaki: Estate of Rev. Māori Marsden.

Marshall, C., & Rossman, G. B. (1995). *Designing Qualitative Research*. Thousand Oaks, CA: Sage.

Marshall, R. (1990). The genetic of schizophrenia. In *Deconstructing Schizophrenia*. London: Routledge.

Mason, O., Claridge, G., & Jackson, M. (1994). New scales for the assessment of schizotypy. *Personal and Individual Differences, 18*(1), 7-13.

Masters, A. (1997). Schizophrenia the illness. In M. o. Health (Ed.), *Mental health in New Zealand from a public health perspective*. Wellington: Ministry of Health.

Matsumoto, D. (2001). *The handbook of culture and psychology*. Cary, NC: Oxford University Press.

Maybury-Lewis, D. (1997). *Indigenous peoples, ethnic groups, and the state*. Boston: Allyn and Bacon.

McDougall, W. (1908). *Social Psychology*. New York: Luce.

Mcfarlane-Nathan, G. (1996). The bicultural therapy project: Psychological service, Department of corrections, Auckland. *Social Work Review, August*, 22-27.

McGorry, P. D., Yung, A. R., Phillips, L. J., & al., e. (2002). Randomised control trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. *Archives of General Psychiatry, 59*, 921-928.

McIntosh, T. (2004). *Theorising marginality and the process of marginalisation.* Paper presented at the Ngā Pae o te Māramatanga demonstration projects on "protocols for research with vulnerable and marginalised Māori", Waipapa Marae, Auckland.

McKendrick, J. H. (2001). The legacy of the stolen generations: Chronic Depression, cultural Alienation, incarceration and disruption of individuals families and communities. In L. J. Kirmayer, M. E. Macdonald & G. M. Brass (Eds.), *The mental health of indigenous peoples*. Montreal: McGill University.

Mead, A. (1994). Misappropriation of indigenous knowledge: The next wave of colonisation. In *Ngā Tikanga, Ngā Taonga. Cultural and Intellectual Property Rights - The Rights of Indigenous Peoples* (Vol. Monograph 23). Auckland: Research Unit for Māori Education.

Mead, G. H. (1934). *Mind, self and society from the standpoint of a social behaviourist*. Chicago: University of Chicago Press.

Mental Health Commision. (1998). *Blueprint for mental health services in New Zealand: How things need to be*. Wellington: Mental health Commission.

Mental Health Commision. (1999). *Early intervention in psychosis*. Wellington: Mental Health Commission.

Mental Health Commision. (2001). *Cultural assessment process for Māori: Guidance for Mainstream Mental Health Services*. Wellington: Mental Health Commision.

Mental Health Commision. (2006). *No Force Advocacy by Users and Survivors of Psychiatry*. Wellington: MHC.

Merriam, S. B. (2002). *Qualitative Research in Practice*. San Francisco: Jossey-Bass.

Metge, J., & Kinloch, P. (1978). *Talking past each other: Problems of cross cultural communication*. Wellington: Victoria University Press.

Mezzich, J. E., Kirmayer, L. J., Kleinman, A., Fabrega, H., Parron, D., Good, B., et al. (1999). The place of culture in the DSM-IV. *The Journal of Nervous and Mental Disease, 187*(8), 457-464.

Mezzich, J. E., Kleinman, A. M., Fabrega, H., Parron, D., Good, B., Lin, K. M., et al. (1997). Introduction to cultural issues section. In T. Wildiger, A. Frances & H. Pincus, et al. (Eds.), *DSM-IV Sourcebook (vol 3)*. Washington DC: American Psychiatric Press.

Mihinui, H. B. (2002). Hutia te rito o te harakeke: A flax root understanding of resource management. In M. Kawharu (Ed.), *Whenua: Managing our resources*. Auckland: Reed.

Milne, M. (2005). *Māori perspectives on Kaupapa Māori and psychology: A discussion document*. Wellington: Unpublished report for the New Zealand Psychologists Board.

MIND. (2000). *New survey reveals un-therapeutic and 'depressing' conditions on psychiatric wards [online]*, from www.mind.org.uk/news+policy+and+campaigns/press+archive/new+survey+reveals+un-therapeutic+and+depressing+conditions+on+psychiatric+wards.htm

Ministry of Health. (1999). *Standards for Traditional Māori Healing*. Wellington: Ministry of Health.

Ministry of Health. (2005). *Raranga Tupuake: Māori Health Workforce Development Plan: Discussion document*. Wellington: Ministry of Health.

Ministry of Health. (2007). *Building on strengths: A guide for action*. Wellington: Ministry of Health.

Ministry of Justice. (2001). *He hinatore ki te ao Māori*. Wellington: Ministry of Justice.

Mojtabi, R., & Nicholson, R. (1995). Interarater reliability of ratings of delusions and bizarre delusions. *American Journal of Psychiatry, 152*, 1804-1108.

Morrison, A., French, P., Walford, L., Lewis, S., Kilcommons, A., Green, J., et al. (2004). Cognitive therapy for the prevention of psychosis in people at ultra high risk. *British Journal of Psychiatry, 185*, 291-297.

Morse, J., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods 1, 2*, 1-24.

Mortensen, P. B., Cantor-Graae, E., & McNeil, T. F. (1997). Increased rates of schizophrenia among immigrants: Some methodological concerns raised by Danish findings. *Psychological Medicine, 27*, 813-820.

Mosher, L. (1999). Soteria and other alternatives to acute psychiatric hospitalisation. A personal and professional review. *Journal of Nervous and Mental Disease, 187*, 142-149.

