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A Case Study for Helping to Prevent Postnatal
Depression:
Towards a Cultural Tool for Maori Women

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ABSTRACT

Postnatal depression is a depressive illness that affects 10-20% of all women. However, in societies with strong kin-based support structures and where customs and rituals are integral to everyday life, there is a very low incidence of postnatal depression. Indeed, there is little mention of depression in pregnancy and motherhood within traditional Maori society. Today, through the impact of colonisation, Maori women live in a very different world to that of their ancestors. The dissolution of the whanau structure, the loss of Te Reo and customs, the increase of solo-parent families and families living in poverty, the effects of drug and alcohol abuse and the increase in family violence mean that Maori women are more likely to suffer from depressive and anxiety based illness than non-Maori. Despite this statistic, there has been very little research conducted around Maori women and maternal mental health.

This research attempts to identify the key issues that affect Maori women during pregnancy and motherhood and which impact on their maternal mental health. It also provides a critical analysis of the efficacy of current maternal mental health services, treatment and tools in meeting the needs of Maori women. Finally, these insights provide the basis for recommendations to improve maternal mental health services for Maori women and principles to guide the development of a tool to help prevent postnatal depression in Maori women. Ultimately this research is about realigning our thinking about working with Maori women and maternal health. The focus is on providing services, tools and an environment that is collaborative and draws on a range of resources to help Maori mothers succeed in all areas of their life, validating the use of cultural rituals, customs and practices within service provision. There is also a need to conduct research that recognises the diverse circumstances and needs of Maori women and that draws on Kaupapa Maori epistemology and paradigms to inform the research. Finally, and perhaps most importantly, this research clearly illustrates the importance of strong whanau structures and systems and the need to provide a society that allows Maori women to benefit from the support of friends and family, regardless of how that 'whanau' is defined.

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To the participants in this project, thank you for your time and for sharing your experiences. This work is a tribute to you all. It is my hope that your experiences will resonate within the wider community, both Maori and non-Maori, and move our society to improve maternal health services for Maori mothers.

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GLOSSARY

This glossary contains those Maori words used throughout the thesis that are not defined in the text.

Aroha	-	love	Tapu	-	sacred
Hapu	-	subtribe, pregnant	Tamariki	-	children
Hoha	-	nuisance	Teko	-	excrement
Iwi	-	tribe	Tikanga	-	customs
Kai	-	food	Tohunga	-	expert
Kaimoana	-	seafood	Wahine	-	woman
Karakia	-	prayer	Waiata	-	songs
Karanga	-	call	Wananga	-	learning
Kaumatua	-	elders	Whanau	-	family
Kohanga	-	learning nest	Whakapapa	-	genealogy
Kuia	-	elderly woman			
Mahi	-	work			
Marae	-	meeting area			
Mirimiri	-	massage			
Mokopuna	-	grandchildren			
Noa	-	profane			
Poho	-	chest			

CHAPTER ONE - INTRODUCTION

This thesis offers an insight into the experiences of Maori women during and after pregnancy, in particular the issues they face and the factors that could improve their experience. These factors will be identified as key ingredients towards the development of an appropriate and effective tool for helping to prevent postnatal depression in Maori women and furthermore create positive maternal health and well-being.

Research Aims

The specific aims of this research are:

1. To gain an understanding of the issues that impact on the maternal health and well-being of Maori women during and after pregnancy.
2. To gather information which could be used to form a cultural tool such as a maternal health programme to help prevent postnatal depression in Maori women.

Much of the past and current literature on postnatal depression is taken from a Western mainstream paradigm. Postnatal depression is defined as a mood disorder within the DSM4 diagnostic manual, which describes the causes and symptoms (American Psychiatric Association: 2000). However, this information is based on the experiences of non-Maori women and therefore it is difficult to assess the relevancy and applicability of this information and the relating diagnostic tools and treatment to Maori women, without understanding and analyzing the position of Maori mothers today.

As a Maori mother that suffered from postnatal depression, which originally went undiagnosed, I became aware that perhaps the current tools used to both diagnose and treat postnatal depression were lacking credibility in the Maori world and that even more importantly, postnatal depression was both under diagnosed and not acknowledged by Maori women themselves and by health professionals working with Maori women.

When examining the cross-cultural literature on postnatal depression there are some important factors to observe. Cultural experiences of postnatal experience suggest that:

- 1) Mothers from non-European ethnic communities often present differently than European mothers. They show different symptoms, have different experiences of motherhood and have different expectations.
- 2) Customs, rituals and strong support networks for these mothers from ethnic communities is important (Kruckman & Smith: 2001).

Further research implies that these cultural rituals, customs and support networks are said to act as integral buffers to the prevention of postnatal depression (Kruckman & Smith: 2001, Mayberry et al: 1999). This supports cross-cultural literature that suggests that those societies with strong kin-based support networks have a very low incidence of postnatal depression (Kruckman & Smith: 2001, Mayberry et al: 1999). Possibly this information might account for the lack of any mention of postnatal depression or mental illness within traditional Maori society. The lack of rituals and customs used today in pregnancy, birth and motherhood could also be contributing to a negative experience of motherhood for Maori women. The impact of colonisation, urbanisation and employment has certainly changed the whole dynamics of Maori kinship systems. No longer are grandparents able to stay home and care for moko, even the instances of whangai are becoming less and less common. The wider extended whanau and hapu often no longer reside in the same environment. The results of these changes mean that today there are many Maori mothers living in virtual isolation from such valuable support networks. Socio-economic factors have also had heavy and devastating effects on generations and generations of Maori. Recent research on Maori women and postnatal depression suggests that it is these factors that now mean Maori women are increasingly likely to be suffering from postnatal depression (Bridgman & Lealailoto: 1997, Sarfarti: 2001).

Despite the inference that Maori women now have a high chance of developing postnatal depression, I felt relatively isolated in my experience. If I as a young Maori mother with a good education, a strong support system and a committed partner could suffer from postnatal depression and still feel isolated, what did this mean for other Maori women without these supports? As a young Maori mother I felt uncomfortable

talking with doctors and midwives about my condition; shied away from attending postnatal support groups (because they were made up of largely non-Maori middle-class mothers); had trouble discussing my situation with friends and whanau and had little faith in conventional treatments like medication and counselling. How was my experience similar or different to that of other Maori mothers?

Whilst I understood that Maori women faced diverse realities and had different experiences as mothers, I was sure that the aspects we did have in common - motherhood and culture needed to be explored so that the journey could begin in working towards models, tools and service delivery that acknowledged and appropriately identified postnatal depression in Maori women. With these models, tools and service delivery working to prevent postnatal depression in Maori women and ultimately improving the experiences of Maori, by giving them the tools to shape their lives and those of their children in a positive and empowering way.

Thesis Structure and Outline

The scale of the research project, namely it being a Master's thesis, determined the approach I took. I decided to conduct a qualitative case-study involving, Maori mothers, kuia and health professionals. I chose to conduct a programme of formal interviews. Instead of focusing on only Maori mothers, I also interviewed health professionals that worked with a number of Maori mothers, and a kuia to give insight into a cultural viewpoint of motherhood. The case-study presented is therefore based primarily on an in-depth discussion of literary sources on traditional Maori society; contemporary experiences of Maori mothers; cross-cultural experiences of postnatal depression; postnatal depression and in-depth qualitative interviews with the participants. However, it must also be noted that because of my position as a Maori mother and my experience of suffering from postnatal depression whilst simultaneously researching and writing this thesis, the analysis is explicitly entrenched in the writer's experiences and perspectives.

The thesis is made up of six chapters. Following the introduction, Chapter 2 looks at the literature on traditional Maori society, contemporary experiences of Maori mothers, and cross-cultural experiences of postnatal depression and postnatal

depression. This discussion is divided into sections, which looked at traditional Maori beliefs and customs around pregnancy, birth and motherhood.

Chapter 3 examines the methodology and research methods that have been employed in this research. A particular emphasis is placed on the role of Kaupapa Maori and Maori centred methodologies within, in all of the research process. The methodology is described as both Kaupapa Maori and Maori-centred throughout the discussion. I initially anticipated locating the research within a Kaupapa Maori paradigm, however while many aspects of the research process clearly fell within a Kaupapa Maori framework, there were other aspects that did not necessarily apply, such as having non-Maori participants and that the majority of the project was carried out using English language both in the methods and the writing up. However, I still felt strongly that the underlying goals, perspectives and intended outcomes of the research were entrenched within a Kaupapa Maori paradigm, with the focus being on improving the lives of Maori.

The interview findings are reported in two chapters. Chapter 4 examines the perspectives of Maori mothers and the kuia in relation to six key themes. Chapter 5 examines the perspectives of maternal health workers using the same themes. The vital points to emerge from this discussion are the issues that impact on Maori women during and after pregnancy and the factors that improve their experience of motherhood.

Chapter 6 attempts to draw together the main strands of the thesis by considering the implications of these factors and issues to the development of a tool to help prevent postnatal depression in Maori women. In particular, it draws on Maori health models to provide a structure by which these factors and issues can be addressed. The final chapter provides the conclusion to the research, makes recommendations and identifies areas for future research.

Definitions and Terminology

These following terms will be used throughout the entire research and therefore require defining and clarification in relation to the context they will be used within.

Kaupapa Maori - in this research Kaupapa Maori is about, by Maori, for Maori, a framework that is determined by Maori culture, values, tikanga and unique life experiences.

Postnatal – occurring immediately after birth.

Antenatal – occurring or existing before birth; the prenatal period.

Maternal mental health – the mental health of women during the antenatal and post-natal periods

Maternal Health Workers – refers to all health professionals that may work with mothers this includes – doctors, nurses, Plunket, midwives, mental health workers.

When I originally set out on this journey I had grand ideas of ending up with a valid and reliable tool that was ready to apply in any maternal health setting for Maori women. It is hard to realise that no matter how honorable and dedicated your intentions are there is only so much you can achieve within the parameters of a research study. And so, instead, I hope this research has a more humble outcome in that it at least illustrates, that in order to improve the lives of our Maori mothers, children and whanau, we must conduct research that identifies, discusses and debates the experiences and realities of Maori mothers in a way that forces our society to provide opportunities, services and pathways for Maori mothers that reflect their dreams, goals and aspirations.

This introduction has outlined the background and premises for this research study, identified the aims of the research, the rationale for the research and the structure that the thesis will follow. The next chapter will provide an in-depth analysis of current literature relating to Maori women and maternal mental health.

CHAPTER TWO - LITERATURE REVIEW

The aim of this literature review is to consider the key issues within the literature that are relevant to Maori women and maternal mental health. It is hoped that this information will provide insight into the experiences of Maori during the antenatal and postnatal periods, from a Kaupapa Maori perspective. It is also envisaged that the literature will identify important components necessary to create an effective maternal mental health programme for Maori women. In terms of its content this literature review discusses: 1) the traditional Maori views of life; and of pregnancy, birth and motherhood and the experiences and practices of maternal health; 2) the effectiveness of modern maternal mental health services for Maori women, and 3) the causes and treatments for post-natal depression and cross-cultural experiences of postnatal depression. The emphasis on cross-cultural experiences of postnatal depression is essential due to the lack of research on Maori women's experiences of postnatal depression. The small amount of literature pertaining to Maori women and maternal mental health is located within the wider Maori women's health literature. An analysis of Maori women's health is not complete, and will make little sense, without taking into account the historical, social, cultural and political context within which it exists. Maori maternal health will also be examined from a holistic perspective incorporating physical, emotional, spiritual and psychological factors.

Maori Worldview

Before examining the literature pertaining to traditional Maori views and practices around maternal health, it is important to give an understanding of the way that Maori viewed the world. This worldview was intrinsic to the lives of Maori in traditional society, but is also a philosophy that guides many Maori who are immersed in Maori culture and ways of living in today's society. A Maori worldview is integral to Kaupapa Maori research and Maori perspectives and models of health.

A Maori worldview stems from ancient knowledge, which originated from the highest heavens, Te toi o nga rangi. Within Te toi o nga rangi resided Io – the Supreme Being. From Io, the knowledge was created and Whatukura and Mareikura became

guardians of that knowledge, which was placed in three kete (baskets), Nga Kete Wananga and two sacred stones, Hikutai and Rehutai (Whatahoro: 1913). From the heavens, the knowledge was then instilled in the sky, the land, the sea and all the realms of the environment, by the tipuna (ancestor) Tane nui a rangi. This is the foundation of Maori belief that everything within the universe is linked and woven together by the strands of Nga Kete. Once Tane nui a rangi had instilled the views and values of Io into the environment, the creation of Man took place. The first being was fashioned from the earth and gifts from every realm in the environment brought life to the first solitary being – Hineahuone, the first Ira Tangata (life essence) (Whatahoro: 1913). This illustrates the Maori worldview in a physical and metaphysical sense. Ever since the conception of Hineahuone, the descendants, the Maori people (Ira Tangata) have strived to find the balance between the physical and the spiritual worlds, as demonstrated by Tane nui a rangi.

Throughout the ages, Maori have attempted to live life based on rites, rituals, traditions, which were brought down from the heavens by Tane nui a rangi at the beginning of time. These traditions guided Maori in the shaping and moulding of their customs according to their environment. These customs were tools aimed at placing te ira tangata at the centre of the search for equilibrium within the universe, between their senses and the environment. These senses within te ira tangata are the dimensions of tinana (physical), whatumanawa (emotions), hinengaro (thoughts/cognition) and wairua (spiritual) (Tangaere, A.: 1997). Hence, the belief today by many Maori that for total health and well-being, each of these dimensions must be strong and in balance with one another.

Traditional knowledge

There is very little literature on views and experiences of maternal health in traditional Maori society, before colonisation. Prior to the advent of written forms, knowledge and practices relating to maternal health were passed on through oral traditions such as waiata and whakapapa. After the nineteenth century, much of the literature was then written from a white middle-class anthropological perspective. One exception is Makareti: 1938. In this account Makareti speaks of many of the traditions surrounding pregnancy, childbirth and child rearing. This is a very significant piece of literature as

it speaks of practices (some that are no longer used) that aided in the preparation of mothers spiritually, emotionally and physically, so that the process of birth and childrearing was enjoyable, spiritual and an integral part of the whole community. Best (1924) speaks of a number of rituals and customs that were performed in order to enhance conception in Maori women. These rites often took the form of prayers, incantations and rituals asking the gods to bless women with conception, and to help prevent conception for those getting too old for childbearing (p.2). Childless women would often carry around inanimate objects such as a carved wooden figurine as a dummy child. Makareti (1938) notes that Maori were anxious to have children and when women especially those of rank, became pregnant, they were showered with gifts and food. According to Best (1924), the most elaborate birth ceremonies were connected to the first-born male child of a high-ranking family. The food especially was seen as a way to ensure the health and strength of the unborn child. Certain foods such as kereru (pigeon) and inanga (whitebait) were given to ensure the abundant supply of breast milk. Food cravings were believed by Maori to be a result of the child craving the food and thus such food was known as whakawaiu – a producer of milk (Best, p.3). Whakawhanau (birth) was never a matter to worry or be anxious over and Maori women did not seem to suffer the same painful experience as many Pakeha women did (Best: 1924, Makareti: 1938). Makareti implies that this was related to the natural life of Maori women, who conducted their daily duties during pregnancy until a few days before confinement. Confinement involved the pregnant women living in a small temporary whare isolated from the kainga (home) (Buck: 1950, Phillips: 1966). An attendant would take care of her every need as she was considered tapu at this stage and up until seven to eight days after birth but it was noted by Best (1924) that these attendants did not prepare food as they were also considered tapu.

During labour, mother, grandmothers, other relatives and her attendant would support the woman emotionally and physically, so she never felt the urge to yell. At the birth of the child, it was shaken upside down to loosen any mucus, which was then sucked out by a relative, allowing the baby to make its first tangi in the new world. The placenta was taken to a special place for burial and any difficulties with placenta removal would result in the woman lying in a shallow stream and the attendant would stand on her poho until it came away.

The mother's breasts were especially cared for from the third month of pregnancy with mirimiri. Makareti (1938) believed that this was the reason Maori mothers never had problems with milk flow but this changed after colonisation. On the rare occasion when there were problems with breastfeeding or if the mother passed away, the child was fed by another whanau member, by breast. Best (1924) also told of such babies being fed the flesh of baby birds. Children were fed until one or two years and weaned by rubbing kawakawa leaves on the nipple, which had a bitter taste.

The tohi was a special karakia that occurred seven to eight days after birth, where boys were made tapu and girls were made noa. The naming of the child also occurred at this point. Makareti (1938) states that traditionally the mother cared for the baby from birth, but had lots of help and support from the whanau. Pere (cited in Mikaere: 1995) notes that the natural parents were never the sole care-givers but were part of the parenting system made up of older members of the community especially the grandparents. Mikaere (1995) also states that whanau involvement in childrearing was a standard practice. Care and education of children was seen as a collective responsibility and a privilege. There are many accounts in the literature of the role of whanau and hapu as careers and nurturers for the mokopuna. This is contradicted however by Best's (1924, p.23) account that 'natives did not like to see an infant handled much or frequently by other than its parents'. A possible explanation for this perspective is that Best, as a European anthropologist, was interpreting Maori customs from a Western paradigm. The baby was massaged gently from birth for good shape and carried on the back of the mother while she worked (Makareti: 1938, Metge: 1995, Phillips: 1966).

According to Makareti (1938), mothers could not bear to hear their babies crying in the night and would sing oriori (lullabies) to soothe them. The first teaching was given to the baby when it began to crawl or walk. The first food was given at around nine months. Infant mortality was not regarded as high but the mother saw cases of premature births and stillborns as an infringement of tapu and some women would purposefully break tapu in order to abort the foetus. (Best: 1924) Makareti (1938) firmly believed that Maori never beat their children, and between 3 and 9 years the children had lots of freedom.

Impact of colonisation on Maori women and maternal health

Colonisation had a huge impact on the overall health and well being of Maori, and maternal health and well-being, along with infant health and well-being, suffered. The introduction of new diseases, deaths from firearms and lifestyle changes all affected nutrition, housing and sanitation. Furthermore, there was a rapidly declining economic base through the dispossession of land, forest and fishing rights and the destruction of traditional tribal structures leading to the break down of the Maori way of life and what Europeans believed would be the extinction of the Maori race (Durie: 1998a).

During the 1900s, Maori women had little access to maternal health services such as Plunket; instead they were seen by public health nurses (Ellison-Loschman: 1997). Ellison-Loschmann's (1997) study of Maori women's experiences of breastfeeding also showed a belief held by Maori women that legislation prohibited Maori women from breastfeeding in public. This belief is still prevalent today and whilst this might have been how Maori women were made to feel, no such law existed. However, this led to change in that there was a huge increase in the number of Maori women giving birth in a public hospital. In 1907 the Tohunga Suppression Act was passed which prohibited traditional health practices. Donley (cited in Ellison-Loschmann: 1997) highlights the overt racism that existed within the hospitals that led to Maori women being instructed on 'proper' hygiene as reflected in 'civilised' society. At the same time Tonkin's work on Maori infant health seemed to imply that vigilant supervision was needed of Maori families (given their tendency to shift houses frequently and not fill prescriptions) if the morbidity rate of Maori infants was to be reduced (Tonkin cited in Ellison-Loschmann: 1997).

Tonkin (p.236) also noted that *'Maoris have elected to follow one of the worst trends of European infant feeding' which was bottle-feeding.'*

So not only were Maori women forced into accepting the European ways of maternal care and childrearing, they were also blamed for their 'choice' to accept such practices.

Whangai

Despite the loss of many traditional aspects of maternal health care for Maori, and the lack of culturally appropriate mainstream maternity services, Maori society continued to apply customs and practices from a cultural perspective to support their whanau and tamariki. One of the most popular practices more apparent from the 1900s (Ihimaera: 1998) was 'Whangai' literally translated to mean 'to feed'. In Maoridom whangai was similar to 'adoption'. It was not a formal agreement bound by law, but rather an informal agreement between whanau members. It seemed to be implicitly understood in many Maori whanau that the older generation had a right to raise their mokopuna; in some cases Maori women produced many children in the understanding that she would not be expected to raise all of them (Binney & Chaplin: 1986) *'The grandparents were sometimes responsible for the upbringing of grandchildren whom they claimed during babyhood' (Phillips: 1966, p.170)*

Often the first-born child would be sent to live with grandparents. If a woman became a widow, whanau members might take some of the children to help out, or if a teenage girl became pregnant whanau might step in to help raise the child. For Amiria Stirling that meant being raised by her elderly Aunt because her aunt was lonely (Binney & Chaplin: 1986). In most cases these children still had very close contact with their birth parents. Both the natural parents and the 'adoptive' parents are valued and admired for their generosity and love (Metge: 1995). From a contemporary perspective this practice could actually be seen as a positive intervention to help families in the raising of their children. Even if children were not a whangai they often spent many weeks or months living with other family members. Whilst parents may not identify it, this was a method to help ease the stress and demands on families. *'Far from seeing it as a strategy for handling failure on the part of birth or adoptive parents, they emphasize the element of aroha in the behaviour of both' (Metge: 1995, p.212)*

Today, such a practice still exists but not as strongly as grandparents often have to work fulltime and the breakdown of extended families has occurred.

Maternal Health Services

From the 1980s, several studies took place that outlined the need for maternity services to improve their ability to cater effectively for Maori women. These studies clearly identified the need for maternity services to develop and provide culturally appropriate care for Maori women (Ramsden: 1990, Ratima et al: 1994).

However, there is a real lack of substantial research regarding maternal mental health and this gap identifies the need for research specifically focussed on Maori women and maternal mental health. Only recently have services been set up to specifically deal with this area. Most research has instead focussed on maternal health services; and mental health issues such as postnatal depression, postnatal psychosis, and drug and alcohol addiction have been included or excluded as part of this subject area. Ratima et al. (1994) carried out a study to identify the key factors necessary to contribute to an appropriate maternity service for Maori women. Maternity service was defined as a generic term given to include antenatal, labour, delivery and postnatal services.

This study noted that normal delivery and related complications are the leading cause of hospitalisation for New Zealand women. In 1992, the rate of hospitalisation of Maori women for conditions related to the birth process were more than three times that of non-Maori. Other issues that were of concern in this study were that parenting was considered more difficult for Maori mothers with few financial resources, lack of support, lower than average living standards and less education than average. All of these factors are also identified by research as contributing to the development of postnatal depression (Kruckman & Smith: 2001, Sarfarti: 2001)

Barriers to effective maternal services for Maori women

Ratima et al. (1994) indicated that there are four clear barriers to effective maternal services for Maori women. The first was that Maori women don't always have access

to information regarding antenatal care, and much of that information is provided by doctors, whom many of the women felt did not contribute towards their need in regards to antenatal knowledge and care. Whilst 50% favoured their doctor as the provider of antenatal care, many others favoured Maori community services such as Maori Women's Welfare League and community health workers, especially since 80% of participants identified strongly as Maori. This indicates that the dissemination of information needs to cater to the diverse circumstances of Maori women and needs to include Maori perspectives and recognition of Maori networks and providers. Powhare (1998) conducted research that emphasized the lack of appropriate education for Maori women on contraception and positive healthy sexual relationships and the need for more input in preventative health measures. From a Kaupapa Maori perspective this barrier indicates that Maori women must be presented with information that reflects their experiences, realities and worldviews. .

