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Exploring the Barriers and Facilitators of Accessing and Utilising Mental Healthcare for Adults with Childhood Trauma.

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Abstract

Childhood trauma is a prolific and pervasive issue, with New Zealand reporting a concerning number of child maltreatment cases each year. Extensive research has highlighted the myriad of negative physiological, neurological, and psychological impacts associated with experiencing trauma in childhood. Despite this, mental healthcare service usage in New Zealand remains relatively low, with the most recent data estimating only 2.9% of the population access some form of mental healthcare annually (Te Whatu Ora, 2023). To understand this disconnect, the current study aimed to explore the lived experiences of adults with childhood trauma and identify the barriers and facilitators that impact accessing and utilising mental healthcare. Employing Interpretive Phenomenological Analysis, semi-structured interviews were conducted with four adult participants to provide an in-depth understanding of their experiences accessing care. Analysis revealed six overarching themes: *Constraints of Living in a Small Town, The Cost of Care, Confronting Internal Barriers, Reaching a Breaking Point* and *A Need for A System that Cares*. From these themes, six primary barriers were identified: Limited Resources, Incompatibility in the Therapeutic Relationship, Lack of Anonymity, Stigma, Lack of Trust and Financial Constraints. Three key facilitators also emerged; Crisis as a Motivator, Support and Positive Healthcare Relationships. Additionally, participants identified several systematic changes that would facilitate future access and utilisation of care. This thesis addresses critical gaps in existing literature and contributes to our understanding of the challenges and supports that impact to mental healthcare for adults with childhood trauma in New Zealand.

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Chapter One: Introduction

New Zealand has notably high rates of childhood trauma, with findings from Fanslow et al. (2021) estimating that at least 50% of New Zealand children will experience one adverse childhood experience (ACE) before the age of 18. Consequently, New Zealand ranks 35th out of 41 developed countries for child wellbeing outcomes (UNICEF, 2020). Extensive research has established strong links between childhood trauma and a range of long-term negative outcomes, including chronic health conditions(Clemens et al., 2018), neurocognitive changes (de Bellis & Zisk, 2014), and various mental health disorders (McKay et al., 2021).

Despite the high prevalence of childhood trauma, mental healthcare utilisation in New Zealand remains relatively low. The most recent available data indicates that in 2022/2023, only 178,600 individuals accessed some form of mental health or addiction service, equating to roughly 2.9% of the population (Te Whatu Ora, 2023). Given the clear evidence of high rates of childhood trauma, its association with numerous adverse outcomes in adulthood and low rates of mental healthcare utilisation, it is critical to explore the factors influencing access to care.

Whilst there is a vast range of childhood trauma literature, adult survivors of childhood trauma remain a significantly under researched population in this field. Furthermore, studies investigating these issues within a New Zealand population are virtually non-existent. In identifying the barriers and facilitators that exist for those who have experienced childhood trauma we can provide more tailored and appropriate support, increasing mental healthcare utilisation and minimizing negative outcomes.

Chapter Two: Literature review

This chapter begins with an exploration of literature outlining the historical and contemporary understandings of childhood trauma, followed by a discussion of the various short and long-term impacts of trauma-exposure in childhood. This chapter will then move to discuss the mental health system in New Zealand and the various facets of mental healthcare services available. Next, several therapies and interventions currently utilized to treat childhood trauma will be outlined before reviewing the limited literature on barriers and facilitators to mental healthcare for this population. This chapter will then conclude with a summary of relevant findings and an outline of the current study's aims.

Childhood Trauma

The section will discusses the historical understandings of childhood trauma and their evolution over the past two centuries followed by an outline of the adverse childhood experiences study. It will then explore the varying conceptualisations of childhood trauma before discussing the varying screening tools implemented to measure childhood trauma and the prevalence of childhood trauma both globally and in New Zealand will be discussed followed by an outline of the current methods of measuring childhood trauma, and the challenges in doing so. Following this, both the risk and protective factors identified in existing literature will be explored concluding with an exploration of existing childhood trauma research in New Zealand.