Mosher, L., Gosden, R., & Beder, S. (2004). Drug companies and schizophrenia: Unbridled capitalism meets madness. In J. Read, L. Mosher & R. Bentall (Eds.), *Models of Madness*. East Sussex: Brunner-Routledge.

Mosher, L., & Menn, A. Z. (1978). Community and residential treatment for schizophrenia: Two year follow up. *Hospital and Community Psychiatry, 29*, 75.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Murchie, E. (1984). *Rapuora health and Māori women*. Wellington: Māori Womens Welfare League.

National Institute for Clinical Excellence. (2002). *Clinical guidelines I: Schizophrenia. Core interventions in the treatment and management of schizophrenia in primary and secondary care*. London: NICE.

Naumann, R. (1990). *Te mana o te tiriti: the living treaty*. Auckland: New House Publishers.

Nikora, L. W., Levy, M., Masters, B., & Waitoki, M. (2004). *Indigenous psychologies globally-A perspective from Aotearoa/New Zealand*. Retrieved 22 April 2007, from http://pscyhology.waikato.ac.nz/mpru/pubs/paps-sums/2004indpsyc.pdf

Nimgaonkar, V., GAnguli, R., Rudert, W., Vavassori, C., Rabin, B., & Trusso, M. (1992). A Negative association of schizophrenia with an allele of the HLA DQB1 gene among African - Americans. *Schizophrenia Research, 8*, 199.

Noda, F. (1998). Mental health issues affecting ethnic minorities in Japan. *Psychiatry and Clinical Neuroscience, 52*, 367-369.

Noll, R. (1983). Shamanism and schizophrenia: A state specific approach to the "schizophrenia metaphor" of shamanistic states. *American Ethnologist, 10*, 43-459.

Norton, J. (2006). A depth psychology for our times: Integrating discourse and personal construct approaches. *Personal construct theory and practice, 3*.

Noseworthy, S. (1997). Schizophrenia: The needs of individuals and families. In P. M. Ellis & S. Collings (Eds.), *Mental Health in New Zealand from a Public Health Perspective*. Wellington: Ministry of Health.

NSW Department of Health. (1997). *NSW Aboriginal mental health policy: A strategy for the delivery of mental health services for aboriginal people in NSW*. Sydney: Centre for Mental Health.

O'Connor, T. (2007). *How biculutralism works through traditional Māori healing: PhD exit seminar*. Auckland: University of Auckland.

O'Hagan, M. (1986). From taking snapshots to making movies. *Community Mental Health in New Zealand, 3*(1), 31-49.

O'Hagan, M. (1999). *Realising recovery: Six challenges to the mental health sector.* Paper presented at the realising recovery conference, Mental health commission.

O'Hagan, M (2004). *Opening address at* The Making Sense of Psychosis Conference, Auckland.

O'Hagan, M. (2006). *The acute crisis: Towards a recovery plan for acute mental health services in New Zealand*. Wellington: Mental Health Commission.

Omeasoo, P. (2000). First Nations Liaison Work. *Visions: BC's Mental Health Journal., 9*, 19-21.

Paewai, S. (1997). *Cultural safety within clinical psychology: Māori perspectives.* Unpublished Masters in Social Sciences, Waikato University.

Palmer, G. B. (1951). Tohungaism and makutu. *The Journal of the Polynesian Society, 60*, 147-163.

Parker, I. (1992). Discourse analysis. In P. Banister, E. Burman, I. Parker, M. Taylor & C. Tindall (Eds.), *Qualitative methods in psychology*.

Parsonage, W. (1957). The education of Māoris in New Zealand. *The Journal of the Polynesian Society, 66*, 5-11.

Pere, R. R. (1991). *Te wheke: A celebration of infinite wisdom*. Gisborne, New Zealand: Ao ako Global Learning.

Pihama, L. (1993). *Tungia Te Ururua, Kia Tupu Whakaritorito te Tupu o te Harakeke: A criticial analysis of parents as first teachers*. MA Thesis, University of Auckland.

Pihama, L. (2001). *Tihei Mauri Ora: Honouring our voices: Mana Wahine as a Kaupapa Māori Theoretical Framework*. Auckland: School of Education, University of Auckland.

Pihama, L., Smith, K., Taki, M., & Lee, J. (2004). *A literature review on Kaupapa Māori and Māori education pedagogy*. Auckland: International Research Institute for Māori and Indigenous Education (IRI).

Pilgrim, D. (1990). Competing histories of madness: Some implications for modern psychiatry. In R. Bentall (Ed.), *Reconstructing schizophrenia* (pp. 211-234). London: Routledge.

Polkinghore, D. (1989). Phenomenological research methods. In R. S. Valle & S. Halling (Eds.), *Existential phenomenological perspectives in psychology* (pp. 41-60). New York: Plenum Press.

Pope, J. (1884). *Health for the Māori: a manual for use in native schools*. Wellington: Government Printer.

Porter, R. (1987). *A social history of madness: The world through the eyes of the insane*. New York: Widenfeld and Nicholson.

Powell, G. (1955). The Māori school - A cultural dynamic. *Journal of the Polynesian Society, 64,* 259-266.

Psarcharopoulous, G., & Patrinos, H. A. (1994). *Indigenous people and poverty in Latin America: An empirical analysis*. Washington DC: The World Bank.