The second barrier was the lack of choice Maori women had in choosing the processes and services for maternal health care. Integral to this process was the ability of Maori women to have a choice; an appropriate maternal health service would ideally enable all Maori women to have options for their maternal health care so they may make an informed choice. A Kaupapa Maori approach to service delivery would ensure that Maori women have control over the choices they make in regards to their maternal health care. Choice is seen as being integral to meeting the needs of Maori consumers, allowing them to have control over their lives and adhering to the Treaty of Waitangi (Dyall et al: 1999, Herbet: 1998, Simpson & Tapsell: 1999).

The third barrier relates to the need for the provision of Kaupapa Maori services, services that reflect Maori goals, aspirations and models of health. It also emphasized the need for mainstream services to be continually working at providing culturally safe services. Thomas (1993) believes the crucial components for the development of effective bicultural services are more Maori trained in mental health; services implementing changes that ensure the service is bicultural; and training that incorporates competencies to work with both Maori and non-Maori clients. These changes are about ensuring that mental health services are meeting the needs of Maori.

The final barrier for effective participation in maternal health care by Maori women was the lack of Maori provider options. Fifty percent of the women chose Maori women providers; 40% would have preferred Maori that were trained health professionals and a third expected support from Maori community groups, such as kaumatua, other mothers and marae communities (Ratima et al: 1994, p.21) This need for Maori providers was reinforced because of the inability of mainstream services to provide appropriate cultural advice and support. The lack of Kaupapa Maori options for maternal health care indicates the current lack of cultural responsiveness by maternal health services.

Maternal and Infant Health Statistics

Recent social statistics of maternal and infant health are important as they indicate the vital impact on maternal mental health. Statistics show that there is an over-representation of Maori infants as low birth weight and premature babies, and consequently disproportionate morbidity and mortality. SIDS (sudden infant death syndrome) is the leading cause of death for Maori infants; and in Maori, death rates is six times that of non-Maori (McCreanor et al: 2004, p.2). Rimene et al's (1998) research also highlights some important statistical information that Maori women have their first child earlier than non-Maori, and this is supported by Underhill-Sem's (1989) research that states that Maori women have their highest fertility five years earlier than non-Maori. Maori women also take longer to complete families and are often unmarried. Sarfarti (2001, p.257) showed that 27% of New Zealand families are solo-parent households with women often living in poverty, having poor access to childcare, higher rates of mortality and poorer general health and mental health. Solo-parent families were more than twice as likely to be Maori. Factors such as solo parent households; infant mortality, teenage parenting and poverty can all contribute to poorer mental health and in particular postnatal depression (Webster et al: 1994: p.43). A very relevant study conducted by Goodwin (1996) looked at support for young mothers during pregnancy, birth and motherhood. In this study the experience of motherhood was largely seen as a difficult time. The pregnancies were often characterised by much conflict and stress. This stress was caused by factors such as poverty, lack of education and knowledge of pregnancy and parenting, crowded living

situations and limited access to resources. The factor that caused most stress and was the most inhibiting for Maori women was the lack of partner support '*Unstable relationships with partners may have caused much stress and depression*' (Goodwin: 1996, p.142). Of all support mechanisms partner support was valued as very significant by the women. This information is thus very relevant to the type of maternal health service that needs to be offered for Maori women because they indicate the needs of Maori women and circumstances in which they live. Many of these factors have also been shown as predictors for the development of postnatal depression. It is these factors that must be considered and analysed when forming policy to guide maternal health service implementation and delivery.

It is also important to analyse these statistics from a Kaupapa Maori perspective. For instance whilst in mainstream Western worldviews teenage pregnancy and solo-parenting may be viewed as a negative factor, which can impact on maternal mental health, this may not be the case for many Maori women and their whanau. These factors may not be so inhibiting to the mental health of Maori mother if they have access to strong social and whanau support. In the past the process of 'whangai' would have been an example of such a support mechanism.

Maori mental health outcome

Both Durie and Kingi (Durie: 2002; Kingi: 2002) have outlined the need for the development of positive mental health outcomes that are relevant to Maori, their experiences, histories and contemporary lifestyles, and that incorporate Maori perspectives of health and well-being. The framework developed by Kingi (2002) allows for consumers, clinicians and whanau to measure the effect of an intervention on the domains of wairua, hinengaro, tinana and whanau, conducted within a holistic framework. This framework can be seen as an example of a Kaupapa Maori approach to meeting the health needs of Maori. The need for Maori outcome measurements was also identified in research conducted by Dyll et al. (2001). Dyll et al's (2001) research identified the expectations by Maori of mental health services and the desired outcomes. To achieve positive mental health outcomes Maori women specified the need for knowledge of different services; whanau involvement, access to Maori kaimahi (workers), an accessible national Maori consumer network, Maori

activities for occupational therapy; education for the police; economic and educational support for whanau; support from health and social services for the protection of their children.

Maori mental health tool

Kingi's (2002) research looked at finding a tool that assesses the effectiveness of mental health interventions in a way that has meaning for Maori. An intervention is deemed effective if it meets the criteria for wellness as defined by Maori health perspectives, concepts and experiences.

If Maori mental health services are to achieve their potential and to operate in ways that best meet the needs of tangata whaiora, then they must be measured against and designed around Maori concepts of health outcome (Kingi: 2002, p.394).

Kingi's (2002) framework for this tool is based on five principles. *The principle of wellness* is concerned with subjective well-being and social functioning. *The principle of cultural integrity* indicates that a cultural measure of outcome must have an appropriate cultural foundation, derived from a relevant philosophical base, which emphasizes the role of culture within a mental health setting. *The principle of specificity* is about specific measures being put in place according to the intervention and that no measure will be suitable for every situation. *The principle of relevancy* is to ensure that Maori clients are dealt with in terms of their own cultural knowledge, as not all Maori will have the same degree of cultural experience or understanding/interpretation of cultural issues. Also measures of outcome should be relevant to consumers, service providers, funders and policy makers. *The principle of applicability* is relatively easy to administer and it is applicable to those who use it in the context within which mental health services operate and to Maori cultural preferences. The three stakeholders involved in determining appropriate outcomes were consumers, clinicians and whānau. The inclusion of whānau was based on the assumption that whānau would be more aware (than clinicians) of the environmental factors that impact on consumers and make allowances for these; they would also be able to straddle social and cultural concerns.

Finally, the outcomes were based on a Maori model of health Te Whare Tapa Wha (Durie: 1998c) that has a holistic perspective of health within a Maori context. This model likens a house to a person’s overall health and well-being. Each wall of the house plays an essential and complimentary role for the total health and well being of a person. The four walls or components being Taha Wairua - spiritual, Taha Hinengaro - Mental, Taha Tinana - Physical and Taha Whanau – Extended family. The spiritual domain looks at the capacity for faith and wider communication, health is related to the unseen and unspoken energies. The mental domain is about the capacity to communicate, to think and to feel- the mind and body are seen as inseparable. The physical domain is about the capacity for physical growth and development with good physical health necessary for optimal development and finally whanau is about the capacity to care and share whereby individuals are seen as part of wider social systems. Using these domains and research conducted with both consumers and clinicians the following outcomes were identified as crucial for positive mental health and well being for Maori. (Table 1.1):

Table 1.1 Domains and Dimensions of Te Whare Tapa Wha

<i>DOMAINS</i>				
	Wairua	Hinengaro	Tinana	Whanau
Dimension 1	Dignity, Respect	Motivation	Mobility/pain	Communication
Dimension 2	Cultural identity	Cognition/behaviour	Opportunity for enhanced health	Relationships
Dimension 3	Personal contentment	Management of emotions, thinking	Mind and body links	Mutuality
Dimension 4	Spirituality	Understanding	Physical health status	Social participation

(Kingi: 2003, p.71)

These dimensions provide appropriate outcomes to consider, utilize and adapt when looking at developing a tool to preventing and treating mental illness in Maori. The use of Maori mental health outcomes is essential to the development of culturally

appropriate maternal health services. From a Kaupapa Maori approach the model of Te Whare Tapa Wha is an appropriate framework by which to address Maori health and well-being because it ensures that spirituality and whanau are just as essential for achieving health and well-being as the physical and mental components.

Culturally appropriate maternal health services for Maori women

A study carried out by Rimene et al. (1998) identified that for maternal health services to be effective for Maori women, health professionals need to have a relationship with Maori women based on respect and understanding of the diversity of experiences, influences and circumstances that impact on Maori women and their health. This includes an understanding of the traditional cultural practices and beliefs that surround pregnancy and childbirth and that still exist today for many Maori women. It is also about giving Maori women the opportunity to gain knowledge of those practices and for strengthening their identity and that of the child. *'It is a matter of not only giving the mother an identity but giving the child one as well'* (Rimene et al: 1998, p.28).

Durie (2002) also reinforces the fact that a strong cultural identity is important for positive mental health. Rimene et al. (1998) looks at concepts such as mana wahine, whare tangata, whakapapa and tapu, which are explored in relation to maternal health. They highlight the special importance and sacredness of the birth process, reinforcing the Maori view of health as encompassing the four dimensions of taha tinana, taha hinengaro, taha wairua and taha whanau.

Ellis (1998) conducted research that emphasized some key needs for the maternity service to be effective for Maori, such as midwives being more proactive and more accessible to Maori; provision of information on traditional cultural practices and methods for Maori; more time educating mothers on maternal health and care and antenatal classes to reflect the needs and perspectives of Maori.

These findings are also supported by Rimene et al (1998) who found that Maori women often find it difficult to make contact with doctors, midwives and health professionals for various reasons. Sometimes they have trouble understanding the 'medical' language of the health professionals and don't realise they are pregnant until late or do not access health services until it is too late. Others have trouble relating to

the mainstream European advice and antenatal and postnatal education provided for them that is often disconnected from their own reality. Many Maori women find marae based services more effective, while others would prefer to be supported and guided by family members, especially mothers and sisters.

An important theme discussed by Rimene et al (1998) was the need for health professionals to understand cultural practices and preferences that Maori women need and desire during the birthing process such as the keeping of the placenta to take home with the whanau. However, it was noted that of equal importance was that health professionals realise that not all Maori women will be aware of such customs and so there is a need for health professionals to seek that knowledge and not make generalisations or assumptions. Tupara (2001) believes that current midwifery training is also leading to assumptions and generalisations about Maori women, this being partly due to the lack of reliable information on Maori and childbirth/childrearing as much of it is written by white male anthropologists, and the misuse of resources contributing to education of midwives in relation to Maori maternal health, and cultural safety training being replaced with Maori studies. She indicates a need for a midwifery programme run within a wananga, or in conjunction with wananga, and utilising different approaches necessary to meet the diverse needs of Maori women.

Spirituality for many Maori is inextricably tied up with the process of pregnancy, birth and maternal health. If services are unaware and ill-equipped for such a connection and spiritual practices and beliefs, then the process is undermined for Maori women and can have a negative effect on the health of the mother, baby and whanau (Rimene et al: 1998, Ryan: 1995).

Ryan's (1995) research is one of the few contemporary accounts that give any insight into the traditional practices and beliefs surrounding pregnancy, birth and maternal health care. She writes of specific customs and practice, both spiritual and practical, that were used traditionally and many of the spiritual beliefs and concepts that underpin such practices. She also emphasizes the fact that Maori women live in a different reality today often disassociated and disconnected from Maori cultural and spiritual practices and beliefs, with changing family structures. For example, instead

of close whanau and hapu units there is now an increase of solo parents. Living circumstances are different, many live on benefits, in poverty, with little education and this has affected the health of Maori women. Most Maori women now have no choice but to become part of the 'norm' and follow the western medical view of maternal health, which sees less homebirths and more hospitalisation and Western practices employed. Interesting statistics that support this notion are the fact that in 1930, 83% of Maori women gave birth at home and by 1962, 95% of births by Maori women occurred in the hospital (Ryan: 1995).

Ryan (1995) insists on the need for health professionals to form a partnership with Maori women based on mutual respect, understanding of diverse cultural patterns, traditional practices and contemporary realities in order to enhance the relationship and experience of childbirth and childrearing. Ryan (1995) outlines an effective model for nurses to follow in order to create such a relationship and experience which includes:

1. Context – Health professionals need to be listening and observing in order to provide a holistic programme involving the four dimensions of Maori health and including contextual elements such as whanau, aroha, mana, and tapu. There needs to be an awareness that Maori women will be at different stages in relation to their knowledge and practice of such concepts.
2. Entering Nursing Partnership – Health professionals must form trust, refraining from using intimidation and allowing for the clients to maintain their identity. The health professionals need to have the ability to read communication patterns accurately, such as body language. There also needs to be an awareness of possible cultural shock, where the women feel uncomfortable and helpless within the mainstream medical system. There should be an acknowledgement of whanau no matter how it is represented and a willingness to work with whanau.
3. Negotiating Nursing Partnership – The health professional should listen and be comforting about the client's background, and situation. They should help to provide insight and information about cultural heritage and be prepared to work with cultural customs and beliefs. Finally, there should be an awareness of contextual impacts such as finance, education and relationships.

Whanau

Whanau often but not always play an integral role in the birth process for Maori women. It is often important for Maori women to feel their whanau have full involvement from throughout the pregnancy, to the birth and the postnatal care following (Ratima et al: 1994, Rimene et al: 1998, Ryan: 1995). Services thus, need to be able to accommodate whanau, remembering that whanau might range from the nuclear family, to extended family, to good friends. A major concern noted by Maori women in the research was the lack of power and respect given to Maori women within the hospital, which left many with a sense of despair, helplessness and loss of personal dignity (Ratima et al: 1994, Rimene et al: 1998, Ryan: 1995). The importance of such support for Maori mothers should not be underestimated and thus services need to adequately provide such support and enable Maori mothers and their whanau to retain power and control within the birthing process.

Post-natal depression

When looking at postnatal depression and Maori women, it is important to acknowledge that postnatal depression is located within a Western medical paradigm of health. In New Zealand, diagnosis and treatment of postnatal depression follows the Western models and understandings of mental disorders. This paradigm does not account for a Maori worldview or Maori cultural beliefs and practices around health and well-being.

Post-natal depression is a depressive illness that affects 10-20% of women (Kruckman et al: 2001, Bishop, L.: 1999). Despite this statistic, until recently the treatment of postnatal depression has not been the subject of research because most researchers and clinicians have not studied it as a separate entity. However, the evidence base has grown to provide information and research on post-natal depression as a distinct mental illness. While there has been a growth of research and information concerning postnatal depression there is still a lack of reliable and valid research material in the evidence base. The data that does exist comes from primarily a Western paradigm, focussing on biological and psychological variables, placing importance on issues

such as hormonal shifts, maternal age, and psychiatric history. To have a complete evidence base to draw on, research must be developed from an indigenous perspective drawing on their knowledge and expertise on appropriate and effective interventions for postnatal depression.

There has been considerable debate historically over postnatal depression within the medical profession. The argument has centred on whether postnatal depression can be viewed as a distinct illness/entity or whether it was part of another medical condition. Today there is still debate, with the DSM (Diagnostic and Statistical Manual of Mental Disorders) manual having changing views on this issue. The DSM II described postnatal depression as a separate entity but the DSM III eliminated this category, and even today within the latest DSM IV manual there is still not a clear category for this illness (American Psychiatric Association: 2000). Many clinicians treat postnatal depression as an affective disorder occurring in the postpartum period, others as a major depressive episode brought on by a stressful event i.e. the birth of a baby (Kruckman & Smith: 2001).

Symptoms

Medically postnatal depression is separated into three categories:

- Postpartum psychosis - rare disorder where the mother has symptoms similar to general psychotic reactions.
- Chronic depressive syndrome - moderate depression disorder and,
- Postpartum 'blues' - minor affective disorder, more common and lasting for several weeks.

The following complaints if continuous can be viewed as possible precursors to postnatal depression: worsening of sleep disturbances, eating problems, intensity and duration of depressed feelings, withdrawal or social isolation, or lack of interaction with new baby (Kruckman & Smith: 2001, Bishop: 1999). However, according to Durie (2001), these symptoms of depression can manifest differently in non-Western cultures and Maori women might not show emotional or mood symptoms but may have other complaints such as physical symptoms, which could still be an indication of postnatal depression. The DSM IV takes account of cultural bias with an appendix

on culture bound syndromes and cultural formulation but does not include Maori-specific illnesses, and is of no use if health practitioners are unable to make such cultural formulations for Maori. Durie (2001) defines cultural formulation as ‘cultural factors relating to the psychosocial environment and cultural elements in the relationship between the individual and clinician’. If doctors and mental health professionals cannot appreciate the impact of culture on a person’s health and well-being then it can lead to misdiagnosis. Furthermore many women that suffer from postnatal depression are unaware that it is an illness and therefore do not seek treatment, and according to Walther (cited in Kruckman & Smith: 2001) it is estimated that only 20% with the disorder actually receive mental health treatment.

There are a number of risk factors that are identified in Western mainstream literature that can act as precursors to the development of postnatal depression. These risk factors or causes can come from both biological and psychosocial origins and provide a mainstream understanding of postnatal depression and current forms of treatment. From a Kaupapa Maori perspective, these approaches in isolation will be ineffective for Maori mothers, as they do not incorporate an holistic approach to health and well-being.

Causes – Biological Perspective

The medical paradigm conceptualises postnatal depression from a biological perspective and a psychosocial one. Biological theories have focussed on the relationship between postpartum depression and hormonal changes, which see a large drop in estrogens and progesterone in the postpartum period. Another possible factor is the decline in prolactin in non-breast-feeding mothers contributing to postpartum depression, although this requires more research (Kruckman & Smith: 2001). Adrenal steroid changes may have an effect on depression levels, as does the role of cyclic adenosine monophosphate, which is primarily related to mothers who experience long labours and then subsequent depression. Other factors or precursors to postnatal depression include women who suffer obsessive-compulsive disorders, changes in gonadal hormones, severe sleep disturbances and anxiety.

While hormonal research has identified some important links with postnatal depression, the research has not been absolutely reliable due to a lack of knowledge on hormonal levels, an over-focus on psychotic levels and small sample sizes (Kruckman & Smith: 2001). Furthermore studies of biological causes alone are insufficient without critical attention on psychosocial and cultural variables.

Causes – Psychosocial perspective

Much of the research on postnatal depression places emphasis on the role of psychosocial variables in contributing to postnatal depression (Brugha et al: 2000, Fontaine & Jones: 1997, Kruckman & Smith: 2001, Sweet: 1993, Webster: et al: 1994)

These psychosocial variables include:

- Personality variables: The role of expectations on new mothers, their attitude or ambivalence towards pregnancy, their feelings about sexual identity, the effect of weight gain and self-esteem issues.
- Demographic variables – The age of mothers – teenage mothers and older women are more likely to suffer from postnatal depression; social upheaval and conditions such as poverty, drug & alcohol addictions and family violence.
- Interpersonal variables – the level of family interaction/support impacts greatly on maternal mental health, as does a lack of partner or marital problems.
- Obstetric variables - traumatic birthing experiences, low birth weight babies and infant mortality can also contribute to the development of postnatal depression.

While this is a broad list of possible causes and factors relating to postpartum depression, it is not exhaustive and research continues to develop new ideas and theories.

The perspectives taken on mental illness such as the medical (biological and psychosocial) directly relate to the kinds of treatment made available for postnatal

depression. There have been problematic issues in the methodology and research used to create effective information and data concerning the aetiology of postnatal depression, the same issues are faced when looking at treatment and interventions. Sample sizes tend to be small and research is most often conducted on hospitalised patients in clinical settings, which can skew data. Very little data exists on postnatal depression, causes and treatments from an indigenous perspective. The majority of evidence points to the fact that more research needs to be conducted before the evidence can be deemed to be very effective. Underlying this is that research in the area of mental illness will always be continual and that no theories exist which are perfect and no one treatment exists to suit everyone.

Psycho-social treatment – Social Support

Research has indicated that social support plays an effective role in the prevention and treatment of postnatal depression across all cultures. Previous research has suggested that prolonged postnatal depression can be linked to lack of social support (Kruckman & Smith: 2001). Brugha et al (2000) sought to reduce risk factors of postnatal depression by introducing an antenatal program 'preparing for motherhood' designed to increase social support and problem solving skills. This programme was not effective in reducing levels of postnatal depression but is isolated in its findings, with the following research projects finding social support playing a significant role in maternal health and well-being. Clement (1995) examined the research evidence to see if 'listening visits' in pregnancy targeted at women with low emotional well-being reduced postnatal depression. The evidence indicated this process to be effective with many women that are depressed in pregnancy, facing continued depression after birth. Barlow et al (2001) found enough evidence to suggest that group-based parenting programs were effective for short-term psychosocial health in the postnatal period but outlined that more research needed to be conducted for long-term benefits to be assessed. Ray & Hodnett (2001) studied supportive relationships during prenatal, labour and postnatal periods and found this type of support to reduce postnatal depression but that again further research needed to be conducted on the most effective models of support to be used.

Psychotherapy

One of the main reasons that women will choose to use psychotherapy as a form of treatment is that it ensures the safety of the baby, whereas that is not assured if drugs are administered during pregnancy and breastfeeding. Psychotherapy focuses on the patient's interpersonal relationships and changing roles. Past research has been favourable towards the use of psychotherapy treatment. The study conducted by O'Hara et al (2000) on the efficacy of interpersonal treatment concluded that this intervention was effective, resulting in significant improvement in depressive symptoms with significant improvement in their psychosocial functioning. Other findings showed a need for treatment to start as soon as possible. This study also stipulated that its participants were from largely middle-class backgrounds and in stable relationships which indicates the need for further research using participants from less advantaged populations. Such a project was carried out by Zlotnick et al (2001) whereby women receiving public assistance and with at least one symptom of postnatal depression were treated with an interpersonal therapy oriented group intervention. This project was successful in preventing the occurrence of major depression during the postnatal period but looked only short term.

Medical Treatment – Drugs

While research has supported the efficacy of psychosocial interventions there is still evidence (albeit) controversial that suggests the need for psychopharmacologic (medication) interventions also. However, the clinicians will suggest that it should be accompanied with psychosocial interventions.

Antidepressant drug therapy has also been shown to lower the rate of postnatal depression; however there is not enough evidence to support the complete effectiveness or safety of antidepressants (Kruckman & Smith: 2001). More importantly it has been noted that there is a large gap in the evidence base with few researchers comparing the effectiveness of antidepressant treatment with psychosocial interventions. Selective serotonin reuptake inhibitors (SSRIs), which include Prozac, Zoloft and Paxil, are often used for the treatment of depression. The advantages of

these drugs are their safety in overdose situations and the dosage amount (Kruckman & Smith: 2001).

Hormonal imbalance is a common explanation for the aetiology of postnatal depression; treatment based around this theoretical standpoint has been the use of oestrogen and progestrogens. However, according to Lawrie et al (2001) and their review of the research, there is no reliable evidence to suggest that these drugs are an effective form of treatment and that taking synthetic progestrogens will prevent postnatal depression; and that in fact with some long acting anti-depressants there is an increased risk of postnatal depression. Oestrogen therapy, while not the most effective either, is of modest value at a late stage of severe postnatal depression (Gregoire et al: 1996).