Historical Understandings of Childhood Trauma

In 1860 Ambroise Tardieu, a French medical doctor, provided the world with its first definition of child abuse and discussion of childhood trauma (Roche et al., 2005). Tardieu specialized in forensic medicine and toxicology and over the span of his 23-year career he provided his forensic expertise in 5,238 documented cases of child maltreatment (Roche et al., 2005). Tardieu’s work was so influential in the field of child abuse that his clinical descriptions of symptoms found consistently amongst abused children gave light to the diagnosis of battered child syndrome (Roche et al., 2005). His paper “Étude Médico-Légale sur les Sévices et Mauvais Traitements Exercés sur des Enfants” (Medico-legal studies on cruelty and ill-treatment upon infants) discussed 32 cases overseen by Tardieu, which he found to be examples of cruel and brutal treatment toward children (Labbé, 2005). Notably, Tardieu recognized that many of the children in these cases were abused by a parent, teacher or other close adult who exercised direct authority over them (Dorahy et al., 2010). Importantly, Tardieu also observed the psychological impacts of this abuse, noting many of the children to be “timid, even fearful, often dazed, with a vacant gaze” (p.328) (Tardieu, 1860 as cited in Roche et al., 2005). While Tardieu’s earlier work primarily focused on physical abuse, he would later discuss other forms of traumatic experiences such as sexual abuse and neglect (Labbé, 2005). Shortly following this, Paul Briquet, a French physician and psychologist, published similar work discussing the psychological impacts of child abuse. Briquet’s work focused on hysteria, challenging the common belief that it was a phenomenon that occurred only in women, caused by the release of toxins from the uterus. Briquet focused on 85 cases of hysteria in children, finding that just over a third of the children had been habitually maltreated, neglected or abused by a parents (Mai & Merskey, 1981). In a later study, Briquet found that amongst adult patients diagnosed with hysteria, 75% had experienced some form of childhood trauma (Dorahy et al., 2010). Expanding on this connection, Sigmund Freud postulated that hysterical symptoms originated from experiences of sexual abuse in early childhood (Dorahy et al., 2010). Freud initially theorized that this early abuse would leave unconscious memories that would be triggered following exposure to an event of a similar nature later in life (Bulut, 2019). However, Freud later withdrew this hypothesis in favour of his Oedipal theory (Bulut, 2019).

Research in the field of childhood trauma continued slowly but steadily into the 20th century but interest remained primarily within the paediatric sector (Dorahy et al., 2010). Societal interest in childhood maltreatment and it's impacts did not gain substantial momentum until the 1960's. Dorahy et al. (2010) attributes this growth in social awareness to an increase in psychological professionals working with children and families. This time period also saw a significant shift in gender roles, as the "liberation of women from the domestic realm" (p.8) insighted new perspectives that had been absent from social discourse (Dorahy et al., 2010). This wider social change contributed to child maltreatment being perceived as a broader societal issue rather than solely a medical concern (Sanson & Wise, 2001). Additionally, evolving societal perceptions of parenting challenged traditional approaches of harsh discipline, emphasising the importance of nurturing children to foster emotional, intellectual and social development (Sanson & Wise, 2001). Since this period, societal interest in childhood trauma has remained strong, with research in the field experiencing exponential growth over the past 30 years (Dorahy et al., 2010). This continued expansion has fostered deeper insights into the long-term psychological, physiological and neurological implications of early traumatic experiences.