Randall, M. (1990). Saadaka Unmari as a cognitive element in illness interpretation and coping behaviour. In *Iryou taio gyousei ni kansuru sougouteki kenkyuu.* Naha: Ryukyu Daigaku Press.

RANZP. (2005). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders. *Australasian and New Zealand Journal of Psychiatry, 39,* 1-30.

Read, J. (2004a). Does schizophrenia exist. In J. Read, L. Mosher & R. Bentall (Eds.), *Models of Madness*. East Sussex: Brunner-Routledge.

Read, J. (2004b). A history of madness. In J. Read, L. Mosher & R. Bentall (Eds.), *Models of Madness*. East Sussex: Brunner-Routledge.

Read, J. (2004c). The invention of schizophrenia. In J. Read, L. Mosher & R. Bentall (Eds.), *Models of Madness*. East Sussex: Brunner-Routledge.

Read, J., Agar, K., Argyle, N., & Aderhold, V. (2003). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions, and thought disorder. *Psychology and Psychotherapy: Theory, research and practice, 76*(1-22).

Read, J., & Harre, N. (2001). The role of biological and genetic causal beliefs in the stigmatisation of 'mental patients'. *Journal of mental health, 10*(2), 223-235.

Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: A review of the 'mental illness is an illness like any other' approach. *Acta Psychiatra Scandanavia, 114,* 303-318.

Read, J., Mosher, L., & Bentall, R. (2004). *Models of madness*. East Sussex: Brunner-Routledge.

Read, J., Perry, B. D., Moskwitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumatogenic neurodevelopmental model. *Psychiatry, 64*(4), 319-345.

Read, J., Seymour, F., & Mosher, L. (2004). Unhappy families. In J. Read, L. Mosher & R.

Bentall (Eds.), *Models of Madness* (pp. 253-269). Eeast Sussex: Brunner-Routledge.

Redko, C. P. (2000). *Fighting against the evil. Religious and cultural construction of the first psychotic experience of youth living in Sao Pauolo, Brazil*. Mcgill University, Ottawa.

Reed, A. W., & Karetu, T. S. (1948). *Concise Māori Dictionary*. Auckland: Reed.

Reet, S. (2004). *Alternatives to admission - A brief paper*: Unpublished report, Mental Health Commision.

Reid, P., & Cram, F. (2005). Connecting health, people and country in Aotearoa New Zealand. In K. Dew & P. Davis (Eds.), *Health and Society in Aotearoa New Zealand: Second Edition*. Melbourne: Oxford University Press.

Rewiti, H. (1856). Murder of a native woman. *The Māori messenger: Te Karere Māori, 2*.

Robinson, D. N. (1986). *An intellectual history of psychology*. Madison: University of Wisconsin Press.

Robinson, S. T. (2005). *Tohunga: The revival. Ancient knowledge for the modern era*. Auckland: Reed.

Roe, D. N. (1997). *Exploring the relationship between individuals experience of self and the course of their disorder*. Unpublished Doctor of Philosophy, Columbia University.

Romme, M., & Escher, A. (1989). Hearing Voices. *Schizophrenia Bulletin, 15*, 209-216.

Ross, C., & Read, J. (2004). Antpsychotic medication: Myths and facts. In J. Read, L. Mosher & R. Bentall (Eds.), *Models of Madness*. East Sussex: Brunner-Routledge.

Rowley, C. D. (1973). *Outcasts in white Australia*. Hammondsworth: Penguin.

Royal, C. (1998). *Te Ao Marama - A research paradigm*. Paper presented at the Te Oru Rangahau, Māori research and development conference, Massey University.

Sachdev, P. S. (1989a). Mana, Tapu, Noa: Māori cultural constructs with medical and psychosocial relevance. *Psychological Medicine, 19*, 959-969.

Sachdev, P. S. (1989b). Psychiatric Illness in New Zealand Māori. *Australian and New Zealand Journal of Psychiatry, 23*, 529-541.

Sadowsky, J. (2004). Symptoms of colonisation: Content and context of delusion in Southwest Nigeria 1945-1960. In J. H. Jenkins & M. Barrett (Eds.), *Schizophrenia, culture and subjectivity*. New York: Cambridge University Press.

Sanders, D. L. (2006). *Illness representations of mental illness in New Zealand.* Unpublished Masters of Science, University of Auckland, Auckland.

Sartorious, N., Jablensky, A., Korten, A., Ernberg, G., Anker, M., Cooper, J. E., et al. (1986). Early manifestations and first contact incidence of schizophrenia in different cultures. *Psychological Medicine, 16*, 909-928.

Satorious, N., Jablensky, A., Ernberg, G., Leff, J., Korten, A., & Gulbinat, W. H. (1987). Course of schizophrenia in different countries: Some results of a WHO international comparative 5-year follow-up study. In H. Hafner, W. F. Gattaz & W. Janzarik (Eds.), *Search for the causes of schizophrenia*. Berlin: Springer.

Schweitzer, R. (1983). *A phenomenological explication of treating interpretation among rural and urban Nguni people.* Rhodes University.

Schwendler, W. (1984). UNESCO's project on the exchange of knowledge for endogenous development. *International Journal of Psychology, 19*, 3-15.

Seale, C. (1999). Quality in qualitative research. *Qualitative Inquiry, 5*(4), 465-478.

Segal, S. P., Bola, J. R., & Watson, M. A. (1996). Race, quality of care, and antipsychotic prescribing practices. *Schizophrenia Bulletin, 47*, 282-286.