While both psychosocial therapy and drugs are used as treatment/interventions for postnatal depression it often occurs after the patient becomes ill. Research suggests that perhaps the most effective form of treatment happens at the preventative stages and this takes the form of psychosocial therapy and early interventions including parenting education and support, psychotherapy and reassurance. It is this type of support that is seen as a given in many non-western cultures and perhaps this may account for the lower levels of postnatal depression amongst these cultures.

Anthropological Paradigm

The anthropological paradigm differs to the medical paradigm in that it views mental illness in a more holistic and cultural way, placing importance on cultural patterns such as family structure and values and beliefs. This supports a Kaupapa Maori perspective, that Maori mental health and mental illness must be viewed within a Maori worldview, taking into account Maori customs, beliefs, cultural experiences and realities. Research also indicates that postnatal depression is more of a Western phenomenon and has limited occurrence in non-western cultures with large supportive kin-groups (Kruckman & Smith: 2001). Within these cultures, what is notable is the amount of social support, rituals and recognition that seems to cushion and prevent postnatal depression. It is precisely these aspects that are lacking in many Western cultures. While anthropologists believe in the necessity of biochemical research in

relation to postnatal depression, it is clearly acknowledged that indigenous and non-western cultures have some very effective forms of preventions and interventions for postnatal depression. Research needs to be carried out though in non-western cultures that have been colonised, conquered or just affected by Western culture, and the impact that has had on women and postnatal depression.

The available research on postnatal depression that is both reliable and valid by Western methodological standards is lacking, especially information based on effective treatments and interventions. The literature available on indigenous and non-western cultures and postnatal depression is even less substantial. Most research that can be found comes from an anthropological perspective that has often been conducted by Western researchers. The main issue that has arisen from such research is the low levels of postnatal depression in non-Western societies that have strong kin-based social systems. In Kenya, the Kipsigis women have support and warm care provided by husbands, parents and relatives; and postnatal depression is uncommon. Chinese rituals in the home seem to account for lower rates of postnatal depression and this is similar in rural Malaysia (Kruckman et al: 2001).

A study on Native American women by Walters and Simoni (2002) identified the negative impacts of colonisation as directly impacting on the maternal health and infant health of Native Americans. They have higher rates of infant mortality; lower rates of prenatal care; higher rates of alcohol and tobacco use during pregnancy; increased risk of physical and sexual abuse; and depression was noted as the most prevalent psychiatric disorder. However, this study also showed that cultural buffers could moderate the effect of trauma on the maternal health of Native American women. These cultural buffers included enhanced self-esteem, cultural knowledge and immersion in traditional health and healing practices. A study by Davis (2001) indicated that South East Asian women living in America relied on traditional cultural practices and rituals such as prolonged rest, affiliation of women, and body balance to achieve optimum mental and physical health postnatal. What are lacking in the evidence base are detailed accounts of how the social systems work to support mothers during the postnatal period, what rituals are used and why, and what are the feelings, perceptions and views of the women towards maternal health issues. If the Western academic world of research is to gain access to such information, then they

must be open to accepting other ways and methods of conducting and analysing research. This highlights the need for Kaupapa Maori research that explores the role of traditional Maori practices and beliefs around birth and motherhood and how this knowledge can be best utilised in today's society.

For many of these societies, qualitative research is the most effective method of research especially when you are dealing with some phenomena that cannot be measured or scientifically proven. Information is mostly gained through experiencing, talking and observing. Furthermore there are certain protocols that will need to be followed and processes implemented. In the indigenous world where there are no strict time limits, where deadlines are not understood, research can take a lot longer than in the Western world. But often the priceless information that is gained makes the wait worthwhile.

Postnatal depression and Maori women

In New Zealand there is very little evidence available on postnatal depression from an indigenous perspective. What is known is that in today's society postnatal depression is more likely to occur in Maori women (Bridgman & Lealaiauloto: 1997, Webster et al: 1994). This is a huge turn around if the literature of Makareti is taken in account where there were very few cases if any of anxiety/depression surrounding childbirth. However, it seems plausible when observing mental health statistics on depression and suicide that see a huge increase in depression and anxiety in Maori women especially in comparison to non-Maori (Durie: 2002).

Whilst postnatal depression was not discussed in the interviews and research conducted by Rimene et al (1998), there were indicators to suggest that postnatal depression was occurring but that there was a lack of education and under diagnosis of the illness and outlined the need for further research in the area.

It is interesting to note that during the interviews, postnatal depression was never mentioned by any of the wahine Maori. This is not to say that it did not occur. Some of the experiences shared by the women would have been a

reflection of postnatal depression. This is an area that may well need further research. (Rimene et al: 1998).

Ryan (1995) also noted in her research that traditionally postnatal depression was not recognised as an illness; any anxiety was overcome with karakia. However, today the illness is going unrecognised and untreated and is causing problems for Maori women, also leading to misdiagnosis and psychiatric treatment.

Bridgman and Lealaiauloto (1997) have conducted one of the few studies on Pacific women and postnatal depression. Their research showed that Pacific women in New Zealand have two contrasting views of birth and the postnatal period. One is the pervasive environment in New Zealand and the stress and demand on mothers including money worries, helplessness, and loss of control and lack of knowledge. Secondly, were feelings of love for the babies. Women again did not find professional health agencies like Plunket helpful and would rather rely on mothers and sisters. Mothers felt that in traditional cultural environments there was stronger family support. In New Zealand this was less the case. Their study in Auckland showed that Maori women and solo parents were at greater risk for postnatal depression.

They also found that the Western diagnostic tools, such as the Edinburgh postnatal depression scale, was not appropriate for Pacific women, as they used concepts and practices they could not relate to and were inconsistent with cultural beliefs (Bridgman & Lealaiauloto: 1997).

Traditional, indigenous accounts of postnatal depression are non-existent; and it may be that traditionally family support structures acted as a buffer against postnatal depression. However, colonisation, assimilation and the impact of the Western lifestyle have meant that traditional kin networks do not exist in the same way.

While there has been very few research projects on postnatal experiences and depression from a Maori perspective, there was a very useful study conducted that supported the need for postnatal interventions for indigenous women that incorporated traditional and cultural ways of supporting the mother and her baby. Mayberry et al

(1999) studied an intervention in Hawaii, where maternal health programs have been established incorporating the values and beliefs of the indigenous peoples on the islands. The program is designed to provide better preventative health care for women in the ante and postnatal periods that are from multiple cultural and ethnic backgrounds. Local cultural and ethnic healers and leaders are involved in providing the best culturally appropriate care for these women. The strategies that take place in this program are based around not only medical practices and education but also cultural protocols. They involve 'talk story' communication – a reciprocal exchange of thoughts, ideas, and feelings about self and other issues. This strategy is used as a purposeful assessment and intervention technique to minimize the development of depressive symptoms in the postnatal period. It was partially motivated by the recent writings describing the lack of rituals and traditions during the childbearing period in the United States, as contributing to the increased incidence of postnatal depression. Other techniques and strategies used are traditional massage and use of cultural concepts of health within the program. This program has been very successful in creating positive maternal health for indigenous women in Hawaii.

Whilst there is little research in New Zealand specifically on postnatal depression and Maori women, recent research made available on mental health and Maori women, maternal health and Maori women and general health issues related to Maori women do however provide helpful and useful information to identify and understand those factors and issues that impact on Maori women and their health, in particular maternal health.

Durie (2001) offers some valuable insights into treatment of depression for Maori. Placing great emphasis on the fact that while Western diagnosis of depression is viewed as primarily a mood disorder, as a mental state, Maori see depression as involving the mental, physical, spiritual and social components. Treatment for Maori women will thus make little sense and be seen as inappropriate if it cannot be related to the Maori view of mental health. It is the notion of including all aspects the mental, physical, spiritual and social that must play a part in the development of maternal health programs for Maori if they are to be effective preventative measures for the onset of postnatal depression.

Assessment should be more than a simple statement about DSM IV categories. They should be capable of measuring the degree to which cultural, social and spiritual factors are associated with problems of health (Durie: 2001, 271)

It is my belief that the western medical paradigm alone does not provide appropriate models, diagnostic tools, understandings and treatments for dealing with postnatal depression in Maori women. According to Durie (2001), a cultural assessment of mental illness will at least provide a basis for a better understanding of the patient and may lead to a cultural formulation, to complement a DSM IV diagnosis. I believe that Western medical perspectives and tools may be effective for Maori women if they can be utilised alongside or within a Kaupapa Maori framework and paradigm of health and well-being.

Conclusion

The themes discussed in the literature review provide a background and rationale for the development of a maternal mental health tool that is based on a Maori cultural paradigm and that utilises both mainstream knowledge and practices alongside Maori knowledge and health practices. According to the literature postnatal depression did not seem to exist within traditional cultural societies with strong support networks and customs and rituals to support mothers. This may have accounted for the absence of postnatal depression within traditional Maori society. Furthermore other cross-cultural studies support the notion of cultural buffers being utilised to successfully maintain positive maternal mental health. Research on postnatal depression indicates that 10-20% of women suffer from postnatal depression, with this figure possibly higher due to the under-diagnosis and mis-diagnosis of the illness. Furthermore research also shows that when looking at the risk factors for postnatal depression many Maori women are impacted by those factors, which increase the likelihood of developing postnatal depression. Current literature also emphasizes the need for maternal health services to meet the diverse needs of Maori women, with outcomes that have meaning for Maori mothers. Cross-cultural studies indicate that it is possible and effective to provide maternal health services and tools, which incorporate cultural maternal health practices alongside mainstream Western health practices.

CHAPTER THREE - METHODOLOGY

'We do not see things as they are, we see things as we are' (Talmud)

In this chapter the issue of appropriate methodology for research involving Maori participants will be discussed, with a focus on research outcomes that are beneficial to Maori. In this research, methodology is the philosophical position that frames the questions that are asked, the methods that are employed and how the analysis might therefore be shaped. The method on the other hand refers to how data is collected. Finally, I will conclude this chapter with a discussion of the role of reflexivity and positionality in this research project.

The main concern in deciding on an appropriate methodology for this research was whether to identify the methodology as 'Maori-centred' or 'Kaupapa Maori'. In carefully analysing the research design and approach I believe that this research has incorporated both Kaupapa Maori and Maori-centred approaches to research. This research incorporates Kaupapa Maori theory and philosophy in the literature, methodology and analysis. However, the research is still governed by Western mainstream guidelines and parameters and so the methods employed in this research fall under a Maori-centred approach. There are a number of different definitions used when describing these approaches to research.

Maori-centred research

Maori-centred research places Maori people and Maori experiences at the centre of the research process. The research places an emphasis on Maori culture, knowledge, values, realities and needs. The outcomes of Maori centred research must be of benefit to Maori society. It also requires the researchers to abide by a Maori system of ethics and accountability (Jahnke & Taiapa: 1999, 49).

Within Maori centred research Pakeha involvement is limited to acting under guidelines, which support a bicultural approach to researching Maori (Tolich: 2002). In my research non-Maori participants participated, with the understanding that the research was about Maori women and that the aim of the research was to improve the

lives of Maori mothers. Whilst I had a non-Maori supervisor for the research, I also had a supervisor with knowledge and experience of Te Ao Maori and Maori research to guide the research process.

Cunningham (1998, 391) describes Maori-centred research as:

‘research where Maori are significant participants, and are typically senior members of research teams; research where a Maori analysis is undertaken and which produces Maori knowledge, albeit managed against mainstream standards for research’.

The control for such research still rests with mainstream organizations and an example of such research would be a longitudinal social science study of Maori households such as Te Hoe Nuku Roa, based at Massey University. Cunningham (1998) claims that the difference with Kaupapa Maori research is that the standards and expectations of the research are set by Maori, and furthermore control of the research also sits with Maori. An example of such research being ‘cultural determinants of health’. Through the use of Maori-centred methodology, this research aims to be reflective of the diverse nature of Maori communities and guided by Maori philosophy and principles.

Kaupapa Maori Research

Kaupapa Maori research is about conducting research by Maori, for Maori, within a framework determined by Maori culture, values, tikanga and unique life experiences. It is also about the decolonisation of previous Western ideas of what constituted valid research, so that research rather than abusing and degrading Maori and Maori ways of knowing, allows for Maori communities to feel empowered and supports the revitalisation and protection of all things Maori. While there are differing definitions of what encapsulates Kaupapa Maori research, most Maori researchers believe that Maori specific research must be determined and coordinated by Maori, working with Maori and for Maori (Cram: 2001, Glover: 2002, Smith: 1999). Today Maori researchers are focusing their efforts into establishing research frameworks, methodologies and theories based on Maori worldviews and experiences. These

efforts are providing researchers with the knowledge and practice to conduct Kaupapa Maori research as well as tools for dealing with the barriers and limitations of conducting such research.

The last decade has seen a rise in the number of Maori researchers and the development of Maori specific research theories and methodologies. According to Cunningham (1998) research only qualifies as Kaupapa Maori if the project is under Maori control, in contrast to Maori centred research where the control still rests with mainstream institutions. However, Glover (2002) stipulates that there is no one way or right way of conducting Kaupapa Maori research but that it involves a multitude of paradigms, theoretical models and analytical frameworks. Takino (cited in Tapine & Waiti: 1997) also believes that there is no single privileged truth according to Maori-centred knowing and being; there exists no single form of Maori theorizing. Cleave (1997) believes that such research is a reclaiming of a tradition, the right to speak and inquire on a basis of an indigenous value system.

Kaupapa Maori research is about decolonising previous ideas and methods of research involving Maori (Smith, 1999). This means Maori being able to regain control over Maori knowledge and resources in the quest for tino rangatiratanga - Maori control over their own destinies. The challenge according to Smith (cited in Glover: 2002) is the need for Maori researchers to convince Maori of the value of research for Maori, and at the same time convince the powerful non-Maori research community of the need for greater Maori involvement. Smith (1999) believes that such development must take into account previous research and current research but not be limited by it.

'Kaupapa Maori' paradigm

An essential component of Kaupapa Maori research is that it is underpinned by a different worldview than Western models of research. This indigenous body of knowledge links humans, plants, animals and gods together. It is based around concepts such as tapu and noa, which work to regulate life and which are often tribally specific. (Cram: 2001, Te Awekotuku: 1991). One core aspect that conflicts with Western views of research is that in the Maori world, knowledge served the community but was never universally available, being specialised and hierarchical.

'Maori society also valued knowledge highly; to such an extent that certain types of knowledge were entrusted to only a few members of the whanau'. (Smith: 1992).

When outside researchers came into Maori communities they were often not given access to certain information and sometimes they were given false or distorted information. According to Bishop (1996) such misconstrued knowledge and meanings are now part of the everyday myths of Aotearoa, believed by both Maori and non-Maori. The Western view of knowledge, however, sets no limitations on what can be researched. Today, as all cultures change and adapt to their ever-changing environment, Maori culture is no exception. The goal of all research is the retention, transmission and development of old and new knowledge and Maori research will not only require access to customary knowledge but also to innovation (Durie: 1998b). Knowledge that was previously only given to certain experts is now becoming more accessible. Many kaumatua realise if this knowledge is not passed on to the next generation it will be lost forever. Within some iwi, this dissemination of knowledge comes with strict guidelines on how it is to be used within, and for the benefit of, the iwi and hapu it pertains to. For the last 12 years, Taiarahia Black of Tuhoe descent has been documenting the traditional rituals of the Urewera people (Massey Focus: 1998). In 1997, kaumatua allowed for sacrosanct laws to be set aside to allow for the filming and recording of traditional waiata. The materials were then to be returned to the people to preserve and aid in the preservation and revitalisation of Tuhoe heritage. *'In the end the good that is old will be preserved and the good that is new will be added'* (Massey Focus: 1998, p.2)

Critiquing Western research paradigms

A Kaupapa Maori approach to research opens up avenues for critiquing Western worldviews and approaches to research. This involves looking at the effects of colonisation, power and social inequalities and questioning Western ideas about knowledge. One criticism Maori have had on past research, conducted on Maori issues, is the focus on negative issues and circumstances faced by Maori (Bishop: 1996, Johnston: 1998, Smith: 1997). Such research *'is seen to feed public suspicion and stereotypes about the unemployment of Maori or the number of Maori on particular benefits'* (Spoonley et al: 1992, p.4).

A further criticism identified by Stokes (1985) is that this type of research on Maori is only descriptive, telling Maori what they already know. These issues also illustrate the fact that Maori research is always political, 'intrinsic to Kaupapa Maori theory is an analysis of existing power structures and social inequalities' (Pihama cited in Glover: 2002). Kaupapa Maori research is about validating and legitimising Maori worldviews, supporting the revitalisation of Maori culture and language and empowering Maori communities so that they can have control over their own lives and well-being. The struggle to legitimize Kaupapa Maori perspectives continues today within a research world that is still largely dominated by a Western paradigm.

Who should conduct 'Kaupapa Maori research'?

There is a range of views and perspectives as to which people are the most appropriate to conduct Kaupapa Maori research, and there are no concrete conclusions. The consensus by most Maori is that Maori should be the primary researchers but that non-Maori can support a Maori research Kaupapa (Cram: 2001). The dangers in this is that being Maori does not guarantee that they identify as Maori and are supportive and knowledgeable of Maori ways of knowing and living. Smith (1997) makes it clear that being a Kaupapa Maori researcher is more than being a brown face and that identifying as Maori is a critical element to being an appropriate researcher. The appropriateness of the researcher is also determined by a range of other factors. Te Awetotoku (cited in Glover: 2002) suggests that researchers need to consider: their tribal background, gender, language fluency, age and ask the question 'Are you the right person to be receiving such information?' Other factors that contribute to an appropriate researcher are knowledge of Te Ao Maori - the Maori world, knowledge of Te Ao Hurihuri - the diverse realities of Maori today, and knowledge of the specific area i.e. health, education, sport.

To meet the need for researchers trained in these areas, some research organisations such as the Health Research Council have made a commitment to training more researchers. Other organisations have established guidelines for working with Maori and established protocols for consulting and working with Maori. While this is a positive step it raises a number of issues. Firstly, the urgent need for Maori research

workforce development where Maori are trained in Kaupapa Maori methodologies and theories. Also, it reinforces the fact that it is often mainstream organisations that are establishing and setting down the guidelines for Maori research instead of Maori themselves. One proactive solution to these issues would be the establishment of a foundation that could *'purchase research relevant to Maori advancement, liaise with agencies involved in research, demonstrate leadership in ethical matters, and actively encourage research which added value to Maori development'*. (Durie: 1998, p.81).

Tikanga

Inherent to Kaupapa Maori research is the need to follow tikanga (customs) and cultural protocols throughout the entire research process (Cram: 2001, Smith: 1997). Furthermore the tikanga applied to the research process will need to be determined by the Maori community being researched. Research and statistics indicate that Maori live very diverse realities (Durie, 1998a). Many Maori especially those that live in urban environments do not have access to traditional knowledge and tribal structures. A large percentage of the Maori population cannot speak Te Reo Maori and have a limited understanding of tikanga (Durie, 1998a). Maori researchers need to be aware of this diversity and set up processes that accommodate these differences. Researchers that confine themselves to one approach may run the risk of scaring off participants. While following tikanga is vital to Maori research methods especially in more traditional environments such as the marae, Kaupapa Maori concepts and tools also need to be developed and employed which allow for Maori participants who are not secure in their cultural identity to feel safe and empowered.

Kaupapa Maori research methods are ultimately based on different epistemological and metaphysical foundations to Western oriented research (Cram: 2001). In the past such Western based research caused a lot of harm to Maori communities and this still effects the way research is conducted today. It often means that the direct route to engaging Maori participants in research will not always be appropriate. Often especially in Kaupapa Maori contexts, links will first have to be made through whakapapa (lineage) at the whanau, hapu or iwi level (Cram: 2001). It allows for control to rest with the people, giving them the opportunity to define the relationship so that they can benefit from the process. It also incorporates a concept integral to the

Maori way of life across all communities although expressed at different levels - 'whakawhanaungtanga'. Bishop (1996) describes the role of 'whakawhanaungtanga' in the research process as identifying your connectedness and engagement through culturally appropriate means. It indicates the difficulties non-Maori would have even at the earliest stage of the research process because they are not able to link in through genealogical ties.

According to Cram (2001) kaumatua are integral to Kaupapa Maori research. Their ability to aid researchers in the best use of matauranga Maori (customary Maori knowledge), kawa (protocol) and tikanga is essential as Maori researchers make their way through Maori communities. They are a valuable source of knowledge especially for Maori researchers with less confidence and competency in Te Ao Maori. Irwin (1994) emphasizes the positive impact kaumatua had in her research experience in terms of cultural safety. The role of kaumatua in this research was by interviewing a kuia to gain an understanding of her perspective and experience as a mother. By the kuia supporting the research and giving value to the Kaupapa, I gained a sense of reassurance that this research would be of benefit and important to all Maori women.

Identified by many researchers is the need for the research process to involve face-to-face meeting with researcher and participant/s, known to Maori as 'kanohi ki te kanohi' (Cram: 2001). The marae can be a perfect environment for such meetings as it allows for tangata whenua to define and set the boundaries for the relationship. The processes that take place on the marae also illustrate the key psychological, spiritual and physical components of the Maori way of living, thinking and feeling (Durie: 2001). For Maori who are not secure in their cultural identity, as determined by the researcher, such an environment can be a positive way of empowerment. All the interviews for this research including the initial meetings were conducted 'kanohi ki te kanohi' in an environment where the participants felt comfortable and safe. Those people that I was not able to meet with face to face declined to participate in the research.

For Maori communities that are involved in Kaupapa Maori research it is important that they are involved in the research process at all stages, not just at a superficial level. This includes consulting, liaising, researching, feedback and dissemination of

methods, results and conclusions. According to Te Awekotuku (1991) it is vital that the knowledge gained from the research benefits the community. Because the relationship is also based on manaakitanga (reciprocity), it is often important for the researcher to be giving back to the community and that might mean more than involvement in the research. Often a researcher will be required to give practical and physical help to the community. That may consist of washing the dishes at the marae or helping out at the kohanga. Those non-Maori such as Ritchie and Salmond that have succeeded in conducting research which are accepted by Maori communities have done so by creating meaningful relationships with those communities that have remained long after the completion of the research (Smith: 1999). Salmond (1983) highlights the importance of such 'relationships' and believes in order to understand Maori accounts of the tribal past one must move from looking at Maori culture in distinct categories to looking at the relationships within Maoridom between gods, ancestors, land and the living. Even if the research methods do not require face-to-face meetings some physical connection needs to be made and will ultimately be more effective (Cram: 2001). Sometimes this might mean meeting before the research is conducted to form trust and build connections. However, this can sometimes cause conflict with ethical considerations from mainstream research boards. This is not just a conflict on ethical grounds; it is also a conflict of worldviews. According to Chief Judge Eddie Durie (cited in Durie, 1998) there is an urgent need for a code of ethics to guide Maori research based on Kaupapa Maori and specialized Maori ethical committees to work in partnership with others. Such conflict of ethics has been illustrated on other occasions and has been identified as a real barrier in the Maori research process. (Durie: 1998, Mutu: 1998).