Adverse Childhood Experiences

In recent decades, discourse surrounding childhood trauma has frequently incorporated the term adverse childhood experiences (ACE). ACE refers to potentially traumatic event(s) that occur within the first 18 years of an individual's life, a concept first identified by Vincent Felitti in 1998. Felitti and other medical professionals at the Kaiser Permanente clinic in San Diego observed a high prevalence of reported historical sexual abuse amongst patients at an obesity clinic. Felitti hypothesized that, for many of these patients, obesity was a protective solution to their struggles with childhood abuse (Felitti et al., 1998). This correlation prompted Kaiser Permanente as well as the Center for Disease Control (CDC) to further investigate the relationship between abnormal/traumatic experiences during childhood and negative outcomes in adulthood. The study, led by Felitti and Dr. Robert Anda, developed the Adverse Childhood Experience Questionnaire (ACE-Q), which asked participants to self-report on a range of negative childhood experiences categorized into three groups: abuse, neglect and household challenges. Data was collected over a two-year period from 1995 to 1997 and a total of 17,337 adults participated as part of their standard medical evaluation. The study found that 64% of participants reported at least one ACE during their first 18 years of life, with a further 12.5% having experienced four or more. Among the categories examined, sexual abuse was the most frequently reported, affecting 22% of participants. Additionally, findings evidenced a significant association between ACE scores and a range of negative outcomes, including mental distress, relationship problems, job performance, financial problems, chronic stress and difficulties with emotional regulation (Felitti et al., 1998). As of 2025, the ACE study is still on-going and continues to be one of the world's largest investigations into childhood abuse, neglect and household challenges. Whilst our understanding of ACE’s has grown dramatically since the initial study was published, ACE’s are still commonly categorized in the same three groups proposed in the original study but have now been further subdivided into 10 categories; physical neglect, emotional neglect, physical abuse, sexual abuse, emotional abuse, exposure to domestic violence, family incarceration, mental health problems, substance misuse and family separation. Since its publication, the ACE study has become particularly foundational in the field of childhood trauma. Findings of the study not only highlighted the prevalence of ACE’s and their subsequent effect on physical health, but the dose-response relationship between traumatic experiences and negative health outcomes (Felitti, 2002). In saying this, the ACE study has faced criticism regarding it inadequacy in capturing the full spectrum of childhood adversity (Hartas, 2019). Hartas (2019) argues that the ACE framework omits critical social and environmental factors such as food insecurity, racism, housing insecurity, being placed into state care, poor socio-economic status or neighbourhood violence. Furthermore, on-going debate exists regarding the synonymity of ACE's and childhood trauma. Whilst a considerable portion of researchers use both terms interchangeably, others argue that trauma is just one possible outcome to experiencing an adverse childhood experience (Bartlett & Sacks, 2019).

Defining Childhood Trauma

Defining childhood trauma has proven to be a complex task among academics, with various disciplines, organizations and researchers offering differing conceptualisations. For example, The World Health Organisation (WHO) defines childhood trauma as "all forms of emotional, physical abuse, neglect or exploitation that results in potential or actual physical or psychological harm of the child". In contrast, the American Psychiatric Association provides a much narrower definition of "actual or threatened death, serious injury, or sexual violence" in the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013).. Terr (1991) provides a broader conceptualisation, stating childhood trauma is "the mental result of one sudden, external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations." (p. 323). Aside from the APA, definitions of childhood trauma in literature tend to arguably be broader than that of trauma that occurs in adulthood. One reason for this could be to account for the vulnerable nature of children and their increased susceptibility to the impact of adverse events. Van Der Kolk

(2005) suggests that childhood trauma is perhaps more detrimental than trauma that occurs later in life due to the lack of coping skills, emotional capacity and brain development that contribute to processing a traumatic event. What can be understood from these varying conceptualization is that childhood trauma involves single or reoccurring event that is frightening, dangerous or life-threatening (Buchanan et al., 2020). These events may be experienced personally, through a close friend or family member or as a first-hand witness (Buchanan et al., 2020).