Selten, J. P., & Sijben, M. (1994). First admission rates for schizophrenia in immigrants to the Netherlands. The Dutch National Register. *Social Psychiatry and Psychiatric Epidemiology, 19*(2), 71-77.

Shapiro, S. (1991). Affect integration in psychoanalysis: A clinical approach to self destructive behaviour. *Bulletin of the Menning Clinic, 55*(3), 363-374.

Sharfstein, S. S. (2005). Big Pharma and American psychiatry: The good, the bad and the ugly. *Psychiatric News, 40*, 3.

Sharp, A. (1997). *Justice and the Māori: The philosophy and practice of Māori claims in New Zealand since the 1970s.* Auckland: Oxford University Press.

Sharples, P. (1993). A Māori perspective. *Community Mental Health in New Zealand, 7*(2), 10-17.

Shih, S.-m., Marcos, S., Nnaemeka, O., & Waller, M. (2005). Conversation on "Feminist Imperialism and the politics of difference". In M. Waller & S. Marcos (Eds.), *Dialogue and Difference: Feminisms Challenge Globalisation*. New York: Palgrave Mcmillan.

Shirres, M. (1979). *Tapu: Being with potentiality for power.* Unpublished Masters, University of Auckland.

Shooter, M. S. (2005). Dancing with the devil? A personal view of psychiatry's relationships with the pharmaceutical industry. *Psychiatric Bulletin, 29*, 81-83.

Shorter, E. (1997). *A history of psychiatry*. New York: John Wiley & Sons Inc.

Shortland, E. (1856). *Traditions and superstitions of the New Zealanders*. London: Longman, Brown, Green, Longmans & Roberts, Patterson Row.

Shortland, E. (1882). *Māori religion and mythology*. London: Longmans, Green and Co.

Smith, G. (1992). *Tane-nui-a-rangi's legacy: propping up the sky. Kaupapa Māori as resistance and intervention.* Paper presented at the New Zealand Association for Research in education/Australia Association for Research in Education joint conference, Deakin University, Australia.

Smith, G. (1997). *The development of kaupapa Māori: Theory and praxis.* Unpublished Doctor of Philosophy, University of Auckland, Auckland.

Smith, L. (2003). *Decolonising Methodologies*. Dunedin: University of Otago Press.

Smith, L., & Reid, P. (2000). *Māori research development: Kaupapa Māori principles and practices: A literature review*. Wellington: Te Puni Kokiri.

Smith, P. (1913). *The lore of the Whare-Wananga*. New York: AMS Press.

Smith, P. (1921). The evils of makutu or witchcraft. *The Journal of the Polynesian Society, 30*, 173-184.

Snowden, L., & Cheung, F. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45*(3), 347-355.

Spitzer, M. (1990). On defining delusions. *Comprehensive Psychiatry, 31*, 377-397.

Stewart, T. (1992). *Māori initiatives within the psychology department, University of Auckland.* Auckland: Unpublished report.

Stewart, T. (1997). Historical interfaces between Māori and psychology. In P. Te Whaiti, M. McCarthy & A. Durie (Eds.), *Mai i Rangiatea: Māori wellbeing and development* (pp. 75-95). Auckland: Auckland University Press.

Strauss, J. S. (1969). Hallucinations and delusions as points on continua function. *Archives of General Psychiatry, 21*, 581-586.

Sue, D., Arrendondo, P., & McDavis, R. (1992). Multicultural counselling competencies and standards: A call to the profession. *Journal of counselling and development, 70*, 477-486.

Sue, S., & Sue, C. (1990). *Counselling the culturally different: Theory and practice*. New York: Wiley.

Sutherland, I. L. G. (1929). The study of the Māori mind. *The Journal of the Polynesian Society, 38*, 127-147.

Szasz, T. (1971). *The manufacture of madness: A comparitive study of the inquisition and mental health movement*. New York: Delta.

Szasz, T. (1979). *The myth of psychotherapy*. Melbourne: Oxford University Press.

Taitimu, M. (2002). *Māori mental health outcome Measures: A consumer perspective*. Unpublished Honours Dissertation, University of Auckland, Auckland.

Taitimu, M., & Read, J. (2006). Explanatory models of schizophrenia. *British Journal of Psychiatry, 189*, 284.

Tamasese, K., Peteru, C., & Waldergrave, C. (1997). *Ole Taeao Afua: The new mourning. A qualitative investigation into Samoan perspectives on mental health and culturally appropriate services.*: The Family Centre.

Tamasese, K., Peteru, C., Waldergrave, C., & Bush, A. (2005). Ole Taeao Afua, the new morning: A qualitative investigation into Samoan perspectives on mental health and culturally appropriate services. *Australasian and New Zealand Journal of Psychiatry, 39*, 300-309.

Tassell, N. A. (2004). *Workforce profile II: An extended analysis of the mental health workforce*. Palmerston North, New Zealand: Te Rau Matatini.

Tate, P. (1993). *The dynamics of whanaungatanga*.Unpublished manuscript.

Tate, P. H. (1990). The unseen world. *New Zealand Geographic, Jan-Mar*, 87-90.

Tawhai, S. (1999). Now the time is right. In J. Leibrich (Ed.), *A gift of stories*. Wellington: University of Otago Press/ Mental Health Commission.

Taylor, E. (1982). *William James on exceptional mental states: The 1896 Lowell lectures*. New York: Charles Scribners Sons.

Taylor, R. (1974). *Te Ika a Maui: New Zealand and it's inhabitants*. Wellington: AH & AW Reed.