Because the approach of this research was Kaupapa Maori and due to the sensitive nature of the Kaupapa, it was really important to meet with participants first, so that they could get a clear understanding of what was involved in the research and what their role would be. It also enabled the researcher to ensure that the participants felt safe and comfortable with the research and confident to approach the researcher with questions or concerns. This particular research did not involve a specific Maori community therefore consultation and liaising did not take place with local hapu or community groups.

The collaborative approach

Maori research focuses on a collaborative approach where knowledge flows both ways and both researcher and researched have something important to contribute and learn and these needs to be acknowledged by the researcher (Cram: 2001). According to Bishop (1996) 'koha' is an appropriate term to describe this aspect of the relationship. It describes the giving of the research project as a taonga (gift) to the participant/s and it is their choice to accept it or not. If they decide to enter into the relationship then the relationship will be seen as ongoing with 'no boundaries or time constraints' (Cram: 2001, p.43). Within this research the concept of 'koha' was practiced. As the researcher I felt that it was important that the participants felt valued for their input within the research. Researchers should also make the effort wherever possible to teach and give the opportunity for the community to develop and learn the skills needed for conducting their own research as a vital part of empowering the community and enabling the community to define that empowerment.' *Every culture has a right to present its own culture to its own people' (Cleave: 1997, 15).*

These notions can often be hard for non-Maori to conceptualize and abide by. It is less difficult for Maori as they have a vested interest in seeing Maori succeed and grow and want to be a part of that, as they are not just helping people, they are helping their own people, their own families and they do not have the ability to walk away and never be seen again. According to Cram (2001) it is essential for Maori researchers to ensure they are not writing about their communities as if they were outsiders, viewing the participants as 'other'. Coming from the perspective of 'insider' allows for accurate interpretations of the Maori world that according to Marsden (1992) can only lie through the passionate, subjective approach. Smith (1995) states also that Maori researchers can be subjective and still conduct valid, reliable and rigorous research. Being a researcher and a member of the researched group is not always an easy job though, especially when the researcher carries a variety of roles such as 'insider' of the community, and as 'outsider' because of Western academic training, gender and age. It can result in a number of difficulties on a personal, cultural, ethical and political level.' *At times it became extremely difficult for me to distinguish between my positions, to sort out where one began and the other ended' (Johnston, 1999, p.5).*

Smith (1999) believes in spite of these difficulties it is important to remember that 'indigenous research is a humble and humbling activity' (p.5).

Being subjective and reflective of my position as both researcher and 'insider' of the research group had a huge impact on this research. Not only was I a Maori mother but I also suffered from postnatal depression throughout the research process. I believe my multiple positions have given strength and meaning to the arguments discussed within this research. However, it has also meant that the research at times has been a great burden to bear, as it has ultimately meant that I have had to question and challenge myself as a Maori, as a Mother and as a researcher.

Barriers to Kaupapa Maori and Maori-centred research

Such difficulties, barriers and limitations when conducting Maori research are brought about partly by the conflicts between the Western worldviews, and Maori or indigenous worldviews, and also because of some of the unique characteristics of Maori researchers and Maori communities.

Time constraints feature in the barriers to conducting Maori research. Integral to the issue of time is the different way Maori view time to the Pakeha view of time. In the Maori world, time is constructed according to the sequence of events; it is not something that can be organised by time frames but rather by the rhythm of human encounters (Durie: 2002). This is illustrated by the processes that take place on the marae '*where time is less a function of being on time than allowing for the full elaboration of events and discourses*' (Durie: 2002, p.77).

The same understandings and rules for time apply in Kaupapa Maori research situations. This often creates conflict with mainstream academic or research organisations that have timeframes and deadlines that must be met often in order to receive funding or for Maori researchers to complete their qualifications. It is often a real struggle for Maori researchers to move from the Maori world where time is about an order of events to the Western world where time is more about meeting deadlines. It may often be a contributing factor in why many Maori postgraduate students take longer to complete their qualifications, and why others fail to finish at all.

An issue discussed earlier is the diversity of Maori communities today. Many Maori have become dislocated from traditional tribal structures and have little or no access to institutions where they can learn Te Reo Maori and tikanga (Mutu: 1998). While there has been a real push for the need of Maori researchers to have a sufficient knowledge of Te Reo Maori and tikanga, there has been little comment on the need for Maori researchers to have an understanding of the position of the high percentage of Maori that have little sense of cultural identity. Research at all levels, whanau, hapu, iwi and at a national level needs to accommodate for this and equip researchers with skills necessary to allow for all Maori to feel safe and empowered.

As stated earlier, Maori research at some level is always political. While research can be a vehicle for important political and social change it can also be a barrier for researchers, in particular Maori researchers. Maori researching especially within their own whanau, hapu and iwi inevitably find themselves caught up in the political and social struggles of the people while doing their research. This sometimes means that the well-being and needs of the people will have to come before the demands of the research. It is therefore very hard for Maori to balance that need with the requirements of the research and that can lead to unfinished research but fulfilled commitments to the people, which ironically, as indicated earlier, is one of the highest priorities for Kaupapa Maori research.

The development of Maori-centred and Kaupapa Maori research is allowing Maori to advance as a people on all levels; as individuals, members of a whanau, hapu, iwi and a nation. As Maori research theories and methodologies grow and develop so too does the urgent need for the development of Maori research foundations and ethical boards in order to support and monitor Maori research. But despite the many barriers that are faced by researchers conducting Maori research, the quest for knowledge develops and advances, largely because such research is not just about obtaining knowledge but about using such knowledge to empower, protect and embrace all that it means to be Maori.

Role of Researcher – Reflexivity and Positionality

Within Kaupapa Maori research, the research should at all times acknowledge the role that one's values, beliefs and experiences play in the research process (Smith: 1999). In fact, Rein (1983) argues that values are essential to any enquiry.

My role as a researcher, the analysis of material and understandings and perceptions of the issues are impacted on by my own values. According to Smith (1999) it is possible for Maori researchers to be subjective and still conduct reliable and valid research. I am a young Maori woman with a Pakeha mother and a Maori father. I have been brought up in a mainstream environment with limited contact and access to my traditional tribal structures, but have been schooled in my Maoritanga through those resources, albeit few, but strong within the urban Maori environment. I have trained within a system, that is dominated by Western values and ideals but that has also been at a time that has seen the emergence of Kaupapa Maori theory and methodology. In terms of the subject area, I have two sons, one is 4 years old and the other is 9 months old. During both my pregnancies, I was attended by a Maori midwife, who was also my partner's Aunt. I have had strong whanau support but suffered from postnatal depression. This was not diagnosed until after the birth of my second son. This situation highlighted to me the lack of education and services available for postnatal depression and just as importantly the lack of maternal health services that met the needs of Maori women.

I live in two worlds, within two psychologies and like many Maori I am impacted on by diverse sets of circumstances. These experiences shape my values and belief systems and are the key motivating factors behind this research. Thus the aims of my research are on a variety of levels, personal, social, cultural and political.

I felt strongly about appropriately reflecting my position and role in the research. However, I was unsure of how to effectively and appropriately include my reflections, thoughts, beliefs and experiences as Maori women with postnatal depression. It was not until reading De Souza's (2002) study *'Walking upright here: Countering prevailing discourses through reflexivity and methodological pluralism'* that I

discovered a label for the process of appropriately articulating my position within the research process.

Reflexivity and positionality is about accurately reflecting, acknowledging and critiquing the researcher's multiple positions within the research process. It focuses on identifying and being explicit about the assumptions, histories, and experiences that shape the researchers' approach to all stages of the research.

Lamb (cited in De Souza: 2002) suggests that a process of critical thinking using reflexivity can be utilised to consider the reciprocal influence of the researcher and their participants. England (cited in De Souza: 2002) also states that research is incomplete until it has included an analysis of the researcher's role in creating the research.

Reflexivity can be used as a tool to enhance the capacity of the researcher to be ethical and trustworthy and to enhance the credibility and vigour of the research, making transparent the positionality of the research. Throughout this research I will use reflexivity to identify and critique my own thoughts, experiences and assumptions based on my position as the researcher and as a Maori woman with postnatal depression.

Research Design

The aims of this research are to:

1. Discuss the maternal health issues that impact on Maori mothers, and
2. Identify factors that improve the maternal mental health of Maori mothers, which can be used in the development of a tool to prevent postnatal depression in Maori women.

The following discussion identifies the study design used for this research on Maori women and issues relating to maternal mental health and well-being. My experiences and reflections on my role as the researcher will be discussed and critiqued alongside a discussion of the qualitative methods and Kaupapa Maori and methods employed in

the collection and evaluation of the data. Ethical issues and limitations will also be highlighted throughout the discussion.

There is little available literature on Maori women and postnatal depression. The research that does exist identifies that Maori women are more likely to suffer from postnatal depression (Bridgman & Lealaiauloto: 1997, Webster et al: 1994). Whilst this research design does not seek to confirm prevalence or epidemiological statistics, it will aim to identify issues surrounding maternal mental health and thus provide a starting point for further studies and research into this area.

For qualitative research the issue is not that of generalisability but access. That is the purpose of the qualitative interview is not to discover how many or what type of people conform to a certain characteristic but to gain access to certain cultural categories and to determine how they view the world (Kingi: 2002, p.72).

Qualitative Research Methods

The methods employed in this study design were qualitative, which seemed the most effective technique of ensuring the methods were complimentary to a Kaupapa Maori methodology and theory. Both methods are holistic in nature and focus on an inductive approach to scientific enquiry. The holistic approach of qualitative research values the connectedness of all processes in the research (Patton: 1990). This aligns with Kaupapa Maori methodology and Maori health models that place great emphasis on the interrelationship of all things (Durie: 2001)

Qualitative research methods were also employed for this research in order to gain a wealth of detailed accounts of the relevant issues involved. Patton (1990) claims that qualitative methods allow the researcher to study selected issues in-depth and in detail. '*Qualitative data provides both depth and detail through direct quotation and careful description*'. (Kingi, 2002, p.70)

Through the use of qualitative methods it is expected that the various themes and ideas will evolve as part of the enquiry process. According to Kingi (2002), to accommodate the application of a Kaupapa Maori research paradigm or a Maori-

centred one, the research approach needs to be relatively flexible and dynamic. A broad open flexible information gathering approach that may provide a diverse range of responses, lends itself to a qualitative approach. The specific methods chosen for this research were literature reviews and in-depth interviews.

Participants

The sampling method was purposeful, allowing the focus to be in-depth on a relatively small sample. It also provided for information-rich cases in order to learn a great deal about issues of central importance to the purpose of the research (Patton: 1990).

A major barrier to the research process was the difficulty in accessing Maori women who suffered from postnatal depression. Thus a key limitation to this research was being able to locate participants that have had experience with postnatal depression. This is due to the stigma related to mental illness and the fact that many women especially Maori choose not to seek help. Furthermore many women have limited knowledge or education on postnatal depression.

Participants included:

1. Maori mothers who had suffered from postnatal depression and kuia with knowledge of cultural practices around pregnancy and motherhood
2. Maori mothers who did not suffer from postnatal depression
3. Health/educational practitioners working with Maori mothers

I was reliant on word of mouth and health/educational professionals to gain access to participants with postnatal depression. I interviewed one Maori mother who had suffered from diagnosed postnatal depression and received medical and psychiatric treatment. Two of the Maori mothers were unsure if they had suffered from postnatal depression as they had little understanding of the term postnatal depression. The final mother did not suffer from postnatal depression

Considering the diverse backgrounds and realities of Maori, the data obtained may not deliver many common themes. However, previous research suggests that despite

such diversity amongst Maori, there are some key commonalities (Durie: 2002). Furthermore the aim of this research was to give voice to the experiences of Maori women and to identify some the issues faced by Maori women during the ante and postnatal periods.

While the experiences of one small group of women cannot be generalised to 'all women' embedded within these experiences are features, which, perhaps in a less sharp form, shape the lives of many women (Graham in Milne: 1998, p.30).

Half of my interviews (4) were with health professionals that had experience working with Maori women and could clearly outline the issues of health professionals working with Maori women during the ante and postnatal periods. I interviewed two Maori midwives, one nurse who had worked for a Maori service providing care and education to Maori mothers and one non -Maori maternal mental health nurse who had Maori clients. There was no difficulty locating these participants and they were all keen to participate, although both the nurses acknowledged that the majority of postnatal depression cases they had dealt with were non-Maori. In order to locate health professionals that worked with Maori mothers, forms were sent out to relevant services in order to then arrange a face to face hui if they were interested. A Kaupapa Maori mental health service replied soon after saying they felt that they did not meet the criteria for the participant categories and suggested that it would be better to meet face to face from the outset. Therefore I met face to face with all the other participants to ensure they understood the nature of my research and could ask questions. The iwi health service that was contacted failed to reply.

Finally, it was also important to have some input into the research that came from a Maori woman with Kuia status in the community. The role and information from kaumatua is invaluable when conducting Kaupapa Maori or Maori-centred research. I knew this would be somewhat difficult due to the busy lives led by many of our kaumatua and also the nature of the research content. I was aware that older Maori women might have difficulty understanding what the concept of maternal mental health and the relevancy of their experiences to the issues. This was reflected in my interview with the kuia who at times felt that her experience did not provide enough

important information; she felt that her experiences of traditional practices and beliefs had been tainted by colonisation.

I located two kuia that agreed to take part in the research; however it was only possible to conduct one interview as within the timeframe. However, one of the kuia could not be interviewed as it was during a period where she had a number of other responsibilities and mahi that took priority. I was also acutely aware of the many responsibilities and demands placed on our kaumatua so I did not push for the interview.

Data Collection

Literature Review

A literature review was an integral part of the research process. It allowed the researcher to become knowledgeable and familiar with the research area. I was also able to identify any gaps in the research and it gave me a good basis from which to develop my interview schedule. The most significant role of the literature review is that the information can be used to compare and critique with the information gathered from the interviews.

A range of resources was reviewed including books, theses, journal articles and websites. In terms of postnatal depression the most helpful and substantial sources came from medical journals and websites. Cross-cultural experiences of pregnancy of maternal health were accessed primarily through journal databases and proved very effective. The most difficult information to find was on New Zealand women and postnatal depression, and more specifically Maori women; only a few articles and books provided this information and highlighted a huge gap in research.

Key Participant Interviews

A case-study approach was employed to provide rich detailed accounts of the experiences of each group of participants (Casswell: 1999). A research interview has one primary objective: to facilitate respondent's descriptions and reflections on their

experiences (Opie: 1999). The methods used were aimed at allowing the voices and opinions of participants to be heard.

The key participant interviews were conducted using a semi-structured, open-ended question format that allowed the informants to formulate their own response to talk for as long as they liked and to ask questions themselves. As the research was guided by a Kaupapa Maori methodology the interviews were conducted 'kanohi ki te kanohi' in an environment chosen by the participant. Five interviews were conducted at their homes and four were conducted at work or school. A small koha was given to the participants to indicate the importance of their participation and reflect the reciprocal nature of the research relationship. The practice of 'koha' is described in the literature as an important part of the 'Kaupapa Maori' research process (Bishop: 1996).

The Kaupapa Maori approach also had a direct impact on the interview process. I was known to many of the participants and this created an environment where the participants felt a lot more at relaxed and at ease. Kaupapa Maori research methodology acknowledges the role of the researcher as both 'insider' of a research group and as outsider in terms of the academic research role (Cram: 2001). Two participants (health professionals) asked to be interviewed together. As Maori midwives they often feel isolated in the medical community and felt that being interviewed together would allow them to support each other. The use of Te Reo was used intermittently throughout some of the korero. As the researcher conducting the research from a Kaupapa Maori paradigm it was important to allow the participants to speak in the language that they felt most comfortable and that could best express their ideas.

The questions used were designed specifically for each group based on their characteristics and experiences.

The questions for Group 1 - Maori mothers/no postnatal depression focussed on those factors that support the mother during the ante and post natal period and their negative and positive experiences. The questions for Maori mothers/postnatal depression focussed on the factors that may have caused postnatal depression, the symptoms and

treatment/interventions and the success of those treatments and their feelings on factors that could contribute to positive maternal mental health.

The questions for Group 2 - The Maori health and educational professionals' interview schedule focussed on their experiences with Maori mothers and postnatal depression. It also examined the environmental and social stressors and psychological variables that impact on the lives of Maori women and what have been effective interventions.

The questions for Group 3 - The Kuia interview focussed on the cultural practices and beliefs surrounding pregnancy, childbirth and maternal care and any of their knowledge and experiences of postnatal depression.

The interviews with kuia needed particular consideration in terms of tikanga, but also their physical health i.e. ability to hear properly; they may distrust the use of recording equipment; explanations of the research purpose and questions would need to be carefully worded for their understanding and extra time would have to be allowed for rests if needed. Time in the Maori world operates in a different way to that of the non-Maori world, which means that, it is most likely that certain parts of the research process will take longer than expected (Durie: 2002).

The participants were assured anonymity in the research, with pseudonyms replacing their real names.

Data Analysis

The use of a Kaupapa Maori research paradigm in data analysis means that data is analysed from a Maori perspective, which influenced the identification of relevant themes and key ideas. The method of content analysis was the preferred method involving the identification, coding and categorization of primary patterns in the data and identifying points of comparison with other data and key themes. This was carried out manually. The interviews were transcribed and then analysed. The information was then categorised into questions and then broken down into categories to highlight relevant themes. Content analysis involves drawing out key themes from each

participant's data, coding these themes and then placing them in categories (Patton: 1990).

Whilst the sample size of this research is small, it is still possible to identify themes and commonalities from the data. Given the lack of research in this area, this study thus provides relevant and important insights into an area that requires further research.

Research Reliability and Validity

It was important for the research validity and rigor to have a triangulation within the research. This occurred through theoretical triangulation, by analysing data that provided different viewpoints and theories as indicated by examining material that looked at postnatal depression from a biological, psychological and cross-cultural perspective.

The interviews were transcribed as soon as possible after the interviews so as not to lose the flow and meaning from the information gained in these interviews. The qualitative researcher makes significant discoveries at both the data analysis and the write-up stages, which prompts further introspection, reflection, critique and conceptualization.

Within this research, the researcher is less *'independent and objective but acknowledges his/her place in the research and the meanings and interpretations that both the researcher and the participants give to the research'* (Parker: 2004, p.170). This particularly suits Kaupapa Maori research methodology where the research has no value if it lacks meaning for the participants and is not reflective of their experiences and realities. This method also moves away from providing concrete answers, models or solutions but rather leaves the concepts, arguments and inferences and conclusions up for further exploration, development and debate. Because this research was a case-study with a small number of participants, the resulting information and data was aimed at providing a beginning point or framework for the development of a tool/s that would be effective in the prevention of postnatal depression in Maori women and the achievement of positive maternal health.

Ethical Considerations

Ethical advice and approval was sought and gained from two ethics committees', the Massey Human Ethics Committee and Bay of Plenty Health Ethics Committee (see Appendix Two). Ethical issues of particular relevance to the proposed research included fully informing the participants of the purpose of the research and their role. Participants had to be made aware of their right to withdraw from the research at any time. It was also important to give the participants the right to remain anonymous and to ensure any organisation they worked for would not be mentioned. This was of particular importance because participants were given opportunities to discuss and critique the specific maternal health services and the health professionals in particular wanted assurance that these services would not be identified in the project. The participants were also assured of anonymity through the use of pseudonyms.

Other concerns related to the nature of the topic and my role as a researcher. Because the participants were required to speak about what could potentially be very emotional issues that could lead to further mental health issues, it was essential to provide the participants with the available resources to seek support after the interview. As the researcher I also faced a potential conflict of role, as I was a Maori mother who was suffering from postnatal depression. In order to protect my own safety, it was important that I was able to have support people to talk with about my own situation so that my own issues did not impact on the participants or myself in a negative way.

As the research involved primarily Maori participants and is conducted within in a Maori-centred framework the research was carried out in a culturally appropriate manner, reflective of a Kaupapa Maori methodology.

CHAPTER 4 – THE PERSPECTIVES AND EXPERIENCES OF MOTHERS AND KUIA

Introduction

The aim of the following two chapters is to present the findings from the interviews. There are three groups of responses that are identified in the findings: 1) Maori mothers, 2) kuia and 3) maternal health workers. The findings are presented using a thematic format that includes: social support; maternal health services; treatment; wairua, hinengaro and tinana; and environmental and social factors. These themes derived out of the literature combining both material on postnatal depression as well as a cultural context. This chapter discusses the perspectives of the mothers and the kuia. The maternal mental health workers perspectives will be presented in Chapter Five.

Social Support

In this section the participants' perspectives concerning their experiences and the importance of social support are described. Social support has been described in the research as an important tool for creating positive maternal health and well-being in mothers and also been identified as an effective intervention for the prevention of postnatal depression in mothers (Barlow & Coren: 2001, Brugha et al: 2000, Kruckman & Smith: 2001, Ray & Hodnett et al 2001). Those cultures that have strong social support systems in place for mothers seem to report less cases of postnatal depression (Kruckman & Smith: 2001). I was interested in seeing what part social support played in the well-being of Maori mothers. The mothers' views will be presented first, followed by that of the kuia.

Mothers

In their interviews all of the mothers indicated the greatest and most effective help and advice came from whanau, in particular their mothers. Other areas of support for the participants were friends and church. For two of the participants, a School for Young Parents also provided significant support.

Whanau

Whanau played a huge role in supporting all of the mothers interviewed. The type and extent of support given, however, differed, with some participants such as Maia and Aroha having considerable support from many whanau members, whereas others like Roimata and Nikki relied only on their mother's support. It appeared that the type and extent of support contributed to the participant's adaptation and coping with motherhood, with Maia and Aroha reporting the least amount of difficulty:

During my pregnancy with Hine, I actually broke up with her father and found myself living at home again with Mum. That support [is] just unspeakable, you just know that you've got that home there. Mum's just a rock. Then there's my older sister who had [her baby] first and I was a fabulous Aunty. Because of all that love... that I gave to Ireland, my sister just completely loved my two when they came along. [She] looked after me. (Maia)

I hung out with my brother or just stayed home. I hung out with my Mum and Dad. My Mum and Dad were there for everything and they supported me for everything. People from home, from the marae [gave] me clothes and money to get me on my feet with my kids. My in-laws were there for me, when the Dad wasn't around. My brothers really love my kids; they're like second Dads. (Aroha)

In contrast, Nikki's main support was her mother, who she came to rely on to not only take care of her children but to help Nikki during her postnatal depression. Nikki had some support from a friend but outside of these two people states that her only other support was the maternal health service, Plunket. Nikki's mother and friend cared for her children whilst she was hospitalised and Nikki expressed her disappointment at a lack of support other than these two significant people:

...[I went] home to my mother's and I went cold turkey off the medication. I spent four weeks in bed. When you're going through withdrawal, it's like heroin addicts and coming off was probably the worst time in my entire life, but I did it. She [Nikki's mother] looked after me and my kids, fed me and changed me. (Nikki)

Roimata also spoke about a lack of whanau support, in this instance about the lack of support by the father of their child and his whanau. She spoke with sadness about the effect this had on her and her child:

I had baby but I would of liked his family to acknowledge me as being the mother of his child and to acknowledge my baby as being a part of his family. They just live up the road and they've not once come to see her... She [Roimata's mum] didn't stop them from coming to see her but they've never once tried. I always wanted them to accept me but they just couldn't. It would of helped a lot if they could of just come and seen her. (Roimata)

The descriptions of whanau support reported by the participants indicate that in today's society, those networks are not as abundant and strong as they were in traditional Maori society. Instead with the dissolution of the extended family, the huge increase in solo parenting and the increasing need for both parents and grandparents to be in employment, Maori mothers are left to rely on only a few people and in some cases only themselves.