Measurement Tools

Trauma is a deeply personal experience, and no two individuals will experience trauma in the same way. Due to this variability, quantifying trauma has proven to be a complex and challenging task, as no existing measurement tool can encompass every event that may be traumatising to an individual (Fallon et al., 2010). Despite this, several validated screening tools are available to measure childhood trauma including, but not limited to, The Child Abuse and Trauma Scale (Sanders & Becker-Lausen, 1995), The Early Trauma Inventory (Bremner et al., 2000) and The Comprehensive Child Maltreatment Scales for Adults (Higgins & McCabe, 2001). The Childhood Trauma Questionnaire Short Form (CTQ-SF), developed by Bernstein et al. (1994), is perhaps the most globally utilised measurement tool for childhood trauma (Georgieva et al., 2021). The CTQ-SF is a self-report, Likert-type scale measure, composed of 28-items depicting various childhood traumatic events. Like the ACE-Q, the CTQ-SF is retrospective, making suitable screening tool for adult survivors of childhood trauma (Schmidt et al., 2018). These various measurement tools have been widely utilised in quantitative research, and whilst they are successful in indicating prevalence, they are only able to paint part of the picture. Westermair et al. (2018) labels the reliance on these psychometric instruments as a key methodological constraint in childhood trauma research. Arguing that whilst this approach is often successful in screening for a large range of traumas, it is not able to distinguish relationships between trauma-subtypes and specific outcomes. Alternatively, researchers will focus on a singular trauma sub-type (i.e. physical abuse) and investigate its associated outcomes in adulthood without controlling for others (Westermair et al., 2018)

Prevalence

Beyond methodological limitations, determining the prevalence of childhood trauma face further challenges, as available estimates heavily rely on cases of childhood maltreatment that are reported and/or discovered by authorities (Saunders & Adams, 2014). While these statistics serve as useful indicators, they do not provide a complete picture, as a large proportion of childhood traumatic events go unreported (MacMillan et al., 2003). Children are often hesitant to disclose abuse for numerous reasons such as; shame, guilt, self-blame, fear of getting in trouble or fear of the perpetrator (Saunders & Adams, 2014). In addition to the underreporting of traumatic incidences, Saunders and Adams (2014) identify inadequate community and national surveillance, along with inconsistencies in screening methods as key factors that make childhood trauma hard to quantify. The authors also argue that at an academic level, differences in conceptualisations of childhood trauma can lead to differences in prevalence estimates. Academics adopting a broader definition to include events such as parental divorce or foster care placement may estimate a higher prevalence than those others only including more severe events such as sexual assault or witnessing a violent death (Finkelhor, 2009). In 2022, the WHO estimated that globally, one billion children between the ages of 2-17 will experience some form of physical, sexual or emotional abuse or neglect every year. Additionally, six in ten children endure some form of physical or emotional abuse in the home. The WHO further report that one in five women experience some childhood sexual abuse compared to one in every seven for men (WHO, 2024).

Childhood trauma is a pervasive issue in New Zealand, with data estimating 55% of the population will experience at least one ACE before the age of 18, a further 11.6% experience at least four (Fanslow et al., 2021). Utilising data from the 2019 New Zealand Family Violence Survey, Fanslow et al. (2023) found that an estimated one in four females and one in nine males will experience sexual abuse before the age of 15. More recent data released by Oranga Tamariki (Ministry for Children) in 2023 found 13,969 reported cases of physical, sexual and emotional abuse or emotional and physical neglect over a 12 month period. However given this represents reported cases, the report concludes this likely significantly underestimates the true prevalence (Oranga Tamariki, 2023). Research also suggests that childhood trauma is disproportionately experienced across demographic groups in New Zealand Of all children in New Zealand, Māori children are at the greatest risk of exposure to physical, emotional and sexual abuse as well as neglect (Fanslow et al., 2021).

Risk

There is no singular risk factor for childhood trauma, rather, a complex interplay of individual, interpersonal and community-level factors work in combination and will consequently increase or decrease the likelihood that traumatic events will occur. At the individual level, risk factors refer to characteristics of either the child and/or the parents/caregivers. A 2023 systematic review by Younas and Gutman analysed 68 quantitative studies on parental risk factors of childhood maltreatment. The study identified several significant predictors, including substance abuse, mental health issues, maternal history of child abuse, marital strife, domestic violence, parental stress, and single-parent families. Data also suggests that children with disabilities are also at an increased risk of maltreatment (Maclean et al., 2017). Crosse et al. (1993) reported that children with disabilities were 1.7 times more likely to experience abuse than their non-disabled peers, based on data from 35 child protective service agencies in the United States. However, the authors stipulate that this figure likely underestimates the true prevalence. More recent findings from Daigneault et al. (2023) suggest children with intellectual disabilities could be closer to 3.5 times more likely to experience sexual abuse. On an interpersonal level, negative parent-child interactions, lack of family cohesion and an absence of positive parenting behaviours have all been associated with an increased risk of childhood trauma exposure (Milner et al., 2022).