Te Hoe Nuku Roa. (1997). *Reports of the Manawatu-Whanganui and Gisborne Baseline Studies*: Department of Māori Studies, Massey University.

Te Hoe Nuku Roa. (1998). *Manawatu-Whanganui, Wellington, Gisborne, Auckland, Regional results*. Palmerston North: School of Māori Studies, Massey University.

Te Pipi Wharauroa: He Kupu Whakamārama. (1909). General News update. *Te Pipi Wharauroa: He Kupu Whakamārama,* p. 7.

Te Pumanawa Hauora. (1997). *Oranga Kaumatua: The health and wellbeing of older Māori people*. Palmerston North: Ministry of Health and Ministry of Development.

Te Puni Kokiri. (1993a). *Na ia o te oranga hinengaro Māori: Trends in Māori mental health: A discussion document*. Auckland: Te Puni Kokiri.

Te Puni Kokiri. (1993b). *Te ara ahu whakamā: Strategic directions for Māori, a discussion document*. Wellington: Ministry of Māori Development.

Te Puni Kokiri. (1996). *Ngā Ia o te oranga hinengaro Māori- Trends in Māori mental health 1984-1993*. Wellington: Ministry of Māori Development.

Te Puni Kokiri. (1999). *Māori living in urban and rural New Zealand. Fact sheet: 4*. Wellington: Te Puni Kokiri.

Te Runanga o Te Rarawa. (1995). *Cannabis Project Report: Northland, A paper prepared for Te Puni Kokri*: Te Runanga o Te Rarawa.

Thara, R., Sucharitakul, D., & Mendis, N. (2001). *Schizophrenia: Youth's greatest disabler*. Geneva: World Health Organisation.

The British Psychological Society. (2000). *Recent advances in understanding mental illness and psychotic experiences*. Leicester: BPS.

Tizard, J. (1940). *The Māori school of learning: A study in psychology and folk lore.* Unpublished Masters thesis, University of New Zealand.

Trieweiler, S. J., Neighbours, H. W., Thompson, E. E., Munday, C. B., V.J, & Comex, J. P. (2000). Clinical attributions associated with the diagnosis of schizophrenia in African American and non-African American patients. *Journal of Consulting and Clinical Psychology, 68*(1), 171-175.

Turkington, D., & Kingdon, D. (2000). Cognitive - behavioural techniques for general psychiatrists in the management of patients with psychoses. *British Journal of Psychiatry, 177*, 101-106.

Turner, M. (2002). *Evaluation of early intervention for psychosis services in New Zealand: What works?* Auckland: Health Research Council.

Van de Fliert, L. (1994). *Indigenous peoples and international organisations*. Nottingham: Spokesman.

Van Putten, T., & Marder, S. R. (1987). Behavioural toxicity of antipsychotic drugs. *Journal of Clinical Psychiatry, 48*, 13-19.

Vicary, D., & Westerman, T. (2004). That is just they way he is: Some implications of Aboriginal mental health beliefs. *Astralian e-journal for the advancement of mental health, 3*(3), 1-9.

Waitoki, M (2006). Cultural competence workshop. Workshop conducted at the Deprtment of Psychology, Auckland University, Auckland, New Zealand.

Waldo, M. (1999). Schizophrenia in Korsae, Micronesia: Prevalence, gender ratios and clinical symptomology. *Schizophrenia Research, 35*(2), 175-181.

Waldram, J. B. (1997). *The way of the pipe: Aboriginal spirituality and symbolic healing in Canadian prisons*. Ontario: Broadview Press.

Walker, I., & Read, J. (2002). The differential effectiveness of psychosocial and biogenetic causal explanations in reducing negative attitudes toward "mental illness". *Psychiatry, 65*(4), 313-325.

Walker, R. (1975). Marae: A place to stand. In M. King (Ed.), *Te Ao Hurihuri: The world moves on* (pp. 21-34). Wellington: Hicks-smith.

Walker, R. (1990). *Ka Whawhai tonu matou: Struggle without end*. Auckland: Penguin.

Walker, R. (1996). *Ngā pepa a Ranginui: The Walker papers*. Auckland: Penguin.

Walsh, R. (1995). Phenomenological mapping: A method for describing and comparing states of consciousness. *Journal of Transpersonal Psychology, 27*, 25-55.

Walters, K. (2002). Substance use among American Indians and Alaska Natives: Incorporating Culture in an "Indigenest" stress-coping paradigm. *Public Health Reports, 117*(Supplement 1), 104-117.

Walters, K., Johnston-Goodstar, K., & Palmanteer Holder, L. (2005). *Conceptualising historical trauma, microaggressions and colonial trauma response: A decolonisation framework for*

healing indigenous families and communities. Paper presented at the Indigenous Knowledges Conference, Wellington.

Warren, W. G. (1998). *Philosophical dimensions of personal construct psychology*. London: Routledge Press.

Whaley, A. L. (2001). Cultural mistrust and the clinical diagnosis of paranoid schizophrenia in African American patients. *Journal of Psychopathology and Behavioural Assessment, 23*(2), 93-100.

Wheeler, A., Robinson, E., & Robinson, G. (2005). Admissions to acute psychiatric inpatient services in Auckland, New Zealand: A demographic and diagnostic review. *The New Zealand Medical Journal, 118*, 1-9.

Whitt, L. (1995). Indigenous Peoples and the cultural politics of knowledge. In *Issues in Native American Cultural Identity* (pp. 223-272). New York: Peter Lang Publishing.