Friends

Three of the mothers talked about one strong friendship that remained throughout the duration of the pregnancy and afterwards:

I had a really good friend my best friend she was my rock through all that. (Nikki)

I had like one main friend that stuck with me; she took me out still and stuff like that so it was really good. (Aroha)

I had] one friend who stuck with me the whole way... Yeah she's probably my only true friend, the rest of them sort of just went off and did their own thing. (Roimata)

Aroha also spoke of the impact that losing many of her friends had on her well-being when she stated:

You know once you get pregnant and none of your other friends are pregnant, [its] sorta 'ohh she's gonna be a Mum now so leave her alone'... that was the biggest factor for me. It was a big factor for me losing all my friends that I had before. (Aroha)

Church and School for Young Parents

As well as support from a friend, Roimata also reported good support from the church that her family was involved with and the School for Young Parents that she attended:

My Mum's church has been really good. They're always there, if I ever need someone to talk to at home. They're more than happy to help me or come over and see me. They are really supportive. If I ever need help with baby they come and watch her. Yeah they are awesome.

This School for Young Parents has helped so much. I think I would have gone crazy if I was at home, with the baby. It was really good to socialize with other young mothers on the same level.

The School for Young Parents acted as an important social support mechanism, helping to provide the young mothers with an education, work and life skills and most importantly perhaps creating a positive and confident attitude and motivation to succeed amongst the mothers. The school was crucial for the young mothers in helping them to form new friendships, where they could relate to other mothers in similar situations. Aroha also illustrates its significance when she states:

[The school has] been a part of me for the past three years. I've gotten so [many] things through the school, like qualifications for jobs and stuff like that. Now I know I can get out there and do something. [I'm] self-confident and [it's] built up my confidence. Before I started here, I was like, "oh I can't get a job" I have nothing to show them and [I've] never done anything before, but now I can see I can get a job...with my bar managers certificate. You can take it anywhere. I owe a lot to this school...for all the stuff they've given me. For the last few years they've been a major factor in keeping myself positive, motivated [and] confident.

Kuia

The interview with the kuia indicated that whanau support was both important and effective in the past. She suggested that support occurred from "...the whole whanau, we were lucky actually... if any of us were hapu, we were supported by both our parents." With the well-being and happiness of pregnant women was ensured by:

Karakia, by little gifts that were specific to our likes or dislikes. They knew what we liked and they used to buy those things for us. If we were sort of hankering for special type of kai, be it kaimoana or whatever they would make sure that that was available for us. We were lucky.

The kuia also reported that Whangai was common practice to help support young parents. In this instance both the grandparents and extended whanau helped to take care of the kuia when she was growing up, enhancing her childhood and creating a wide set of support systems to draw from. In the kuia's case her name was significant in ensuring that she could link to a wider whanau support system:

I was sort of [a] whangai too, because my grandparents had me until I was about 7 years old, oh no it might have been older, about 9.... I stayed with them and I stay [Ed] with some grandaunt. I was loved by a whole lot of people, not just my Mum and Dad. Probably because I carried my grandmother's name. My grand aunts and my aunts had much love for my Kuia; they wanted to care for me too.

Cross-culturally, many indigenous societies with highly developed support networks of friends and family seem to experience little incidence of postnatal depression (Kruckman & Smith: 2001). This could explain the low incidence of postnatal depression in historical Maori society given the strong kin based support networks. Kruckman & Smith (2001) suggests that social support networks are crucial for the well-being of mothers during and after pregnancy. Both the mothers and the kuia are supportive of the literature given their comments.

Maternal Health Services

There was a diverse response from the participants regarding the effectiveness of the maternal health services provided to the mothers during the ante and postnatal periods of their pregnancy. Whilst, the mothers spoke of a range of services experienced it must be noted that none of the mothers spoke of antenatal education/classes. It is difficult to assess whether this was because they did not attend antenatal classes or whether they did not find that service effective.

Mothers

In the mothers' interviews the range of maternal health services included midwives, Plunket and the hospital. The most important aspect of the services for the participants was the way in which they were treated by health professionals.

Plunket

Three of the four mothers that were interviewed had no confidence in the Plunket service. Plunket is the primary provider of health services and education for mothers and their babies. Two mothers (Aroha and Roimata) stated that they felt Plunket was unreliable and that they had difficulty accessing the service. The third mother (Maia) described Plunket as being “*hoha to me*” and stated that she “*didn’t need them to come in*”. For Aroha, the difficulties with Plunket concerned the location of the appointments and the Plunket nurse being responsive to her needs. Roimata’s concerns related to the Plunket nurse not keeping appointments:

I thought Plunket was pretty sad. With Melanie it’s been easier because Plunket comes here to school, but with my son, I think I only saw Plunket twice. They tell you, ...we come to you...and then once you have baby you’ve got to come to us and make an appointment. It was hard then because I didn’t have any transport and I couldn’t get anywhere. (Aroha)

I just found them [Plunket] slack. They would make appointments to come and see me and they never did, they would always have some excuse. They wouldn’t even bother ringing. (Roimata)

The experiences of these three mothers suggests that there needs to be further improvement in making services accessible to these Maori women and providing services that effectively engage them as Maori mothers. Ellis (1998) and Rimene et al (1998) identified that access to maternity services had been as a significant barrier for Maori. The experiences of these three Maori women with Plunket appear to reinforce Ellis and Rimene’s point.

In a complete contrast, Nikki, the fourth mother interviewed, reported a completely different experience of Plunket. Nikki described her Plunket nurse as extremely helpful and crucial to the effective diagnosis and support for her postnatal depression. She stated:

Plunket [were] fantastic. She [Plunket nurse] was my savior. She picked up on all the warning signs. I ended up in the system and she got the ball rolling and I really don’t think I’d be here without her actually – (Nikki).

The opinions about support from Plunket were varied and may have been as much because of the individual needs of the mothers as the service delivery and the individual relationship that is established between mother and nurse.

Midwives

Three of the four mothers had positive experiences with their midwives, and spoke of the supportive and positive nature of the relationship. Forming a positive relationship between the health professional and client is identified in the literature as essential to effective and appropriate service provision (Rimene et al: 1998). Whilst the mothers did not identify specific characteristics of the midwives it was clear that trust was formed in the relationship when the health professional acted in a supportive and positive way:

With both my kids I had the same midwife. She was really good, [I] already knew her a little bit [and had] a relationship going on. (Aroha)

My midwife was good. She was really supportive and, really encouraging. She always told me I was doing a good job and gave me good advice. (Roimata)

So midwife wise I had three because they were a company of three. So I had three really good ones, they were all senior people and they were really good. I liked that whole team. (Maia)

In contrast, Nikki did not have a satisfactory relationship with her midwife. Nikki related this to the failure of her midwife to take her concerns seriously as illustrated in this comment:

No my midwife wasn't crash hot. Cos I'd told her when I first got pregnant that I'd suffered form depression and I was a bit worried about it, and she really didn't take me seriously. (Nikki)

The Hospital

Maia was the only participant who commented about the service she received at the hospital. She was not impressed with the treatment in the hospital by staff during and after her labor. In her experience the facilities provided were excellent but the attitudes from staff were degrading and their practice unsafe:

The [hospital staff] forgot about me after I had baby. That photo of us that you can see there, I'm actually sitting on a lazy chair. I'm sitting there for half an hour holding baby; you know bliss and all that. I go to stand up and I'm drenched in blood. I'd actually bleed out and so service wise it makes for a good story...It shouldn't have happened and then the dumb cow goes to me, like I'm bleeding and I take all my stuff off, I didn't care who was there, and the nurse comes in and says to me "oh look at this mess you've made". I loved the facilities that they had there, they were excellent for me when I had Hine but there are those, ditsy people, who say silly stuff. It's not my fault that I bleed out, "hello".

Kuia

The kuia felt that services to Maori women are best met solely by Maori organisations – Kaupapa Maori, as she felt that Maori women were more likely to access support from Maori agencies. However it is also noted that in this particular area there are no Kaupapa Maori services that provided maternal mental health care:

I think it would be a lot more effective if [mainstream services] operate separately [from Maori services] because working together sometimes with pakeha agencies is not the same. Our people are not so inclined to tap into those agencies, the pakeha agencies, but if they think it's a Maori organisation or a Maori hauora organisation there's no qualms about seeking assistance from those sorts of organisations.

Treatment

In this section the participants' perspectives and experiences pertaining to treatment will be discussed in length. The experiences for these women suffering from postnatal depression are very important. Only one of the women interviewed received treatment through the hospital. Her experiences are discussed in detail in this section but it needs to be acknowledged that this is only the account of one person.

Mothers

Two of the four mothers commented about their experiences of counselling as a positive intervention that helped with depression, relationship and past issues. Counselling is also noted in past research as an effective method of treatment for postnatal depression (O'Hara et al: 2000, Zlotnick et al: 2001):

I went and got myself some counselling and I've been in counselling for the last two years. My ex-partner and I were going through the family court and I ended up with this counsellor. We ended up getting on and having a rapport so I went back for some [additional] counselling. (Nikki)

I'm going to counselling now to deal with issues that I never even knew were there. It's helped me realise a lot and that a lot that has happened is not all my fault. (Roimata)

Another mother felt the need for someone to talk too that was not from the whanau but did not have access to such a person. Whilst she had a close whanau, this mother identified the need to have an anonymous person to talk too. This supports the need for health professionals to understand that whilst a Maori mother may have close whanau support this doesn't mean that she won't benefit from support gained through other avenues. It is about providing options.

Nikki, the mother that suffered from severe postnatal depression reported that for her the Plunket nurse was the key person in diagnosing the postnatal depression and organising for the appropriate help:

My Plunket nurse... organised for me to go to Mothercraft and she organised [for] me to go for my psych assessment.

Nikki's treatment involved care at a Mothercraft unit situated an hour away from her home. This service is free and provides support and care for new mothers or mothers who are struggling to cope for a period of up to 2 weeks:

I actually went to [the] Mothercraft unit... for a couple of weeks and that was awesome, just getting my son into a routine, just to help me out really.

Nikki was the only mother in this study diagnosed and treated for postnatal depression.

Despite the effective support and actions of the Plunket nurse, she reported that many aspects of the treatment she experienced from mental health services were poor and ineffective. The range of treatments Nikki was offered included medication, psychiatric treatment, and a rest home. In some instances, Nikki felt that the services provided actually hindered her progress:

When I got to the ward I was accosted by one of the patients and that just set me right off and if you've ever been to the old ward, it was hideous, it was dreadful.

Despite Nikki's criticism of the mental health services, she stated that it was the doctor and the midwife that let her down the most. According to Nikki both failed to accurately interpret the signs of her postnatal depression:

I really do believe it should have started with the doctor. I went into the office and I'm very good at just sitting there looking calm, cool and collected, but I was trying to tell him that I wanted to end my life; I wanted to end my son's life. Because I wasn't sitting there breaking down I don't think he took me seriously, so I think that's where it started. I felt he should've offered me a bit more than tranquillisers and anti-depressants.

Medication was an issue that Nikki felt strongly about. She stated that drugs were used as a 'band-aid' approach without thought to other interventions. Medication is discussed in the literature as an appropriate form of treatment for postnatal depression especially postnatal psychosis (Gregoire et al: 1996, Kruckman & Smith: 2001). However, it also illustrates that medication alone is not the most effective treatment but rather a variety of methods appropriate to the client need to be employed (Kruckman & Smith: 2001). In addition medication is seen as more appropriate as a short-term benefit but that other procedures need to be explored for long-term results:

I took myself to the doctor and I basically just received some valium and some prozac, that was his answer to curing me...I was heavily medicated, sedated at night... I have absolutely no faith in the system whatsoever. I think what I needed at the time was not to be shoved into the psych ward without my baby. I needed counselling; I think I needed good food, exercise [and] good support. With the medication the side effects were just horrific. (Nikki)

Nikki's experience with the medical system illustrated that in her case little attention was paid to the cultural, spiritual, physical and social aspects in her treatment. It seems that the health services only concentrated on treatment from a biomedical perspective, which for Nikki as a Maori mother was not appropriate or effective.

Wairua, Hinengaro and Tinana

This section looks at maternal health from a holistic perspective. The Te Whare Tapa Wha model of health identifies wairua, hinengaro, tinana and whanau as the four walls that must be strong in order to have overall positive health and well-being (Durie: 2001). The participants were not aware of this model, however all these domains played an integral part in their experiences as mothers. Whanau was identified as playing a significant role in the lives of Maori mothers and was discussed in length at the beginning of this chapter. This section will focus on the mother's emotional, spiritual and physical well-being and how this impacted on them during the ante and postnatal periods.

A common feature with the mothers was their belief that they had to prove to friends, family, health practitioners that they were coping and did not need help. Even when feeling depressed and upset the mothers were often too embarrassed to seek any help. These characteristics are common in many women when taking on motherhood. Society has always portrayed women as nurturers, carers and mothers. Mothers face many expectations, the most significant expectation is that being a mother comes naturally and all women should be able to cope as mothers. These expectations and beliefs within society contribute to mothers finding it difficult to seek help and offers a significant explanation of the many undiagnosed cases of postnatal depression:

I was pretty good at hiding it, putting on that the house is clean and you're coping. Underneath it all I was just falling apart. I actually knew cos I was crying, and I knew I wasn't having very good thoughts about life and my son. (Nikki)

I didn't want anyone to know that I was finding it hard and stuff, no one really saw it. (Aroha)

I [thought I] wasn't a good enough mother... [but] I always tried to prove everybody wrong, like I could do it and everything. (Roimata)

The level of spiritual and emotional well-being differed for each mother. Whilst all the mothers required good social support to aid them during and after pregnancy, their emotional well-being had a huge impact on their ability to cope and be happy.

Nikki's depression began in pregnancy and after a hard labour she felt emotionally, spiritually and physically drained:

I was finding it really hard to walk around cos I was so big and things were going wrong and I think my depression started then. Spiritually I was just flat. I had a really fast and furious labour and my son was 9 pound and I was just exhausted, emotionally and physically.

Her depression became more severe to the point of suicidal thoughts:

I wanted to kill myself; I wanted to end my son's life because I wanted to get away from the pain. I became really obsessed about cleaning, everything, the walls, the floors, everyday I'd exhaust myself, so I could sleep.

In the end, Nikki felt the treatment from the hospital, psychiatrists and medication led to her being unable to function and it was her own inner strength and belief in her children and her mother's support that enabled her to battle out of depression and gain emotional and psychological stability and strength:

I just knew I wasn't functioning with all the medication and seeing the psychiatrist. I knew I had to fight for my life everyday, for my kids and myself. I just made a decision when I ended up in there [psychiatric ward] to fight a bit harder and not give up. I'd been on the medication for probably about 8 months or so and I stayed at the ward for four days. I discharged myself at a two hour meeting with the registrar and the psychiatrist and I went home to my mother's. I went cold turkey off the medication.

Nikki believed that good exercise, counseling, good support and good food were the key ingredients to achieving well-being. These ingredients show that Nikki required physical, emotional and spiritual help to achieve optimum well-being.

I needed counselling, good food, exercise, and good support. I decided to eat cos I suppose what I was doing was starving myself so I'd get sick and die probably. I just made a conscious effort to fight. I went and got myself some products from the health food shop and had a special diet made.

Roimata reported that she suffered mild depression and anxiety:

I thought in the beginning it was alright. I was kind of happy but then later on it sort of hit me, that I was going to ruin my life basically and how would I achieve anything with a baby...I suffered, I still suffer with anxiety which is when I'm around too many people, I get all sweaty and nervous, anxious.

After I had baby [the anxiety] was pretty bad, but I thought I must of spiritually picked it up off my baby's father because he has anxiety. I thought I must have got it off him. It's like a whole lot of little comments just play in my mind that [I'm] fat and just not so attractive. [My] self-esteem levels went really down.

Roimata, Aroha and Maia gained emotional strength from their babies and the unconditional love they provided. Their children were also strong motivating factors in these mothers making something of their lives and achieving success. These comments indicate that well-being for these mothers is not just about surviving day to day but clearly these women understand and desire to have a positive and successful future:

She makes me happy. I always look forward to coming home to see her because she loves me...I guess that's what I wanted was just someone who can accept me for who I am and she does. [She] learns new things everyday and it's really exciting and gives me heaps of hope. Gives me motivation to be the type of person to do something with my life. (Aroha)

Spiritually, I suppose [motherhood] sort of gave me a sense of grounding, put me in my place. I don't just have myself to look after anymore; I have someone else that's depending on me. I know a lot of people and plus myself [that] didn't have much motivation to get things and that's [where] I've changed heaps. That's what I'm going to do with my kids, I'm gonna make that better for their lives later on. (Maia)

Aroha gained emotional strength from:

... the thought of having someone else to give love too. This baby's mine and being called Mum and all the people that were happy by me being pregnant and just seeing the joy on people's faces. You wanna work on yourself to make life better for your kids.

Aroha also felt it was important for her children that she remained happy and positive regardless of her situation, in particular the lack of involvement from her partner:

If I'm upset about him not being there, then the kids will get upset because I'm pissed off. So I just have to keep up, [being] cheerful. Thinking about how my kids would be if I was down in the dumps, depressed and shit. So that kinda kept me positive.

Maia was feeling insecure and lost before pregnancy and despite a dysfunctional relationship with the partner became pregnant. Despite this, however, of all the

mothers, Maia's experience of pregnancy and motherhood was the most positive on an emotional and spiritual level:

Even before the pregnancy, my relationship wasn't working out, I was kind of lost and insecure and then I think that's even why I got pregnant...I had made my relationship my whole life and that was falling to crap and what was I supposed to do. Emotionally, physically and spiritually I was completely depleted.

Maia was feeling depressed before the birth of her babies, however being pregnant and giving birth provided Maia with joy, purpose and a will to move on:

I have to say with Hine the whole experience of being pregnant, it gave me purpose...you just knew you couldn't [get down] because I still had Hine. I think that's the beauty about women that survival kicks in, instinct, that mother kind of thing. You just do it day by day.

Physically it [being pregnant and giving birth] was just wonderful, it really was. I really loved it, it was just amazing, all of a sudden I knew my body had that purpose and for a woman it is to give birth... I loved that afterwards it was amazing, even though it was sore to walk down the street; my body did the job it was meant to do.

Maia had a few spiritual experiences with her birth and found a sense of spiritual fulfilment through the practice of gratitude. Maia's comments also emphasize how effective spiritual grounding was in her well-being:

There's a card somewhere from a friend of mine, she's this Pakeha women and it had this karanga for a female baby in it. I ended up reading that, just out of the blue when Wairua was born, and Mum was like wow how did you do that because all of a sudden there was this freshness in the air. I don't know, I just kind of instinctively did it.

One thing that I learnt [from motherhood] spiritually was being grateful. I don't live it all the time but it's something that I try too. It was during the time that I had Wairua that I started to really experience and try and live that and tried to apply it. So it was starting to live a life of gratitude rather than what I missed out on and try and concentrate on what I did actually have and then feel blessed by it.

Maia also found gaining her independence through living on her own and engaging in positive activities like walking and artwork enabled her to feel more confident and happy:

I got my own place that was a great feeling that kept that momentum going. That was the first time I had a house on my own, so buying furniture for it was like a new buzz and like you got an old fridge from the op shop but you're so proud of it.

What really came out of being in [my own] house for me was I discovered that I actually liked art. I started doing all the mosaic things that you've seen. I think art kind of saved me [and things] like writing, DVD's and the movies. I was [also] in awe physically of everything as well [and so] I started walking everyday.

On reflection Maia felt that in order to get through the difficult times she had to make a conscious choice to be positive and look forward. It was these characteristics that defined Maia's experiences of motherhood:

Looking back [on motherhood], it's because I choose to look back on positive things. If I wanted to I could concentrate on the nights of crying that I did have because their Dad wasn't there, but it would only just lead to more crying now. I choose to [be positive], otherwise the girls would be a burden, otherwise my life would suck, otherwise what's the point. So you do have a choice, you can choose not to and you can choose to and I choose to because I quite enjoy it. Like every other Mother you still have your moments, but that's normal.

The experiences of these mothers indicate how important emotional, spiritual and physical well-being is to their overall well-being, their ability to cope with motherhood and to overcome depression and anxiety.

Environmental and Social Factors

This part of the findings focuses on the social and environmental factors that impact on Maori women as they embark on motherhood and the impact that a lack of partner and a stable relationship has on their well-being. The kuia's views cover a range of social factors, which impact on Maori mothers.

Mothers

Lack of partner

Although the mothers did not attribute environmental pressures like alcohol and drug abuse or violence to their maternal well-being, they did feel that the lack of a committed partner and father to their children caused huge emotional distress.

All four of the women interviewed had partners that were not fully committed to the role of partner or father. The relationship troubles went to the heart of the negative feelings and experiences associated with being mothers, causing the mothers to feel down and low. However despite these difficulties every mother found the strength to keep going, this was largely related to the need to provide a better life for their child/ren:

I was pretty down. Apart from my mother I wasn't really getting the support from my partner. My partner and I weren't living together, so I was on the benefit and I was on my own more often than not and it was tough. (Nikki)

Their Dad wasn't around most of the time. (Aroha)

[There were a lot of issues] with my baby's father and my Mum, sort of like this battle and I was just in the middle. I was just so much younger than he was.... My Mum stopped him from seeing her [the baby] because he is an alcoholic. (Roimata)

I didn't have a partner so that made that whole single mother thing, it's not meant to be this way, like it's meant to be all fluffy ducks. But that wasn't even a downer either it was just one of those things you had to get through. (Maia)

Culture

Aspects such as whanau and karakia were spoken about by Maori mothers and noted implicitly throughout their discussions. However, at the conclusion of each interview all of the mothers were asked specifically if they would have appreciated learning more about their culture, in particular Maori maternal health practices, during their pregnancy and in motherhood. Three of the four mothers said yes.

Kuia

Lack of Partner

The kuia also remembered a whanau member that suffered from postnatal depression which she believed was partly the result of the relationship with the father:

I think my great grandmother suffered from post-natal depression and I think I can put that down to, not so much to the fact that she was hapu or having children, it was more the fact that she knew my great grandfather wasn't exactly true to her and I think that probably sent her sideways.

Poverty

The kuia felt that poverty was a huge issue for Maori families and being able to provide the basic necessities such as food for their children. The kuia was part of the Maori Women's Welfare League, which tries to help such families by providing food parcels:

Social issues are not having enough money to even buy kai. I mean we have rallied around a few of our clients. Actually it's hard to believe you can only get three food parcels from food bank and you have to have some sort of criteria before you can have it. In some cases we can't wait to do that so we have to ring around our women and they supply what's required and we drop it off to them. They've come from broken homes, where drugs are prevalent and other things and where they're treated not very well, that impacts on [Maori mothers] self-esteem.

Summary

The participant interviews provided important information on key issues relating to Maori women during pregnancy and through their journey into motherhood. Whilst the interviews contained different perspectives, that of Maori mothers and kuia, significant themes and commonalties arose from the data.