At the community level, several factors contribute to the risk of childhood trauma. Communities with high rates of crime, violence (Wade et al., 2014), high unemployment rates (Manyema & Richter, 2019), high rates of food insecurity (Chilton et al., 2015), poverty, and limited economic opportunities (Larkin et al., 2012) all present significant risk factors. Research also highlights intergenerational trauma as a risk factor of childhood trauma. Yehuda et al. (2001) examined the impact of parental PTSD among holocaust survivors on their children. Among the 51 participants, 32 had at least one parent with lifetime PTSD diagnosis. Utilising the Childhood Trauma Questionnaire, individuals with parental PTSD reported significantly higher rates of emotional abuse and neglect (67% vs. 37%) and physical neglect (56% vs. 21%) compared to those without. A 2008 follow-up study of 211 offspring of holocaust survivors indicated a higher prevalence of mood disorders, PTSD, anxiety disorders and substance abuse disorders (although this was to a lesser extent) (Yehuda et al., 2008).

Protective Factors

Not all childhood traumatic experiences will foster negative outcomes, at the very least these outcomes will vary in severity from one child to another. A growing body of literature has explored the role of protective factors on the individual, interpersonal and community levels that work to mitigate the impacts of traumatic experiences in childhood (Milner et al., 2022; Austin et al., 2020). At an individual level, certain characteristics can enhance a child's ability to cope with trauma, including positive self-esteem, secure parental attachment, ability to emotionally and behaviourally self-regulate, good physical health, strong peer relationships, involvement in hobbies and positive activities, social competence, and good coping skills (Milner et al., 2022). Among parents and caregivers, protective factors include social and emotional competence, nurturing parental skills, employment, high level of education, positive self-esteem as individual protective factors (Milner et al., 2022). Interpersonal protective factors include a positive parent-child relationship, two-parent household, extended family support, middle to high socio-economic status, strong cultural identity, strong social network and economic security (Meng et al., 2018). At the community level, protective factors include low levels of community violence as well as access to healthcare, childcare, good schools and affordable housing (Austin et al., 2020; Jean-Thorn et al., 2023). However, not all protective factors have the same level of influence. Findings from Meng et al. (2018) indicate that as a child ages, the influence of these protective factors will shift, with interpersonal and community protective factors becoming more significant in mitigating negative outcomes during adolescence. Additionally, the study found that the earlier the trauma occurs, the more protection factors are needed. The authors stipulate this could be due to the heightened vulnerability of early childhood development, necessitating stronger protective influences (Meng et al., 2018).

Impacts of Childhood Trauma

In a research context, interest in the impacts of childhood trauma on mental and physical health has been interdisciplinary. Extensive literature across medical, psychological and educational fields have evidenced an extensive range of psychological, cognitive, behavioural and social impacts, leading some academics to classify childhood trauma as a public health crisis (Magruder et al., 2017; Lambert et al., 2017). This section will explore these short-term and long-term effects of childhood trauma, discussing its impact on the stress response system, brain development and function, psychological impacts, attachment and social development, and physical health.