Wieman, C. (2001). *An overview of the six nations mental health services.* Paper presented at the mental health of indigenous peoples, Montreal, Quebec.

Williams, H. W. (1992). *Dictionary of the Māori language: Seventh Edition*. Wellington, NZ: GP Publications Ltd.

Winter, D. A. (1992). *Personal Construct Psychology in Clinical Practice: Theory, Research and Applications*. London: Routledge.

Wong, D. (2006). *Clinical case management for people with mental illness: A biopsychosocial vulnerability-stress model*. New York: Haworth Press.

Worby, G., & Rigney, D. (2002). Approaching ethical issues: Institutional management of indigenous research. *Australian Universities Review, 45*(1), 24-32.

World Health Organisation. (1973). *Report of the international pilot study of schizophrenia*. Geneva: WHO.

World Health Organisation. (1975). *Schizophrenia: A multinational study. A summary of the initial evaluation phase of the International Pilot Study of Schizophrenia (IPSS)*. Geneva: WHO.

World Health Organisation. (1979). *Schizophrenia: An international follow up study*. London: Wiley.

World Health Organisation. (1996). *Schizophrenia and public health*. Geneva: WHO.

World Health Organisation. (1999). *The mental health of indigenous peoples: An international overview*. Geneva: WHO.

Zhang, H. (2001). Seeking dialogue between two research paradigms: Use of Quantitative measures to supplement a qualitative study. *Post-Script, 2*(1), 97-114.

Zilborg, G., & Henry, G. W. (1941). *A history of medical psychology*. New York: Norton.

WHAT IS THE RESEARCH ABOUT?

We want to ask kaumatua and kuia, rangatahi, tangata whaiora, Maori professionals and members of the wider Maori community about their views on extra-ordinary experiences such as hearing voices. This project acknowledges Maori as the experts of their own experiences.

WHO IS CONDUCTING THE RESEARCH?

Melissa Taitimu (Te Rarawa), is conducting this research for her PhD at the University of Auckland (UOA). Her supervisors are **Dr John Read** (Director of Clinical Psychology, UOA) and **Dr Tracey McIntosh** (*Tuhoe*, Senior Lecturer, Sociology, UOA) The rangahau whanau includes **Pio and Kiri Jacobs** (*Te Rarawa*, kaumatua and kuia of the project) , **Rhys Jones** (*Ngati Kahungunu*, Senior research fellow, , UOA), **Rawiri Wharemate,** (*Nga Puhi*, kaumatua, Kidz First) **Tracey-anne Herewini** (*Ngati Kahu ki Whaingaroa, Ngati Kahungunu, Rangitane.* Mahi takawaenga, EPI centre), **Patte Randal** (Rehabilitation psychiatry), **Jason Turuwhenua** (*Ngati Porou / Tuhoe*, Lecturer, Maori Liason, UOA) and

Naida Glavish (*Ngati Whatua*, Tikanga advisor, ADHB)

HOW DO I TAKE PART OR FIND OUT MORE ABOUT THE RESEARCH?

Call Melissa Taitimu on:
Waea: 09 373 7599 Ext: 84990
Emera: m.taitimu@auckland.ac.nz
to:

- **Find out more about the research**

- **Arrange a time to be interviewed**

- **Attend one of the research information hui being held at various Marae in the Auckland and Northland area early 2005**

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE on 19/05/2004 for a period of three years to 19/05/2006 Reference 2004/122

THE UNIVERSITY OF AUCKLAND
NEW ZEALAND

NGA WHAKAAWHITINGA:
STANDING AT THE CROSSROADS

Maori ways of understanding mental health and well-being

Members of the Maori community are invited to take part in an upcoming research project

KAUPAPA OF THE RESEARCH

The overall kaupapa of this research is to contribute to the hauora (health) of Maori. To do so this project aims to:

- **Conduct research that is done by, with and for Maori in a Maori way.**

- Argue that there is no *right or wrong* way of understanding our experiences rather different people have different views that are related to their cultural background

- To feed findings back into our communities via public hui and health services

- Present the information in a way that can be used by all stakeholders: tangata whaiora**,** members of the wider Maori community, health workers, health services, governmental bodies and researchers

- To assist mental health staff provide appropriate services for Maori

WHAT WILL I HAVE TO DO IF I *CHOOSE* TO TAKE PART?

- **Attend a one hour interview** at a location of your choice. A marae or room at the university can be booked for you.

- The interview will ask Maori why they think people have certain experiences and what they think should be done about them if anything

- You will have the opportunity to know every question in the interview before we begin

WHAT DO I GET OUT OF IT?

- **A bound summary of the research report** (at the conclusion of the project)

- **The opportunity to have your voice heard** and contribute to the health of Maori

- **Kai and a koha for participating**

HOW AM I PROTECTED IF I PARTICIPATE IN THE RESEARCH?

- Members of the rangahau whanau are available to ensure tikanga is followed during all interviews and writing of the report

- You can refuse to answer any of the questions and ask any questions

- **You can invite support persons** to the interviews or request for a kaumatua or kuia to be present

- **You will not be identified** and responses in the report will be anonymous

- You can ask for sections of their interview to be left out of the final report

- You will be given the opportunity to look at the report before it is submitted and provide feedback (*if you wish*)

- You will have the opportunity to take part in sharing the research findings with the community

- You will be offered further support from psychological services or kaumatua/kuia after the interview if required

APPENDIX B: PARTICIPANT INFORMATION SHEET

Participant Information Sheet
Nga Whakaawhitinga: Standing at the crossroads: Maori ways of understanding mental health and wellbeing

Tena koe,
My name is Melissa Taitimu (Te Rarawa). I am a student, conducting research funded by the University of Auckland as part of my PhD in the Department of Psychology regarding Maori mental health.