Social support is a theme that is covered in the literature and was of significance in the interviews for both the Maori mothers and the kuia. For the mothers the most

influential and effective form of support came from their mothers and a key friend. This highlighted the lack of social support that was available to the mothers due to less involvement from extended whanau and friends. The interviews with the mothers showed that community organisations like the School for Young Parents and church groups provide an important source of advice and support. The Maori mothers seemed to have more faith in the support, education and advice they received from such social support systems rather than the maternal health services. Whilst, the mothers had positive relationships with their midwives, three of the mothers were unsatisfied with Plunket and none of the mothers spoke about attending antenatal classes. A number of explanations were provided for this; Maori mothers had trouble relating to the people working in these services, lack of transport, lack of knowledge and the services being seen as culturally inappropriate. The interviews with participants acknowledged that the current services were not adequately meeting the needs of these Maori women in terms of education, delivery and support. This can result in misdiagnosis and under diagnosis of postnatal depression in Maori women. It also means that not only are many Maori women not being treated for postnatal depression, they are also not being provided with appropriate education around treatment.

The mothers identified the impact of whanau, social, physical and mental factors on their maternal health and well-being . According to the one mother that suffered from severe postnatal depression these factors were omitted from her treatment process. Furthermore, those were the exact things that eventually helped to heal this mother. These included exercise, good nutrition, counselling and whanau support. Instead the medical system relied primarily on drugs and psychiatric intervention.

Finally, for the Maori mothers the most crucial social factor affecting their maternal well-being was clearly the lack of a partner, contributing to both the relationship and the parenting.

CHAPTER 5 – THE PERSPECTIVES AND EXPERIENCES OF MATERNAL HEALTH WORKERS

Introduction

Recent studies have identified that for maternal health services to be effective for Maori women, health professionals need to have a relationship with Maori women based on respect and understanding of the diversity of life experiences, influences and circumstances that impact on Maori women and their health; and an understanding of Maori cultural patterns, practices and preferences in relation to maternal health (Ellis: 1998, Rimene et al: 1998 & Ryan: 1995)

The aim of this chapter is to present the findings from the interviews with the maternal health workers concerning social support; maternal health services; treatment; wairua, hinengaro and tinana; and environmental and social factors. The chapter concludes with a summary of the main findings from the interviews of the maternal health workers.

Social Support

The biggest factor that the four health professionals interviewed identified from their experiences of working with Maori mothers, was the impact of having support during and after pregnancy. All of the health professionals interviewed reported that those mothers with whanau support or strong support networks coped far better than those who were alone. Moreover, when they were asked to comment on factors that impacted negatively, all spoke about a lack of appropriate support.

The health professionals described social support in fairly similar terms to the mothers and saw it coming from whanau, friends and other mothers. For them, whanau support was the most important form of support for Maori mothers during the ante and postnatal periods. That said, each participant stated differing reasons why whanau support was important. For Joy, whanau support was important because it was on the “positive side” for Maori and was counter to the negative statistics and perceptions of Maori. Whereas Robyn and Diane tended to emphasise the positive

practical and the emotional dimensions of whanau support for mothers. When asked about the positive factors for creating well-being Robyn stated that these would include:

A supportive whanau or some people around the house that could help, especially afterwards, especially with the baby. You know time out that kind of thing. Sleep, getting sleep is really important. I guess being able to access services offered within reach of the women concerned. She might have had people in her whanau who have been through similar situations so would be up with what needs to happen. Developing other support networks with other Mums too is a really big factor. Being able to talk about your experiences and sharing them, yeah, with other Mum's. (Robyn)

Diane reported that a connected whanau support system that provided emotional and physical support for both the mother and the child was a key factor in preventing postnatal depression in Maori mothers. She said that in her experience:

If you get a whanau that is really connected as a family that has a huge impact. A Maori [mother] that has their family around them often doesn't actually get post-natal depression. They're really well supported, they get breaks, and there's heap of family involvement with that child. (Diane)

In contrast, the lack of appropriate social support was perceived by the maternal health workers as a significant obstacle to the maternal well-being of Maori mothers. Robyn illustrated this point when she said:

If there's no whanau support it's a huge factor. [In] the cases we've seen it's probably been a younger member, or a younger teenage Mum, that might have separated from the whanau, due to conflict or whatever. They don't have the whanau around for support or friends, someone in their situation and [they're] also a bit reluctant to say, "Yeah, you know I need help" as well. (Robyn)

Robyn also made the point that whilst she as a health professional could identify symptoms and the behaviour that indicated if the mother was coping, whanau were also important in understanding how the mothers were coping. For her, whanau were often better able to provide insight into the mother's emotional well-being:

You can see signs of how [mothers] are bonding or how involved [the mother] is with the care, what support is around her and what she is reaching out for as well. We often rely a lot on whanau members to actually talk to us from her point of view because often asking some women alone is not enough. (Robyn)

During her interview, Diane expressed concerns about whether the lack of diagnosed postnatal depression in Maori women was because they are well supported by whanau or that they had trouble expressing concerns about their situation in front of whanau members:

I wonder sometimes whether it can also be difficult for [them] to be expressing what's going on. I haven't actually come across a lot of Maori or picked up on a lot of post-natal depression but its just things that you wonder about is there opportunity for them to express it as there's a lot of people around or is it you know that they are well supported and that's what they do they actually talk to their family about how they're feeling. (Diane)

This comment raises the point made by Kingi (2002) who asserted that health professionals need to realise that as well as identifying that whanau is integral to the well-being of Maori, it is equally important for them to determine the best role for whanau. In some cases this might mean that clients have less involvement with whanau if it makes them feel uncomfortable about being open and honest.

In this regard, Diane also reported that it had been her experience that Maori mothers often had other whanau members involved in the care of the babies and that this presented a challenge for health professionals needing to provide education to all the whanau.

Whilst, whanau was identified by the health professionals interviewed as the primary and most effective form of support for Maori mothers. Robyn considered home help as a “big factor that helps” mothers who are “struggling to cope... with the demands of housework, dishes and all that stuff.” She also reported that her service as well as encouraging support with housework also found “childcare... [a] really useful support” for the women.

Maternal Health Services

In this section the participants' perspectives concerning the efficacy of maternal health services for Maori women will be discussed. There was a diverse response from the participants regarding the effectiveness of the maternal health services provided to the mothers during the ante and postnatal periods of their pregnancy.

There was a range of issues that emerged from the four interviews relating to health services. The two midwives (Kiri and Joy) interviewed spoke about appropriate training and education within maternal health services. All of the participants discussed issues regarding collaboration with Maori and who are the best people to deliver maternal health care to Maori women. Finally the four maternal health workers also identified issues around access to services. These issues are also discussed extensively in the literature when looking at appropriate health service delivery to Maori (Ramsden et al: 1990, Ratima et al: 1994).

Maternal Health Workers

Appropriate Training and Education

The two main areas discussed by the maternal health workers within the area of appropriate training and education for maternal health workers was professional development and cultural safety.

Professional Development

In the two interviews with the midwives, training and education centred on the need for continual, relevant and appropriate professional development for maternal health workers. This professional development was regarded as particularly important in the area of postnatal care, breastfeeding and working with Maori clients.

Kiri, a trained midwife, felt that independent midwives needed further training in appropriate postnatal care in particular breastfeeding and on postnatal depression:

Independent midwives need to make more of a commitment to [postnatal care]. I think it's really disappointing the way some independent midwives practice. They're not interested in breast-feeding so it's really sad, they just do the delivery and that's it. Where as in actual fact post-natal [care] is actually the most important one.

The midwifery training should be extended because all midwives should be lactation consultants. It's difficult to become lactation consultants because you've got to have so much clinical experience before you can do it. You've got to do hours of clinical experience but I think that they could do a two-stage thing. Where they start at the [with the] theory and then they follow up with a

practice. In all honesty it wasn't until I started doing [lactation training, that] I learned to sort of change my attitude and I've got a passion for it now. (Kiri)

Joy also agreed with Kiri that midwives needed to have extra support in order to deliver more effective postnatal care:

They need to be looking at having the extra supporters for professionals and independent midwives. Having that extra post-natal back up because it's hard being on call 24-7. The recommendation is that you should only take 6 women a month, that's the college of midwives recommendation, but the reality is that there aren't enough midwives. So you're taking on more right? And so those pressures are higher on you as a person and we are Maori women and we've got our own whanau at home and post-natal depression stuff to deal with. (Joy)

Joy not only felt the stress of the demands required by a midwife but also as Maori women with commitments to whanau. Joy also spoke about professional development being left to the responsibility of the individual rather than the employer. However she noted that where she worked, the midwives organised such training as a collective:

From a professional point of view as an independent midwife there is a review process that we go through. One of the criteria is to maintain ongoing education. Ongoing education with post-natal depression, that becomes our own responsibility to maintain for ourselves as professionals. The sad thing though is that if there was a study day on post-natal depression someone has to do that, somebody has to organise it. That's one thing we do as a collective, we put together those study days, somebody would co-ordinate it and get somebody to come and talk to us. (Joy)

Cultural Safety

Issues around cultural safety were reflected throughout the interviews with the maternal health workers. Kiri and Joy felt it was important that health practitioners recognised that Maori are diverse and should not be treated as a homogenous group. The literature also reflects the diverse nature of Maori society, and their different needs, expectations and desires. They reflected on the way in which Maori women were differentiated from Pakeha and the expectation that all Maori mothers would want to be together in the wards. This emphasises the importance of health professionals refraining from making assumptions or generalisations about Maori clients:

There was always one side for all the well off Pakeha ladies and then all the Maori were sent down to all the [other] rooms. Sometimes that worked and sometimes it was, you know, whoa. Because they label us, they think we're all the same, where as in actual fact I could be a very dark Maori woman but not identify as one. They probably think, 'oh whanau whanau, put them altogether'. (Kiri)

Kiri also mentioned that there is a lack of motivation from New Zealand staff in comparison to English midwives to undertake appropriate cultural training. Cultural safety training and Treaty of Waitangi training has become an essential part of training within health services. This comment indicates that New Zealand staff needs to be undertaking such training. More research may need to be conducted to discern whether New Zealand staff are engaging effectively in this training and how it may be improved:

Interviewing English midwives; they actually know more about the Treaty of Waitangi than [New Zealanders]. They've heard about it before they came here and they read all about it when they get here. They're really keen and as soon as they get here enrol in The Treaty of Waitangi [courses]. I've had a hell of a job getting staff that have been here for 10 or 15 years to go. (Kiri)

Who should deliver maternal health care to Maori mothers

All four of the participants spoke about who they thought should be working with Maori mothers. Kiri and Joy acknowledged that Maori mothers could display a range of behaviours that could only be understood from a cultural viewpoint, which could cause difficulties for non-Maori with limited education or understanding of these cultural dimensions. They noted however that it could also lead to Maori mothers going to non-Maori professionals in order to hide their situations. Durie (2001) notes in his research that whilst Maori are diverse they can also have common characteristics. Whakamaa is a concept that often describes the characteristics displayed by Maori especially when dealing with health professionals. This can come across as being shy, non-committed, and reserved. Furthermore if the client is suffering from a mental illness, they may also present differently than non-Maori in terms of behaviour and symptoms (Durie: 2001). Joy also mentions however that truly understanding the client can also act as a barrier if the client is afraid or unwilling for the professional to know about their situation:

Some [Maori mothers] are very good at just saying what they need to say rather than actually what they have. That comes down to the relationship they have with their caregiver. The work ratio that I've always taken as a midwife was around the 95/ 98 % Maori and I get on well with most of them but then there's still a lot that teko to you or that are hiding something. But do you risk facing that as a professional and do you risk that you may not see them again through the rest of the pregnancy. Or do you just keep it in the back of your head as a professional and be aware of what's going on. They're not wanting to share with you but at least they still come in and have regular care. They have to perceive that you're on their side, cause mate if we muck it up, we won't see [them] again. That's why I reckon a lot of Maori women will go to non-Maori professionals because they can hide themselves better. Generally speaking there's no insight [by Non-Maori] and they can tell [them] what ever story they like and [they don't have] a clue. (Joy)

I looked after a lady and with her third baby she went to somebody else, a Pakeha midwife. She said to that midwife I really like my other midwife but she carried on too much about smoking. (Kiri)

Diane also felt that another barrier to appropriate maternal healthcare for Maori mothers was health professionals not accurately assessing the most appropriate way to deliver material to Maori women:

I think [as health professionals] you're sometimes starting at a different level [with Maori mothers]. I also think sometimes that there are health professionals out there that don't bother to explain things. (Diane)

Collaboration between services

In the 1980s the government put in place policies and initiatives to improve the health sectors responsiveness to Maori (Ramsden: 1990, Ratima et al: 1994). A result of this action saw health services having to improve their delivery at all levels from policy to practice. One process was ensuring that appropriate collaboration and consultation took place between health services, and their local iwi and Maori community. Simultaneously a move was also made by the government to assist Maori in providing their own health services to their communities. Robyn felt strongly that maternal mental health services for Maori women could be improved by effective collaboration between mainstream and Kaupapa Maori services:

[Cultural input] would be a huge benefit to us. I would like to see more Marae based services being run and we could do weekly or monthly visits to do education and help support the workers there. I think that would be wonderful and it would be great even if [Maori mental health service at the hospital]

came on board a bit more too and got a worker that could work with us out there in the community, especially on maternal issues. (Robyn)

The maternal mental health service is a very new initiative within the hospital in this area; the community have yet to establish any such services but Robyn sees the collaboration between hospital and community services as vital:

[There needs to be] more availability for [Maori mothers] to talk about feelings, talking with other Mum's as well, so a lot of Mother's groups, parenting type groups. [They] seem to have a really positive impact. Marae based would be really beneficial to the preventing or treating mental health, maternal mental health issues. More awareness out there and having a resource person within each kind of iwi that might be able to be there to talk or recommend services [would be good]. (Robyn)

Access to services

Access to services and information were difficult for the mothers because of issues such as transport, whakamaa, distrust, isolation and money. Maori mothers seemed to be particularly wary of support groups, seeing them as mostly made up of middle-class white mothers whose experience of motherhood differed greatly from their own. The health professionals highlighted the need for the development of support groups, which enabled Maori mothers to have access by providing transport, a culturally safe environment, information, education and support in an appropriate and relevant way to Maori mothers:

There's not enough support groups but having said that I think one of the biggest issues [for Maori mothers] when it comes to support groups is that [they're] whakamaa, being shy. [They] won't even talk to their own whanau, what make you think they're going to talk to strangers? Or there's no transport to get there or there's every excuse under the sun not to actually deal with the issues that are holding them back. (Joy)

Robyn highlights the difficulties for Maori women in attending support groups but obviously sees benefits in such groups for Maori women:

Some Maori women are reluctant to come in and attend group kind of processes. [They're] not feeling comfortable enough in asking for help or acknowledging that there could be a problem. That often holds people back from getting the treatment that they are entitled to. Another factor is money, because accessing these sorts of supports is not cheap. There is [also] room for conventional as well as traditional treatment. (Robyn)

She also felt strongly that many Maori mothers are not aware of the services available to them and their entitlements. In the following excerpt Robyn speaks of the current services being made available in a way that primarily suits Pakeha and that these services are not reaching Maori women and the communities they are part of:

A lot of women don't know what's out there in the community. We make people know that they can access our support and that it's ok to access help. Knowing what's out there like Parents as First Teachers, Plunket's a big resource if it's used correctly. The same goes for WINZ (Work and Income New Zealand) and the benefits and the disability allowances that can pay for counselling [which many] people aren't aware of. (Robyn)

I also think that there's a cost involved. There are some very good counsellors but you can't afford to go to them. If you needed to go once a week it's very costly. They do have groups around but some Maori women won't go to the Maori support groups because they're afraid. They're scared that it won't be confidential and it will all get passed on. (Joy)

Diane also saw access as a significant barrier to providing effective support for Maori mothers seeing appropriate people in support positions is essential to Maori mothers accessing services:

Access to services [and] having the right people. You can have all the services in the world but if they are not good services well then they are not actually meeting the need. When you are looking at complex stuff, it's got to be someone that [Maori mothers] can actually relate to. I mean you're not always going to get it right but there are personalities and there's cultural stuff. Maybe a Maori woman might better cope with talking to a Maori about post-natal depression experiences. Certainly to expect [Maori mothers] to come out of their environment and go somewhere is just not working. (Diane)

This discussion on services highlights that support groups can be an effective tool for creating positive maternal well-being but also identifies that the current support groups available are not effective for Maori women.

Treatment

In this section the maternal health workers' perspectives and experiences pertaining to the treatment provided for maternal mental health issues will be described. The

maternal health workers spoke about a range of treatment options based on the needs of the mothers and the severity of their postnatal depression.

Services

From the maternal health workers' perspective, treatment came primarily in the form of health services and medication. Robyn spoke about the range of treatment options available to mothers with postnatal depression, including the psychiatric ward.

However, Diane felt that the ward was not an appropriate place to treat postnatal depression. All four maternal health workers felt that medication could be effective in the treatment of postnatal depression. The two midwives also noted however that Maori mothers often felt stigma about taking medication and that more appropriate education was required on medication for postnatal depression.

Robyn outlined the process if a mother needed to be admitted into the psychiatric ward:

We will look at hospital admission. If it's a safe environment the mother may be with her baby and what we do in that case is they make the family/whanau room available to stay, where people can stay over with the Mum and we can also get a nurse to be there 24 hours for safety. The other option is to go to the in-patient psychiatric unit. In which case, the baby, for safety reasons, is not allowed to be admitted with the Mum. We would rely if we can on whanau/family to care for the baby and we work out a plan where baby can visit Mum in the ward several times a day, especially when she's breastfeeding and when she's maintaining that bond. If it's a really severe kind of psychotic episode we may [give] Mum more medication in which case it's not safe to breastfeed. (Robyn)

On the other hand, Diane however felt that the ward was not an appropriate place to treat mothers with postnatal depression. Durie (2001) and Rimene (1998) state that Maori women are more likely to delay getting help and do not see a psychiatric ward as an option:

As far as the ward system I would hate to see any mother with post-natal depression being in the wards. It's kind of like you almost want the mental services in categories, maybe a separate floor for post-natal depression. (Diane)

The mother's home is in fact the preferred option by the maternal mental health team for the treatment of postnatal depression. This ensures the mother is in a familiar environment with her baby:

Treating at home is our first option if we can. Mum might go home with baby and we put a nurse in the home. That can be 24 hours a day for possibly up to about two weeks depending on what staff we have available. We always look at the risk factors to, if there are issues, risk to self and baby, we have got to look and maybe admit [to hospital]. (Robyn)

For less severe cases of postnatal depression or where a mother may just need support initially with her baby and developing routines, she can attend a Mothercraft service or a church-based service several hours drive away:

If there's no severe issue the Mothercraft unit can deal with the mum and baby. Luckily it's free. [The mothers can go] Monday to Friday and come home in the weekend. I have known some to go for about four weeks but that would probably be at the top end of the scale. Most women that I have met have found about a week to two weeks to be enough just to get into a good routine with their baby and work on anxiety or depressive issues. They often medicate too because they've got a psychiatrist liaison team that works closely with Mothercraft, so it's quite a safe environment in terms of the mental health side of things. There is also a place run by the Salvation Army that can actually support, especially young mothers and their babies. The [mothers] may be having difficulties with parenting and need a little bit of extra support and that can be a live in situation for up to about six weeks or maybe longer. (Robyn)

However for all these services Robyn stated that Maori women were more reluctant to make use of them because it requires them to be separated from their whanau:

I do find that there's a bit of reluctance, because from our angle [they've] been separated from the whanau and that's a big issue. So to be honest Maori women [are] probably a bit reluctant, we'd rather they stay here and do what we can. (Robyn)

Robyn reported that there needed to be a centre for mothers locally to provide education and support, which might enable Maori mothers to have better access and feel more comfortable:

Another thing that would be brilliant would be a place where Mothers and babies could go to here, like a drop in centre where you can just go during the day, or even at night. I don't know if that is possible but having something out there for Maori women would be a big factor. Even with the maternity ward,

it's often too small and cramped and women have to be out of there within a couple of days. [The hospital is] only actually funded for 48 hours providing [the mothers] have no complications, so that's not really a lot of time to gain some of that knowledge and support. (Robyn)

Medication

The maternal health workers interviewed suggested that medication with appropriate education and monitoring could be effective in treating postnatal depression and that Maori women need to be informed about this.

Both Kiri and Joy highlighted that Maori mothers often have stigmas against taking medication:

One of the women that I dealt with that had post-natal depression didn't like the idea of medication. I think because there's another addiction, that taking of that tablet. I think the other thing too is being labelled and then being abnormal and maybe the thought of being institutionalised. If they go to the doctors, the first thing they do is put them on medication and then they will come back and say, "I don't want to take these tablets." (Joy)

Part of it is [the mothers] don't understand the medication and the doctors don't often explain it very well to them so they just fight it, they think it's going to change them. (Kiri)

Robyn felt that medication was especially important when a mother was suffering from severe postnatal depression or postnatal psychosis, but she also identified the risks and side effects when taking medication:

A lot of the new medication is not researched enough to know what the side effects are so in that instance unfortunately the Mum has to often bottle feed the baby. Medication does have its place as well especially when there's quite a severe depression or psychoses going on, you want to get the women better a lot quicker.

With the side effects some women have to stop breast-feeding and it's obviously a really important part of motherhood and bonding. I have noticed that some women [are] really unhappy to take the medication because of that. You always do a risk/benefit type analysis in those situations and if there are huge risk factors towards the baby if Mum's not medicated, we need to kind of weigh that up. I have seen really positive and some not so positive [outcomes of medication]. The negative side of it is whereby it may affect your energy levels a bit, being a bit more tired. (Robyn)

Diane indicated that those mothers who used medication responded more quickly than those who didn't, however she also noted that mothers were still able to heal without the use of medication:

I think medication is really really good, with all the mood swings and all that, it just stabilizes it. I think the ones that do go on medication respond a lot quicker than the ones that don't. It doesn't mean you can't do it without medication.

Wairua, Hinengaro and Tinana

The Te Whare Tapa Wha model of health identifies wairua, hinengaro, tinana and whanau as the four walls that must be strong in order to have overall positive health and well-being. The health professionals were aware of the need for a holistic approach to care and treatment and spoke of the need for mothers to be cared for physically and emotionally. However, there was little mention made about the place of spirituality as a component of healing.

The Maori midwives acknowledged the effect of breastfeeding and proper postnatal care on the physical well-being of both mother and baby. It was noted that unlike traditional Maori society there was now a lack of appropriate care taken in the postnatal stages:

One of the biggest issues with Maori women is breastfeeding, it's the girls mother, the grandmother, because they want to have the moko for the night or a couple of nights... and then they go on the bottle and you know baby takes the bottle a lot better, so it's sad really. The mother needs to go with her, and go with the baby so they breastfeed. (Kiri)

Or the other thing is that [the mothers] want to get out and party again. I've seen that when I've been at a night club and you go to the loo and you see somebody you just birthed them or you know Kiri's birthed them and we're in the toilet and she's busy telling me how much milk she's expressed. Her babies only 2 – 3 days old and I'm thinking what and then [the babies] get sick. When I had my baby, man, I wasn't allowed to leave the house, my mother never left the house and we hardly ever stay home now with our little babies. We have found that it has to be two weeks for baby to be established on the breast. (Joy)

Joy spoke of what it was like for Maori mothers in traditional Maori society. She noted in particular that women spent time after the birth, recuperating, being looked after, establishing breastfeeding and healing:

Traditionally for Maori it was 40 days; 40 days where they lived together and someone would look after the mother who's just had the baby. They would be looking after the baby, but the baby would be fully breast-feeding. That's another issue too, is that their partners weren't allowed to touch them for 40 days. There's no pressure, but also it's allowing that time to come strong again and that's around a 6-week period. When their body gets back to normal, traditionally that mother was kept separate from her partner to help her heal. It's all the natural contraception stuff and that's a good form of contraception. You know you're naturally supposed to nurse your children. (Joy)

The maternal health workers placed significance on the impact of a positive emotional well-being to the overall well-being of the mother and baby. The development of self-esteem and motivation were identified as key factors in enabling mothers to cope better and succeed:

I think one of the biggest factors is self-esteem; they know that they have that well-being within them. If they're depressed or they're in an abusive relationship, if there's good self-esteem, there's recognition of why they're not feeling well and then making those steps towards becoming well again. I think that is a self-esteem issue. There was one lesson that I learnt, as I got older I made a decision for myself that I'm actually worth something and I'm worth more than what I was getting and until women can recognise that in themselves there's not going to be a lot of change. (Joy)

The Maternal health workers also noted that it was hard to distinguish with Maori women whether they had postnatal depression or just general depression. Postnatal depression is more likely to occur in women that have suffered depression in the past. It is possible then if maternal health workers have noted a general depression in these women they may also be suffering from postnatal depression.

The other thing really to recognize when were talking about post-natal depression is that it's a life depression so it's not only post-natal depression, [Maori mothers] will be suffering from some degree of depression. If there aren't very good family dynamics when they were growing up, they tend to do the same cycle that their parents did. (Joy)

I found that a lot of Maori women didn't know what post-natal depression was, they didn't know whether they had it or not. In the time that I did work

with Maori families I was recognising that I actually hadn't actually seen a lot of Maori women presenting a lot to me.... The majority [of] women that I saw had a lot of kids so I think a lot of the time you forget about the post-natal depression stuff because there's so much going on. The depression, you can see that but if you are talking with a Mum about post-natal depression, I don't think that they could actually grasp that. We actually find ourselves in the same position where we actually overlook post-natal depression for the depression is there anyway. You can see that they maybe feeling down for financial reasons or relationship issues and things like that. I know certainly if you bring post-natal depression up with them, it's a foreign concept to them. (Diane)

Robyn and Diane spoke of the way Maori women present when they are depressed. Symptoms included silence, lack of engagement with whanau and baby, and being withdrawn:

What I generally look for is someone who's a little bit detached, Maori women might become a little bit detached from her whanau or unwilling to communicate and withdraws a little bit. That's the main issue we often look for and usually you can tell by observation in terms of the level of mood. We would often look for how the mother is interacting with her baby. (Robyn)

In Maori women you can see all the tension but you know they're not complaining. With Maori women you can notice stress. I don't know whether they present anxious. I guess they just have different functioning. With depression it's probably just that silence, so it's not verbal. Maori women they naturally carry on really well with children, they cope, they multi-task really well. (Diane)

As mentioned earlier only a small reference was made about spirituality and maternal health. Joy found that the Maori mothers she worked with that were suffering from mental illness had more faith in taking steps to heal their spiritual well-being than in taking medication:

What I've found is that there's more leaning towards the spiritual well-being before medication. If you can get the wairua right then you don't need that medication. You don't need the therapy [by] going to the tohunga or who they believe is a tohunga. (Joy)

Some Maori women have [gone] to tohunga and have found that really useful [when] dealing with spiritual issues. (Diane)

Environmental and Social Factors

This part of the findings focuses on the social and environmental factors that impact on Maori women as they embark on motherhood. This discussion will look at the maternal health workers perspectives on the issues of drugs, alcohol, gambling and family violence.

Drugs, alcohol, gambling and family violence

The group of participants were very aware of the role of environmental factors that impacted on the lives of Maori women, and the effect that had on their maternal health, overall well-being and the well-being of their children. The most prominent factors included drugs, alcohol, family violence, poverty and gambling. Maternal Health Workers were also very aware of the cyclical nature of these factors, where generations of Maori whanau have been impacted on by these environmental factors.

Both the Maori midwives spoke of their experiences in the homes of Maori whanau and the evidence of alcohol and drug abuse. Joy indicated the impact that has on the baby's development and the potential that is lost:

I've been into homes with the grandmother and then the daughter that I'm delivering and the sister. The two sisters, I birthed both of them and the babies and they're sitting around drinking Woodstock's [alcohol] at 11 – 12 o'clock during the day. The grandmother's there and they're smoking up a storm; kids are running around in this smoke environment. The other thing that impacts is if there is a lot of drug abuse, what that does to the development of the baby. Their brain cells are already knocked off [and] they can't reach their potential because this potential has been broken. (Joy)

Kiri felt that these addictions come about from poverty and a lack of effective whanau support. Ironically, though, the whanau support is often not available as these addictions are prevalent within in all generations of the whanau:

Like [Maori mothers] smoking marijuana. I think a lot of [Maori mothers] have low self esteem, the one's that are smoking and [have] probably been smoking it for years. I suppose a lot of it's peer pressure and money has a lot to do with it also. Some of them come from low-income employment; poor families and they don't have a lot of whanau support.

It's a vicious cycle really. I remember a girl that I looked after and as I was speaking to her about the effects of marijuana her mother was horrified and said "Oh now I know why she was such a bad child". She said 'you know I did everything that she's doing', and then she said 'now it's going to affect my moko as well, she'll probably do the same till one of them stop it'. In actual fact both of the ladies that I've come across that have had drug problems, it is a family thing. It's not just the one person; it's all of them. Yeah and the attitude is "oh it's sweet as". (Kiri)

Robyn spoke of the impact that drug and alcohol abuse can have on mental health and how it can contribute to the development of postnatal psychoses:

I have seen that drug use has been a bit of a problem out there. With marijuana use we can see that can impact negatively on the mood, dropping the mood and the motivation. Any kind of psychotic factor [drug use] is likely to contribute to that side of it, especially post-natal psychoses. Alcohol as well can impact [on the mother's mental health]. Also we do see the odd bit of family violence and partner violence, in which cases some women are afraid to even talk about what's happening in case it gets out there. (Robyn)

Diane also attributed the social pressures that exist for Maori mothers on the types of services they access. She identified that there were a range of complex factors that impacted negatively on Maori mothers preventing them from living a healthy lifestyle. She felt that any health service or maternal mental health programme needed to be responsive to all those factors:

... there's social [and] financial stuff, whether it's formula or just surviving day to day... financially also you're looking at transport to get to services. That has a massive impact [and] just limits the services that you can get. If you're looking at family violence [Maori mothers] tend to close themselves off anyway so they're isolated. Self-esteem is the first thing that is affected in family violence. You usually see it when you first walk in the door, the violence, it's tense, when you walk in there and you're giving information, you're aware that their attentions elsewhere. You'll find alcohol abuse. You'll find violence. You'll find a cycle of violence; family violence, it just goes from one [generation] to the next and the next. You'll find gambling is huge at the moment. So I guess that's a difference with a Pakeha woman. [With the mental illness], it's a lot to do with the baby; you know they're not coping. Where as with Maori women, there are a lot of other things going on like gambling and alcohol abuse. It has to be a different tool to differentiate between [Maori mothers and non-Maori mothers], to work basically. (Diane)

Joy felt strongly that there was a tendency for Maori mothers to avoid talking about and dealing with issues such as alcohol and drug addiction:

[Maori mothers] can't see anything straight away. You've got to point it out to them and say look this is what it's done. But they also avoid the issue, there's no discussion about the issue mainly because they're too whakamaa to talk about the issue or there's no understanding of the issue because they've knocked off a few more brain cells and there's no actual connection. (Joy)

Joy also felt that Maori suffered from environmental factors because addiction was an innate part of their being. Whilst literature does not support this viewpoint, it emphasizes the experiences Joy had with Maori mothers, as their midwife, and the effect that had on the way she viewed Maori mothers:

I think another thing is gambling as well, gambling is a big issue, because Maori are very addictive, so whatever they do it becomes an addiction, whether it's drinking, playing play station whatever it is, it becomes very addictive to them. It's in their nature. (Joy)

Education

Education was a high priority for health professionals working with Maori mothers in the ante and postnatal periods. In particular the lack of knowledge by Maori mothers around maternal mental health such as postnatal depression and the difficulties in creating access to that information was noted:

I found that a lot of Maori women didn't know what post-natal depression was, they didn't know whether they had it or not. There is a little bit of stigma too with this issue so I think a bit more awareness would be really useful and it would help whanau members recognise it too and say 'hey it's alright to talk about these things'. Education is the other thing that's really important. Providing education about factors that help you feel better and also what's going on for you biologically. So if we can give a thorough educational package. It can really help in giving out information to whanau and visitors to read as well. So educating the whole whanau. (Robyn)

Joy felt that education had a positive effect on Maori enhancing their self-esteem and their opportunities for a positive future:

It wasn't until I came here that I really noticed a lot of young Maori becoming well educated and I think that has a positive effect not only on themselves as people but on their ongoing lives and what they choose to do. (Joy)

Joy felt a productive strategy in helping Maori mothers was to focus on improving their lives, self-esteem issues and creating a positive future for themselves and their children rather than focussing on the stigmas associated with postnatal depression:

I think it's mainly dealing with those negative impacts and giving them a vision of what life could be like. Again there's the budgeting and sussing out the money things, stopping the drinking and the smoking and leaning towards those more positive things, about how to be a good Mum. Instead of yelling at your kids and maybe slapping them around because they're pissing you off because you are having a drink. Focus more on the self-esteem issues [with] that Mum, maybe that's one of the strategies as opposed to dealing with the label. (Joy)

Summary

The interviews with maternal health workers indicated that there are a range of issues and complex factors that need to be explored when looking at Maori mothers and maternal mental health. In particular, it was identified in the interviews that those mothers who had little social support had a more negative experience of motherhood, lived in a less supportive environment and were more susceptible to social pressures like drugs and alcohol.

It was also identified by maternal health workers that there is a lack of suitable community services providing social support that is appropriate and effective for Maori women. It was further described by one of the maternal health workers that whilst there are a number of maternal health services providing education and support, these were largely not being accessed by Maori women. It was also implicit through the interviews that whilst maternal health workers could identify some of the barriers that inhibited Maori mothers from accessing services, they did not have any clear solutions on how to provide more effective and accessible services to Maori mothers.

The two Maori midwives interviewed supported the idea that Maori women were better understood by Maori health professionals that understood the diverse circumstances and realities of Maori. This understanding had a direct influence on the way Maori mothers were dealt with. The other maternal workers also strengthen the

argument that particular cultural knowledge and understanding of Maori mothers experiences must be integral within service delivery, to be effective for Maori mothers. This is of crucial importance with treatments and interventions of postnatal depression for Maori women. The maternal health workers were supportive of collaborating with Kaupapa Maori and iwi health services to provide a more comprehensive and relevant service for Maori mothers.

The maternal health workers spoke in-depth on the fact that Maori mothers deal with a complex range of social, cultural and environmental pressures in their lives. It is these factors such as drug and alcohol abuse, family violence and lack of education that act as barriers to attaining positive maternal health and well-being. Furthermore, it was also identified that this is often an intergenerational problem affecting all levels of the whanau unit.

Perhaps the most subtle, but clearly evident theme, running through the dialogue is the belief by both maternal health workers and Maori mothers that in order to succeed despite these barriers there is a need for Maori mothers to have or gain a strong self esteem, motivation, self-belief and spiritual grounding. These factors alongside medical support may then provide Maori mothers with a positive and empowering experience of motherhood; tools with which to cope with mental health issues; an ability to provide a safe and nurturing environment for their children; and the positive development of themselves and their whanau on a mental, physical and spiritual level.

CHAPTER SIX: IMPLICATIONS FOR MAORI MATERNAL HEALTH

This chapter will discuss the key findings presented in chapters four and five in terms of the implications they have for the first aim of this study, namely the gaining of an understanding of the issues that impact on the maternal health and well-being of Maori women during and after pregnancy (see page 9). The discussion presented both identifies and analyses the key themes that emerged from both the literature and the participant interviews. The issues and factors that are identified will also be discussed in terms of the significant impact they have on Maori women during the ante and postnatal periods. They will also be considered and acknowledged as important issues, which determine whether Maori mothers have a positive experience of motherhood.

Towards maternal health and well-being of Maori Women

The key findings have been arranged into the following themes: social support; maternal health services; treatment; holistic health care; education; access and environmental factors. These themes were identified in both the literature and the interviews as key contributors to the maternal health and well-being of Maori mothers. Each theme will be discussed in terms of the constructive factors and risk factors that affect the maternal well-being of Maori mothers.

Social support

Social support was identified by the maternal health professionals and the Maori mothers as the most important factor in ensuring Maori mothers had a positive experience of pregnancy and motherhood. Such support was crucial in balancing any difficulties or problems during this time. The mothers described social support as whanau, friends, School for Young Mothers and church. The key constructive features of a strong support system were: emotional and spiritual support through listening, advice, counselling, physical comfort, motivation; practical support such as physical caring for the mother and the baby, housework help, and day to day contact. However, the mothers also identified the risk factors that contributed to an ineffective support system and these included: a lack of partner support, ineffective maternal

health services and coping with postnatal depression and isolation. The maternal health workers noted that social support could also include parent support groups; however none of the mothers attended these groups. This might be because in general these groups had a lack of Maori content and therefore participation. The mothers with stronger social support system coped with their situation better and had positive maternal mental health.

The interview with the kuia, past literature and data on cross-cultural experiences indicate that cultures with strong and highly developed kin and social support networks have a very low incidence of postnatal depression (Kruckman & Smith: 2001). Certainly this may account for the lack of information on postnatal depression in traditional Maori society. Even as much as fifty years ago based on the kuia's experience the whanau networks were both very committed and extensive in their support for new mothers. Extended whanau were readily available to help care for both the mother and the baby. For young mothers in particular it was very common for the first-born child to be raised as 'whangai' with the grandparents (Ihimaera: 1998, Phillips: 1966).

In today's society the structure and role of the whanau has changed and this perhaps has been to the detriment of the maternal health of Maori women. For many Maori women it is not possible to draw on extended whanau and even grandparents for intensive support. It is less common for extended whanau to be living in the same household and grandparents have to stay longer in the workforce. Three of the four mothers interviewed made no mention of their father and for all four participants their own partners displayed little in the form of emotional support and commitment.

Maternal health workers felt that a strong 'whanau' was key to the positive well-being and health of Maori mothers. This support provided the mother with both emotional and physical aid. Whanau provided such care as financial support, advice, caring for the baby so the mother could rest, people they trust to talk too and active involvement with the baby.

Other support came in the form of friends and a school for young parents. It was interesting to note that three of the four mothers emphasised the fact that they really

relied on the support of one key friend that 'stuck by them' through the entire time. Two of the mothers were attending a school for young mums and placed great significance on this service as integral to their development as mothers, their ability to make new friends with other mothers and a positive, motivating and supportive environment. All four mothers interviewed were solo mothers, and young, which placed them at a higher risk for postnatal depression according to research (Rimene et al: 1998, Sarfarti: 2001, Underhill-Sem: 1989). The School for Young Parents provided crucial support for 2 of the mothers interviewed, providing Maori mothers not only with an education but also with a strong social support network. This type of school is a relatively new initiative and further research would be of benefit to analyse in more depth how these schools improve the lives of Maori mothers and their experiences of motherhood.

Maternal Health Services

There was a range of issues that emerged when looking at maternal health services. A key risk factor for effective services to Maori mothers was the lack of training by health professionals on postnatal depression and cultural perspectives. Maternal health workers identified the need for more training in postnatal depression and in cultural education. However, it was noted that it was not always easy for practitioners to organise such training and in terms of cultural education it was mentioned that there was a lack of motivation by New Zealanders to undertake such training. An important point that was further recognised was the need to treat Maori as a diverse group rather than to make generalisations.

All maternal health workers agreed that Maori mothers are a unique group and have different needs, experiences and expectations than non-Maori. They further supported the idea that programmes and models of health care will be inappropriate for Maori if they do not take into account these characteristics. It was also identified by the midwives that many Maori mothers relate better to Maori health practitioners because of their knowledge, understanding of Maori perspectives and experiences, which supports the literature (Rimene et al: 1998). However, a point not mentioned in the literature was that for Maori midwives this understanding could also lead to Maori mothers turning to non-Maori in order to hide their realities and situations.

A constructive factor identified as a way to provide a more culturally appropriate maternal health service was through collaboration with Kaupapa Maori and iwi health providers. The maternal health workers felt strongly about the need for more effective collaboration with Maori community groups in the delivery and implementation of appropriate services. However, the kuia interviewed felt that Kaupapa Maori services working independently were more effective. On this issue research is also divided, some research suggests that bicultural services meet the needs more effectively while others argue for segregation and the importance of Maori developing services for Maori by Maori. The key point here is that the literature and the interview material suggest that one of the most important aspects of service delivery to Maori women is that they have 'choice' (Dyall: 1999, Herbet: 1998, Simpson & Tapsell: 1999). This means that Maori mothers need to have the opportunity to choose the most appropriate services to meet their needs. This may require adequate education on the services available to them, as well as the development of tools and services that more effectively meet the needs of Maori women than the current services do. After examining the interviews and the literature I believe that maternal health services need to allow for Maori mothers to retain power and control over the choices they make in regards to their health care. This means that the philosophies and foundations which underpin health models need to be based on Maori epistemology whilst also recognising the diverse needs and experiences of Maori women and the bicultural and multicultural environment they exist within.

The Maori mothers had diverse experiences with maternal health services. Three of the four felt happy with their midwives. Three of the four mothers were dissatisfied with Plunket. What emerged from the interviews were that Maori mothers have a level of distrust with mainstream health services and are not accessing and making use of the current services enough. This was due to a variety of reasons; being unable to get transport; unhappy with the type of service being offered and failure of the health practitioners to meet their needs. The mother (Nikki) who needed the most help was in fact the mother that received the most inappropriate and ineffective care. She felt that the current services failed to accurately identify her needs. She also felt that there was an overemphasis on medication within the treatment process. What is clear from

the interviews of both maternal health workers and Maori mothers is that the current services are not being utilised by Maori mothers and thus are not meeting the needs of Maori mothers; what is not clear is how maternal health workers and Maori mothers feel this can best be achieved. The literature also supports the argument that the current maternal health services do not meet the needs of Maori mothers (Dyall: 1999, Ellis: 1998, Rimene et al: 2001).

Treatment

The mainstream treatment options for Maori mothers of mother care units; psychiatric care and inpatient services were identified by the maternal health worker as not easily accessible for Maori women, who see themselves being separated from whanau and often from their babies. The Maori mother who used these services had no faith or belief in the system at all. A maternal health worker felt it was indicative of the need for a community service that better met the needs of Maori mothers.

Medication was also found to be an ineffective form of treatment by one of the Maori mothers who suffered from severe postnatal depression due to the physical side effects and the number of drugs she had to take. She also noted that other forms of treatment were not considered alongside medication, yet it was other forms of treatment; counseling, nutrition, exercise, sleep and support which were effective. The literature is not conclusive on the efficacy of medication for the treatment of postnatal depression, but most research does conclude that medication should be used alongside other treatment options (Kruckman & Smith: 2001). The maternal health workers felt a lack of education on the use of medication may well find mothers fearful or reluctant of using medication. There is a lack of literature however that looks at Maori mothers and the use of drugs as treatment. This highlights an area for further research looking at why Maori mothers may be reluctant to use medication as a form of treatment.

Holistic health care

A theme that ran throughout the data was the impact of pregnancy and motherhood on the physical, emotional, psychological and spiritual well-being of Maori women. All the participants identified aspects of their physical and emotional needs during

pregnancy and the effects that had on their overall well-being. There was a direct correlation between levels of emotional and psychological stability with the mother's ability to cope. The two mothers that had the most positive experience and a strong sense of purpose and motivation also showed a level of spiritual grounding.

For all the mothers a strong belief in wanting more for their children and the strong love felt for their children enabled them to overcome obstacles and in one case severe postnatal depression. The discussions with the maternal health workers emphasised the need for a holistic approach to the care of Maori mothers, ensuring that both the physical and the emotional well-being in particular were catered for. Two practitioners also mentioned that spirituality often played a part in Maori mothers' mental health and well-being.

The focus on a holistic approach is congruent with indigenous and Kaupapa Maori philosophies and models of health. Durie's (1998c) Te Whare Tapa Wha is an example of a model that indicates the need for the four components to be strong in order for positive mental health and well-being for Maori – emotional well-being, physical well-being, spiritual well-being and whanau. Kingi's (2002) research has established outcomes that were identified by a range of clinicians and consumers as crucial for positive mental health and well being for Maori. These outcomes used domains that were based on Durie's Te Whare Tapa Wha model. The use of Maori mental health outcomes and models could provide an excellent framework for the development of a tool to prevent postnatal depression in Maori women.

Education

Maternal health and parenting education was highlighted by the maternal health workers as a crucial factor in achieving positive maternal health and well-being. Lack of education around pregnancy, healthcare, parenting and mental health for Maori mothers was seen as a significant risk factor to poor health and well-being for the mothers and their children. Lack of education has also been noted in the literature as a significant barrier to effective participation by Maori women in maternal health services (Powhare: 1998, Ratima et al: 1994, Stone: 1988). This was supported by the fact that none of the Maori mothers mentioned attending antenatal classes.

Furthermore, because three of the four mothers did not form positive relationships with Plunket it could be assumed they weren't receiving education from that source. Whilst it was acknowledged by Maori mothers that whanau and friends provided them with positive support and advice, it was clear in the interviews that the Maori mothers had received no information or education around postnatal depression. This lack of education means that the mothers could have been suffering from postnatal depression but did not understand their symptoms or behaviour and so did not seek help. Certainly symptoms of postnatal depression were evident within the interviews with the Maori mothers. This highlights the need for more effective education provided in a way that Maori mothers could trust and relate to.

Access

Access to services is identified in past research and these interviews as vital for maternal health and well-being of Maori mothers (Dyall: 1999, Ratima et al: 1994). Transport inhibits many mothers from easily accessing services. Feelings of isolation, distrust and whakamaa also play a huge role in preventing Maori mothers from seeking education, support and even more crucial treatment. Prevention of postnatal depression must happen in the antenatal stages which puts responsibility on primary health carers such as doctors and midwives to provide environments and help that enables Maori women to feel open and trusting and willing to participate in achieving positive maternal mental health. The maternal health workers all acknowledged that the current system was not effective, in that services and treatment options are not being utilised by Maori mothers. It was suggested by a maternal health worker that more collaboration needs to take place with Maori health services and resources and mainstream providers. The intervention project in Hawaii for indigenous mothers works on such a premise and has been successful in preventing postnatal depression and creating positive maternal health for indigenous women, ensuring their needs are met on an emotional, physical, medical, spiritual and cultural level (Mayberry: 1999).