You are invited to share your matauranga (knowledge) by taking part in this research. The major aim of this project is to recognise and value Maori ways of understanding those experiences that are commonly termed as psychotic/schizophrenic by western psychology. It is anticipated that this research will contribute to a goal of holistic assessment and treatment methods for tangata whaiora. It is expected that 60 individuals will be interviewed for this project. The participant group will consist of 10 Kaumatua/kuia, 10 clinicians (Maori and Pakeha), 20 tangata whaiora and 20 Maori from the general population. Therefore, if you consider yourself a member of the Maori community and you are over 18 years of age, you are eligible to participate.

If you agree to take part in this study, you will be asked to have a korero (interview) with myself regarding your opinion on those experiences commonly labeled as schizophrenic (for example, hearing voices or seeing things others cannot). The interview will take about 45 minutes to an hour to be held at a place, time and date that suits you. If you would like to meet with me, you have the choice of the following locations; a private room at a place of your choice, at the University of Auckland's Waiapapa Marae, at your choice of Marae, or in a private room in the Psychology Department at the University of Auckland. If you choose to participate, my aim is to allow you to speak freely with out fear of judgment. You will be fully informed of the interview content before it begins and do not have to answer any questions you do not wish to.   You may have support person/s present at the interview. I would prefer to audiotape the interview but this would only be done if you allow it and could be turned off at any time. You can withdraw information any time up to two weeks after the interview. At the end of the study, the audiotape will either be erased or returned to you, depending on what you want. A Hui will be held for all participants and support persons after the report has been written to have a korero about what was found and how the findings should be used in the community.

If you do want to take part or have any further queries please let me know by e-mailing me or phoning me on the contacts below. Attendees and the korero at any hui associated with the research will remain anonymous. Should you decide to take part and participate in individual interviews, what you say will remain anonymous. The signed consent form, which you will be asked to fill out at the interview, will be kept separate from the information you provide.

Thank you very much for your help in making this study possible.

Melissa Taitimu	**Dr John Read**	**Dr Tracey Mcintosh (Tuhoe)**
m.taitimu@auckland.ac.nz	Department of Psychology	Department of Sociology
The University of Auckland	The University of Auckland	The University of Auckland
Private Bag 92019, Auckland	Private Bag 92019, Auckland	Private Bag 92019, Auckland
Tel 373-7599 extn. 84990	Tel. 373-7599 extn. 85011	Tel. 373-7599 extn. 82123
The Head of Department is:	**Professor D. McCarthy**	
	Department of Psychology	
	The University of Auckland	
	Private Bag 92019, Auckland.	
	Tel. 3737-7599 extn. 86429	

APPENDIX C: PILOT INTERVIEW SCHEDULE

Introductions/Information:

Initial mihi session/karakia

Whakawhanaungatanga/gathering of general demographic information: age, gender, level of involvement /identification with Maori community

Discussion of information sheets, signing of consent form

Highlight the importance of participants' contribution to research and mental health of Maori overall and thank them for time. Offer participant to assist in interpretation process by revising information collected from interview. Discuss dissemination and how information will be returned to participant (hui, meeting).

Question and answer session re: research procedure and objectives

Discuss list of support persons and organizations if required

Emphasise that there are no right or wrong answers or expectations regarding participant's responses / importance of their view
Highlight that participants do not necessarily have to discuss personal experiences

Provide participant with example of methodology below:

There are many ways in which we group things in our lives to give them meaning. For example when I mention the items, truck, car and donkey, which two would you say are alike and different to the third item? There is no right or wrong answer, as everyone has different ways of doing it. I already have a list here of 10 different ways in which these three thing can be grouped.

Discuss how their construct provides information regarding how they give meaning to the items.

This research is interest on your way of understanding a range of experiences that I have printed here on cards.

Interview/Personal constructs

Present participants with triadic groups of experiences. Allow participant time to read each experience, become familiar with the items and ask any questions.

From your first impression, how would you group these experiences so that two are alike and different from the other one as you did in the example before?

Ask any questions as you go, and please talk about the thoughts you are going through to come to your decision.

If you find that you cannot group the experiences then please tell me this also.

Once all cards have been sorted for a particular construct:
Why did you place these two together?
What is it about xy that makes them different to z?

Can you give me some other examples of experiences that are ....?

So am I right when I say this experience has not been included because it is not.... Can you give me any other examples of those experiences that are.....?

What questions would you be asking around these experiences to get a better understanding of what was going on? (Diagnostic processes).

What would you recommend for someone to do if they have this sort of experience?

- **Questionnaire:**

Ask participants to rank from 1-does not apply to 10 definitely applies regarding relevance of each construct to all of the items in the questionaire

- **Open ended questions:**

Why do you think maori are more likely to be diagnosed as schizophrenic and are readmitted at higher rates than non-Maori?

What do you think should be done about it?

Wbat is your understanding of Maori and pakeha treatments for these experiences?

What research would you like to be done in the future in this area.

End with karakia and kapu ti.

APPENDIX D: PILOT QUESTIONNAIRE

Extra-ordinary experiences: Questionnaire

Please rate each of the experiences in column one on a scale from 1 to 10 for each of the dimensions provided below. For example, 1= negative and 10=positive, any number between 1 and 10 can be used to indicate how strongly that experience is rated for that dimension.