Environmental factors

This research clearly shows that the effect environmental factors play in the lives and well-being of Maori mothers and their babies cannot be underestimated. Drugs,

alcohol, gambling, solo parenting, family violence and poverty were mentioned by all the maternal health workers as prevalent within Maori homes. Often this was mentioned as cyclical, whereby there were generations of whanau battling these addictions and situations. Research shows that people living in these environments are more likely to be impacted on by factors that contribute to poor mental health (Durie: 2001, Ratima et al: 1994, Sarfarti: 2001, Goodwin: 1996). It is apparent from statistics and past research that it is vital that the whole picture is taken into account when dealing with Maori whanau, and that an approach is needed that can deal with a range of complex and intertwining factors. An interesting point made by a maternal health worker was that mental health issues might be going un-diagnosed because so much time is spent on dealing with the more apparent mental health problems such as drug and alcohol addiction. A further point was made that in order to make any real difference in their lives it is imperative that any treatment or support looks at changing Maori mothers' underlying mindsets and values, inspiring and helping them to want a different life for their children and themselves and to believe and feel good about themselves. Durie (2001) goes further to say that for a complete and strong self esteem and self worth, Maori must have a strong sense of cultural identity. Three of the four mothers interviewed said they would like to know more about their culture and the cultural models of parenting and health care.

The findings from this research and the relating literature not only provide discussion and analysis of the key issues that effect Maori women during the post and ante natal periods but also inform us on key factors that must be included in any tool to aid in the prevention of post natal depression in Maori women and create positive maternal health and well-being. Both the literature and the interviews clearly show that the current services are not adequately meeting the needs of Maori women and their maternal well-being. This has implications not only for the future of these mothers but also for the future of their children.

Towards the development of a cultural tool to enhance Maori maternal mental health

This second part of the discussion will focus on the implications that the key research findings have for the second aim of the research: gathering information, which can be used to form a cultural tool such as a maternal health programme to help prevent postnatal depression in Maori women. This chapter will present and describe the factors that this research identifies as essential for appropriate and effective maternal health care for Maori women. The following key areas need to be considered in the development of an appropriate and relevant maternal health tool for Maori women: outcomes of the tool; choice of services; development of social support systems; using the right people; catering to environmental stressors and a preventative cultural approach to postnatal depression. The discussion will conclude with an outline of three key principles that can provide the framework and philosophy of the maternal health tool: the principle of *tuhonotanga*, the principle of *whanaungatanga* and the principle of *rangatiratanga*.

Outcomes

Both the current research and the past literature establish the need for mental health services to use tools and programmes that reflect outcomes which are of benefit and give meaning to Maori people (Dyall et al: 2001, Kingi: 2002). This premise is based on the idea that Maori are unique, share commonalities and have different needs, expectations and experiences to non-Maori. Kingi (2002) has provided extensive research into developing a tool that assesses whether programmes and mental health services are providing care, which reflect a set of outcomes. These outcomes are based on the holistic model, *Te Whare Tapa Wha*, and data obtained from research with consumers, whanau and clinicians. The components that are included within this model not only give meaning to Maori but also allow for all parties – whanau, tangata whaiora and clinicians to be involved in the healing process and provide a tool that can meet the diverse needs of Maori. Therefore a successful tool for maternal health care and education for Maori women needs to ensure that its components, framework and processes are developed in line with the appropriate outcomes.

An outcome of real significance identified implicitly by the mothers and explicitly by the Maori midwives is the need for any maternal health tool or programme to not only provide mothers with support and tools to enhance their experiences but to ultimately help these mothers to gain positive self-esteem, a strong cultural identity and motivation to live a healthy and successful life. Outcomes only determine what it means to be successful or healthy for Maori mothers. In order to gain those outcomes this premise needs to be inherent within the foundations, frameworks, policies and practices of the mental health services for Maori women.

Choice

Another key finding from the both the interviews and the literature was the need for maternal health services to provide choice for Maori women and be accessible. This can be reflected by providing a tool with a range of options – a maternal health service that allows for Maori mothers to choose their midwives, general practitioners, health pathway, and/or maternal health provider. Most crucially these options need to be providing a service that can meet the needs of Maori women that are seeking a Kaupapa Maori approach to health care and those that want to adopt a mainstream approach but still exist within today's society as a Maori with a unique set of life experiences and diverse realities. Mayberry et al's (1999) research identifies that cultural rituals and practices can be very effective in preventing postnatal depression.

To enable appropriate choices and opportunities for enhanced maternal health care for Maori women any tool, programme or service needs to provide the opportunity for cultural growth and development. Again, cultural identity is identified as an integral outcome for Maori in terms of their mental health and well-being. In terms of maternal health care this means a number of things:

- a) That the spiritual, physical, mental and whanau aspects are included and given importance in their journey,
- b) That cultural processes, customs, rituals and beliefs are reflected in their care, education and within the frameworks of any maternal health tools or programmes,
- c) That opportunities are provided for Maori mothers to learn and develop their cultural identity and role as a Maori mother in today's society,

- d) That knowledge of traditional practices is incorporated in maternal health care (such as mirimiri, karakia, tohunga, storytelling) as interventions, education and support practices for Maori mothers.

Social Support

The current health policies reflect and identify the importance of social support structures for Maori women during and after pregnancy. This may mean providing appropriate support for the enhanced involvement of grandparents and extended families and friends in helping to support Maori mothers and their children. This may mean that extra support; education and aid are given to family and friends so that they may better help the mothers. Much of the cross-cultural literature on postnatal depression identifies social and kin based support systems as acting as buffers against the development of postnatal depression (Davis: 2001, Kruckman & Smith: 2001 & Walters & Simoni: 2002). New Zealand's environment does not provide formal pathways for whanau and friends to be actively involved in the support of mothers. Based on this research there are huge benefits to both mother and child if their support systems, however they are defined, are actively involved throughout the entire process of pregnancy birth and motherhood. For young Maori mothers the circumstances change again, they often face extra hurdles because of their youth. Friends are less likely to stick by them; family members may take longer to adjust as well as often having to take on an active role in the process. For these mothers both the literature and interviews emphasize how important friendships with other young mothers are for these women. Both Aroha and Maia received significant support from friends made through the School for Young Parents. These types of schools may be exactly the type of service that can provide the appropriate support, care and education for young Maori mothers.

People

Much of the research identifies that Maori women are not accessing services because of their distrust and whakamaa (Rimene et al: 1998). To remedy this situation it is vital that there are people within maternal health services who have understanding and training in the following areas:

- traditional maternal health practices
- Te Reo Maori and Tikanga Maori
- Postnatal depression
- Postnatal depression and Maori women
- Diverse realities of Maori women
- Maori women and depression

It must be acknowledged that whilst some Maori women may feel more comfortable with Maori health professionals' other Maori mothers will choose to access non-Maori maternal health workers, and so it is essential that both Maori and non-Maori are able to pick up symptoms and signs of postnatal depression in Maori women.

Environmental stressors

Any maternal health tool or programme must take into account the complex and diverse environment and social factors that can impact on Maori mothers. An effective tool must be able to provide education and support to help Maori mothers and deal with a range of factors: financial problems, drug and alcohol addiction, solo parenting, gambling, family violence and intergenerational addictions.

A key factor highlighted from the interviews and research was the huge impact that a lack of partner had on the mother's well-being (Goodwin: 1996). Many of these mothers may have been facing other difficulties in their lives, but not having a strong and positive relationship with their partner, and their partner not taking a proactive role in the parenting, was the cause of much angst for these women. Therefore a maternal tool or programme targeted at these women should provide an avenue for these mothers to address those concerns whether it is through counselling, spiritual healing or self-development. In particular, focussing on relationship work with partners, and education and support for fathers.

Postnatal depression

Both this research and the literature indicate Maori women are suffering from postnatal depression but that it is often going un-diagnosed and misdiagnosed because of the other factors that are impacting on their lives, and a lack of education for Maori mothers and their whanau on postnatal depression. There needs to be a concerted effort by all health professionals that work with Maori mothers to ensure they are providing such education in a way that is relevant to Maori. Postnatal depression needs to be taken seriously at both the prevention and intervention levels as undiagnosed postnatal depression can have serious and detrimental effects on the mother, the child and the whanau.

Table 6.1 Key factors for a Maori maternal health tool

FACTORS	IMPLICATIONS
Outcomes	Appropriate and relevant to Maori consumers
Choice	Range of options – Kaupapa Maori and mainstream
Social Support	Development of strong support systems
People	Maternal health workers with appropriate training and knowledge.
Environmental Stressors	Identify and provide support mechanisms to cope with environmental factors.
Postnatal Depression (PND)	More education on cultural experiences of PND

Principles for a Maori Maternal Health Tool

The following principles are based on the information from the interviews and the literature. They should be considered in the development of any tool developed to enhance the health and well-being of Maori mothers.

The principle of Tuhonotanga

This principle is about the interconnections between Maori mothers, their whanau, the environment and their culture. It recognises the importance of viewing health in a holistic manner and adopting frameworks and tools that incorporate holistic models of health. Any tool developed on the basis of this principle must reflect the complex and diverse lives of Maori women and their connections with Te Ao Hurihuri (the ever-changing world) and Te Ao Maori (the Maori world).

The principle of Whanaungatanga

This principle encompasses the importance of whanau however that may be defined by an individual and the importance of social support systems in the well-being and health of Maori mothers. This principle is more about relationships than biological families. Whilst biological families can play an integral part in the lives of Maori mothers, it is important to recognise that other support structures also provide education, support and love such as friends, churches, wider family relations and community groups.

The principle of Rangatiratanga

This principle is about creating tools that empower Maori mothers to take control over their own destinies and that of their children. This means providing services that enable Maori mothers to make informed choices about the pathways that best meet their needs and goals. It is also about empowering Maori mothers in their Maoritanga. For some this might mean giving them information and opportunities to begin on the path to learning about their culture, for others it might be developing their pride and knowledge in their

culture through Te Reo, Tikanga and Maori health practices. Finally, it is about ensuring that Maori maternal health tools have outcomes that are meaningful and appropriate to Maori Mothers

6.2 Principles to guide the development of a Maori maternal health tool

	PRINCIPLES		
	Tuhonotanga	Whanaungatanga	Rangatiratanga
IMPLICATIONS	Interconnectedness, Holistic model of health, recognition of diverse Maori experiences	Strong ‘whanau’ based support system, broad definition of ‘whanau’	Empowerment, control, health tools that are meaningful and effective for Maori mothers

The principles of Tuhonotanga, Whanaungatanga and Rangatiratanga can be seen as providing the key concepts to help guide and inform the development of a maternal mental health tool. The key factors: environmental stressors, people, social support, choice and outcomes are the areas the tool must address to achieve the desired outcome which is twofold: positive maternal mental health and well-being in Maori mothers and the prevention of postnatal depression in Maori mothers.

CHAPTER EIGHT - CONCLUSION

The concluding chapter will cover a review of the aims of this research, the methodology and the key findings and their implications. The limitations of the study and the areas for future research will be discussed and I will close with some comments on my journey as a researcher.

The aims of this research were to gain an understanding of the issues that impact on the maternal health and well-being of Maori women during and after pregnancy, and to gather information which could be used to form a cultural tool such as a maternal health programme to help prevent postnatal depression in Maori women. Aspects of both a Kaupapa Maori and a Maori centred methodological approach were utilised alongside qualitative enquiry. The outcome of this approach was a collection of data that provided in-depth and detailed information on a number of themes and which are analysed within a framework that acknowledges and reinforces Maori paradigms and perspectives.

While some attempt has been made to develop maternal health services that meet the needs of Maori women, an examination of the literature suggests that little or no attention has been given to Maori maternal mental health. Whilst, Western mainstream research acknowledges that postnatal depression is often under diagnosed and misdiagnosed in women no real insight is provided for why this is occurring for Maori women. This research attempted to address this question. The findings from the interviews conducted with maternal health workers suggest that because Maori women are often dealing with many complex issues and environmental factors, postnatal depression is overlooked in order to deal with the more pressing issues such as money and family violence. Furthermore, it is difficult to assess whether Maori women are being accurately diagnosed by mainstream health professionals, if there is no understanding or training in the realities and experiences faced by Maori mothers.

To ensure that the maternal mental health of Maori mothers is both taken seriously and given priority there needs to be a comprehensive and collaborative approach by the government, maternal health services and the Maori community to providing an overall maternal health service to Maori women that addresses both the psychological

and the social factors that impact on Maori mothers. This ultimately means more education, more policy development, more funding and more research on Maori women and maternal mental health

Future Research

There are many issues that require further research in this area. In particular the need for research looking at the incidence and epidemiology of postnatal depression in Maori women, which also identifies the number of undiagnosed and misdiagnosed cases and the number of psychiatric admissions.

There needs to be further research on the symptoms and causes of postnatal depression in Maori women and the role of dual diagnosis for Maori women who are suffering from more than one mental illness, rather than ignoring the presence of postnatal depression.

Maori women and society would definitely benefit from research into how effective general practitioners, midwives and maternal services are in identifying postnatal depression in Maori women and treating it effectively.

An issue of serious concern in the research, which needs to be developed, is the role of Maori males in the parenting process, how the role has evolved, what their role is today and how it can be improved.

Also, research is needed that looks at the positive results related to Maori parents; the success of Schools for Young Parents; Maori parents that are succeeding and leading fulfilling lives; the positive impact of extended whanau and the positive influence of culture on Maori parents and whanau.

Limitations

Like any research this project's limitations has implications for both the conclusions it reaches and the direction of future research.

The sample size in this project was small and whilst this enables the production of more in-depth and personal data, without the support of other literature no concrete conclusions or generalisations can be made. The validity and rigour of the research findings can be seen however in its comparisons with the available literature, and there were some common themes that ran throughout both the literature and the findings. Where the findings were particularly weak was due to there being only one interview with a kuia. For the data from this interview to be properly and effectively utilised there needed to be more data from similar sources. It also meant that the majority of cultural expertise on this topic came from literature.

Another limitation of the research was the lack of discussion by the Maori mothers on the impact of their culture during pregnancy, birth and motherhood. To gain access to such information questions may need to have been more specific around that topic rather than implicit.

A positive outcome of these limitations is that it provides information on the directions of future research in this area in terms of literature, methodology and analysis.

Summary

Whilst it may be effective to provide a maternal health service to Maori mothers that makes use of both Maori and non-Maori resources, this research suggests that the underlying premise and framework that such a service is based on should come from a Kaupapa Maori paradigm that employs and supports the use of Maori health models and perspectives. It is no longer possible to claim that Kaupapa Maori does not apply to all Maori, extensive research by Maori academics shows that despite the different realities faced by Maori there are key commonalities that can be drawn on, which reflect Maori aspirations, development and well-being. This research also shows how the experiences of Maori women, whilst different, all illustrate the relevance and importance of tinana, wairua, hinengaro and whanau to their overall maternal mental health and well-being. Maternal health services that offer medical, psychological and physical support and education are vital to the health and well-being of Maori mothers. However, this research suggests that equally if, not more vital, is the ability

to provide a maternal health service that enables Maori women to access strong and effective support systems that nurture and provide a safe environment where Maori mothers can grow, develop and be empowered to live positive and successful lives for themselves and their children

As a Maori people we must take a look at the results of progress. If a progressive, successful society means that we have isolated families and mothers raising children with limited support networks, facing a myriad of complex socio-economic and psychological barriers alone, with largely absent fathers, are we really moving in the right direction? If extended families and strong support networks were seen as essential to survival in more 'simpler' times then should not strong extended whanau support systems be at the core of our functioning in today's society of complex issues and problems. The nature and make-up of whanau may have evolved but the roles and responsibilities should remain the same. In the end if the focus can turn from independent isolated living to interdependent communal functioning, the welfare of our whanau will be ensured.

Finally, my journey as a researcher has been meaningful on a number of levels and has developed my understanding of the research process. As a Maori researcher I can truly understand now the pressures of conducting research for communities of which one is an integral part of, and the demands that places on you to ensure that the research does justice to the participants and to your people. In particular, I have had to learn the importance of writing up research that not only has meaning for the participants, but also to the wider community, so that they can have a clear understanding of this research process and the implications of the research. I believe this research provides some important conclusions and recommendations for maternal health service delivery for Maori women, which will be beneficial to the future development of those services. Like all researchers my biggest hope is that this piece of research does not remain on the shelves of the university library, but is passed through the hands of many students to help their understanding of Maori maternal mental health.

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APPENDIX ONE – INFORMATION AND CONSENT FORMS

A Case study for helping to prevent postnatal depression – Towards a cultural tool for Maori women.

INFORMATION SHEET

Ko Tainui toku waka
Ko Ngati Kauwhata, Ngati Raukawa me Rangitane oku iwi
Ko Tahuriwakanui toku hapu
Ko Aorangi toku marae.

Ko Marama Merritt toku ingoa. My name is Marama Merritt and I am currently enrolled as a candidate for the degree of Master of Philosophy at Massey University. The focus of this research project is to gather information that will aid in the development of a cultural tool for helping to prevent postnatal depression in Maori women. The specific aims of this research are:

1. To gain an understanding of the issues that impact on the maternal health and well-being of Maori women during and after pregnancy.
2. To gather information which can be used to form a cultural tool such as a maternal health programme to help prevent postnatal depression in Maori women.

The supervisors for this research project are Kieran O'Donoghue and Wheturangi Walsh-Tapiata. If you have any concerns regarding the research they can be contacted at the School of Sociology, Social Policy and Social Work, Palmerston North, Massey University.

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I can be contacted at:
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As the researcher I will be selecting the participants based on the following categories:

- a) Maori mothers who suffered from postnatal depression
- b) Maori mothers who did not suffer from postnatal depression
- c) Kuia with knowledge of traditional cultural structures and cultural practices around pregnancy
- d) Health and educational kaimahi working with Maori women during the ante and postnatal periods.

There will be no more than 10 participants involved in the research. Participants will be involved in a face-to-face interview conducted by the researcher. Participants may

choose to bring a support person to the interview. The interview will take place in an environment chosen by the participant and it will be 1-2 hours in length.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- *Decline participation;*
- *To withdraw from the research at any time;*
- *To have privacy and confidentiality protected;*
- *To ask questions at any time;*
- *To decline to answer any question;*
- *To receive information about the outcome of the research in an appropriate form.*

The interviews will be audio taped and then transcribed.

- *You have the right to ask for the audio tape to be turned off at any time during the interview*

All material from the interviews will be kept in a secure storage system. A summary of the research findings will be given to the participants. The involvement of the participants and the information shared will be treated with respect and value. A list of support groups and counselling services will be provided to participants that wish to seek such support. Alternatively, please contact the supervisors or the researcher of the project if there are any other concerns.

Committee Approval Statement:

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 04/43. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspn@massey.ac.nz

A Case study for helping to prevent postnatal depression – Towards a cultural tool for Maori women.

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I wish/do not wish to have tapes returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: **Date:**
.....
Full Name – printed

Committee Approval Statement:

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 04/43. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspn@massey.ac.nz

APPENDIX TWO: ETHICS APPROVAL FORM

Bay of Plenty Ethics Committee

234A The Strand
National Bank Lane
Whakatane
Ph/Fax: 07 308 5026
Email: adc@ihug.co.nz

24 August 2004

Marama Merritt
261 Gravatt Road
PAPAMOA

RE: HEC PN Application – 04/43
Towards a cultural tool for the prevention of post-natal depression in
Maori women.
Centre: BOP Site Specific BOP/04/06/029
Investigator: Marama Merritt


Thank you for your letter received 13/8/04.

The Bay of Plenty Ethics Committee deputy Chair has reviewed your response and advises that the study has received provisional approval subject to the following issues being satisfactorily addressed:

1. It is suggested that the title of this study should be changed to clearly indicate the case study limitations.
“A Case study for helping to prevent postnatal depression – Towards a cultural tool for Maori women”
2. We note that your response to the second point states that you have consulted with local Kaumatua. Would you please provide the contact details and provide a letter of support from one of those organizations.

Once this information has been received a final approval letter will be issued.

Yours sincerely


pp Roy Carroll
Acting Chairperson.

Bay of Plenty Ethics Committee

144-146 The Strand
P.O. Box 134
Whakatane
Phone/Fax (07) 308 5033
Email: Adcam@clear.net.nz

8 October 2004

Marama Merritt
261 Gravatt Road
PAPAMOA

RE: HEC PN Application – 04/43
Towards a cultural tool for the prevention of post-natal depression in Maori women.

Centre: BOP Site Specific BOP/04/06/029
Investigator Marama Merritt

Thank you for your letter of response received on the 22 September 2004.

The various issues raised in my letter of the 24th august have now been satisfactorily addressed, final ethical approval for this study is granted under Chairs delegated authority.

Approved Documents

Information Sheet and consent form (*Undated*)
Marama Merritt. 26 Gravatt Road. Papamoa.

Accreditation

This Committee by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Progress Reports

The study is approved until 28/6/2006 (2 years) The Committee will review the approved application annually. A progress report is required for this study on 6th October 2005. You will be sent a form requesting this information. Please note that failure to complete and return this form may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Requirements for SAE Reporting.

Please advise the Committee as soon as possible of the following:

- any study in another country that has stopped due to serious or unexpected adverse events
- withdrawal of Investigational product from continued development
- withdrawal from the market for any reason
- all serious adverse events which result in the investigator or sponsor breaking the blinding code at the time of the SAE or which result in hospitalisation or death.

Amendments:

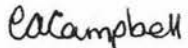
All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementations is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

General

It should be noted that Ethics Committee approval does not imply any resource commitment of administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Please quote the above ethics committee reference number in all correspondence.

Yours sincerely,



Carol Campbell
Committee Administrator



Massey University

OFFICE OF THE ASSISTANT
TO THE VICE-CHANCELLOR
(ETHICS & EQUITY)
Private Bag 11 222
Palmerston North
New Zealand
T 64 6 350 5573
F 64 6 350 5622
humanethics@massey.ac.nz
www.massey.ac.nz

25 May 2004

Marama Merritt
37 Waikari Road
RD5
Matapihi
TAURANGA

Dear Marama

Re: HEC: PN Application – 04/43
Towards a cultural tool for the prevention of postnatal depression in Maori women

Thank you for your letter dated 10 May 2004 and the amended application.

The amendments you have made now meet the requirements of the Massey University Human Ethics Committee: Palmerston North and the ethics of your application are approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, a new application must be submitted at that time.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

A reminder to include the following statement on all public documents "This project has been reviewed and approved by the Massey University Human Ethics Committee, Palmerston North Application 04/43. If you have any concerns about the conduct of this research, please contact Professor Sylvia Rumball, Chair, Massey University Campus Human Ethics Committee: PN, telephone 06 350 5249, email humanethicspn@massey.ac.nz".

You should now forward your application to the appropriate Health and Disability Ethics Committee for their approval, along with a copy of this letter of approval. Please forward a copy of the HDEC approval to this office once received, along with a record of any changes requested.

Yours sincerely

Professor Sylvia V Rumball, Chair
Massey University Campus Human Ethics Committee: Palmerston North

cc Mr Kieran O'Donoghue & Mrs Wheturangi Walsh-Tapiata
School of Sociology, Social Policy and Social Work