Experience	Negative-Positive 1-10	Possible-Not Possible 1-10	Abnormal-Normal 1-10	Spiritual-Physical 1-10	Familiar-Bizarre 1-10
A person hears voices almost all of the time commenting on what they say or do					
A person hears voices telling them to kill themselves					
A person hears voices and tells you they are the voices of spirits (kehua)					
A person can hear voices arguing with each other that others cannot hear					
A person can smell dead bodies everywhere, although others cannot					
A person can feel another person touching them although there is no-one there					
A person can see someone standing in the room when there is nobody there					

Experience	Negative-Positive 1-10	Possible-Not Possible 1-10	Abnormal-Normal 1-10	Spiritual-Physical 1-10	Familiar-Bizarre 1-10
A person doesn't want to leave their house because they think that everyone is watching them, talking about them and following them					
A person believes that someone or something is putting thoughts into their head and/or making them do things they don't want to do					
A person believes they are ill, about to get ill or die as a result of being cursed (makutu)					
A person thinks a message that is only for them is being sent to them through the television					
A person believes they are possessed by a spirit (kehua)					
A person believes they are the devil or a demon					
A person is speaking with their words all mixed up and doesn't make sense to you					
A person sits frozen in their chair, won't move and appears completely unaware of what is going on around them					
A person can feel ants crawling all over their body even though others can't see any					
A person begins to move in an					

uncontrollable fit like manner					
A person believes they have a guardian spirit or kaitiaki protecting them		333			
A person goes into a trance and loses a sense of time and place					
A person feels a non-physical connection to all things					
A person can sense a presence in and/or around them					
A person begins to have dreams they think are predictive of future events					

APPENDIX E: FINAL INTERVIEW SCHEDULE

Introductions/Information:

Initial mihi session/karakia

Whakawhanaungatanga/gathering of general demographic information: age, gender, level of involvement /identification with Maori community

- **Discussion of information sheets, signing of consent form**

Highlight the importance of participants' contribution to research and mental health of Maori overall and thank them for time. Offer participant to assist in interpretation process by revising information collected from interview. Discuss dissemination and how information will be returned to participant (hui, meeting).

- **Question and answer session re: research procedure and objectives**
- **Discuss list of support persons and organizations if required**

Emphasise that there are no right or wrong answers or expectations regarding participant's responses / importance of their view being the right answer...their view as an individual or whanau member rather than limited by contstraints of work or known limitations in services

Highlight that participants do not necessarily have to discuss personal experiences
We are looking for the personal meaning they give to the experience.

- **Outline of interview:**

Provide participants with EOE one at a time:

A person hears voices talking to each other

A person hears a voice that others cannot hear that putting them down and/or telling them to hurt themselves (persecutory voices)

A person hears voices and tells you they are spirits or ghosts (spiritual voices)

A person can see someone or something in the room when nobody is there

A person believes they are ill, about to get ill or die as a result of being cursed.

A person believes they are possessed.

A person is speaking with their words all mixed up and doesn't make sense.

- **Ask following questions for each experience**

What does this experience means to you /how you make sense of it?

What do you think might cause a person to experience this?

What questions would you ask someone who was experiencing this to gain a better understanding of what is happening to them?

You said the experience means....can you give me examples of other experiences you think are similar? And different?

What advice would you give them if they wanted to know what to do?
Who should they get help from?

Have you or anyone you know ever experiences this? *Emphasise their choice to decline answering this question.*

- Open questions

You will be asked your opinion on the current issues facing Maori in mental health today.

I have some general questions for you then you have the opportunity to ask me some that you may not have asked yet.

What does the word schizophrenia mean to you?

In *your experience, how do you think Maori treat experiences that could be labelled as schizophrenic.*

- what is your opinion of this treatment in terms of availability, effectiveness?

- how do you think pakeha treat these experiences?

- what is your opinion on pakeha treatments?

 Prompt: medication? Therapy? Assessment?

For those with contact with mental health services: Can you give me examples of when you have used Pakeha or Maori pathways?

Why do you think Maori are diagnosed with schizophrenia at higher rates and readmitted at higher rates to hospitals once they receive the diagnosis?

What do you think could be done to address this issue? (increased rates)

What qestion's would you want answered in research regarding Maori and the diagnosis of schizophrenia?

This is optional: Can you tell me of an extra-ordinary experience of yours or someone that you know.

- **Demographic information**

How old are you?

What is your iwi?

What do you want me to record as your occupation?

How long have you been working/been in contact with mental health services?

Are there any comments you would like to make before we finish?

Thank you for participating, your contribution has been invaluable.

Karakia to finish

Kai and kapu ti

APPENDIX F: CONSENT FORMS

HUMAN SCIENCES BUILDING

Level 6, 10 Symonds Street
Auckland, New Zealand
Telephone 64 9 373 7599
Facsimile 64 9 373 7450
The University of Auckland
Private Bag 92019

CONSENT FORM

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS

Title: Nga Whakaawhitinga: Standing at the crossroads. Maori ways of understanding mental health and wellbeing

Researcher: Melissa Taitimu

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

I understand that I may withdraw myself or any information traceable to me at any time up to two weeks following the interview without giving a reason.

- I agree to take part in this research.

- I agree/do not agree that the interview will be audio/video taped

Signed:

Name:
(please print clearly)

Date:

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN SUBJECTS ETHICS COMMITTEE

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE on 19/05/2004 for a period of three years to 19/05/2006 Reference 2004/122