Life Course Perspective

The Life Course Perspective (LCP) provides a valuable framework for understanding how trauma-exposure in childhood leads to negative impacts into adulthood (Fink & Galea, 2015). LCP is a multidisciplinary theoretical framework, integrating insights from a variety of academic fields including, social work, anthropology, and sociology (Hutchison, 2010). First developed in the 1960's by sociologist Glen Elder Jr. following his analysis of three longitudinal studies centred on the continued development and life trajectories of its participants (Hutchison, 2010). Whilst examining the data sets that spanned several decades, Elder observed the significant impact the Great Depression had on the lives of the children and families in that data set. Noting this link, Elder called for a developmental theory that focused on historical life forces that contributed and structured a child's development and later livelihood (Hutchison, 2010). LCP draws heavily on traditional developmental theory in psychology and is purposive in contextualising how experiences in childhood shape an individual's development as they grow into adulthood and beyond (Hutchison, 2010). Central to LCP is the idea that that there are certain and salient stages of life that are particularly susceptible to influence (Kira, 2022). Given childhood encapsulates the most significant developmental stages, children who experience trauma are therefore more vulnerable to the quantity and severity of long-term adverse impacts (Monnat & Chandler, 2015).

Stress Response System

Perhaps the most immediate effect of trauma is its impact on the body's stress response system (SRS). When an individual encounters an event or condition that is threatening, frightening, or stressful, the body's SRS is activated. These system is made up of a myriad of individual and interacting bodily networks that direct the body's attention toward protecting itself against the perceived threat by redirecting metabolic resources away from homeostasis and towards self-preservation (Charmandari et al., 2005). A key component of the SRS is the Hypothalamic–Pituitary–Adrenal (HPA) axis, a neuroendocrine network involving the hypothalamus, the pituitary gland and the adrenal gland. (Herman et al., 2016). The primary function of the HPA axis is to produce cortisol, a critical stress response hormone responsible for a wide range of bodily processes (metabolism, immune response, sleep-wake cycle etc.) (Herman et al., 2016) . The HPA functions through a chain reaction of hormones, operating in a negative feedback loop. When the brain perceives something as frightening or threatening, the autonomic nervous system will signal the hypothalamus to release corticotropin-releasing hormone, triggering the pituitary gland (located at the base of the brain) to release adrenocorticotropic hormone (ACTH) (Herman et al., 2016). ACTH then signals the adrenal glands (located at the top of the kidneys) to release cortisol (Herman et al., 2016). Activation of the HPA axis leads to changes in heart rate, metabolic rate, blood pressure and alertness (Smith & Vale, 2006). Whilst the HPA axis is vital for survival, chronic or frequent activation of this system can have long-term negative consequences on both the brain and the body (Guilliams & Edwards, 2010). When an individual experiences chronic stress, the HPA axis can become over-activated leading to frequently increased levels of cortisol in the body (Guilliams & Edwards, 2010). Consistently elevated cortisol levels caused by over-activation of the HPA axis (also called HPA axis dysfunction) can have several long-term consequences such as increased risk of autoimmune disorders (Stojanovich & Marisavljevich, 2008), hypertension (Burford et al., 2017), and mood disorders (Watson & Mackin, 2006). Prolonged and chronic overactivation of the HPA axis has been linked to an increased risk of developing anxiety and affective disorders later in life (Juruena et al., 2020).

Brain Development and Function

The dysregulation of the stress response system caused by trauma-exposure can have detrimental impacts on the development, structure and function of a multitude of stress sensitive areas in the brain (De Bellis & Zisk, 2014). The effects of trauma on the brain are a pertinent consequence to consider when discussing childhood trauma due to the critical periods of brain development that occur in childhood (Cross et al., 2017). Whilst there are large bodies of research into the area of childhood trauma and subsequent impacts on brain development, the majority include a focus on comorbid disorders such as post-traumatic stress disorder (PTSD). Although not as extensive, literature investigating the effect of child trauma in non-PTSD individuals has evidenced significant impacts on brain development and function. For example, the hippocampus, which plays a major role in learning and memory, is induced into a state of physiological hyperarousal when exposed to trauma (Woon et al., 2010). In this state memory processing is negatively impacted and is abnormally processed and regulated. Additionally, the hippocampus can also suffer structural damage as a consequence of childhood trauma (Teicher et al., 2012). In observing the MRI scans of PTSD diagnosed individuals with histories of childhood sexual and physical abuse, Bremner et al. (1997) reported a 12% reduction in left hippocampal volume in comparison to a control group. Additionally, participants in both Teicher et al. (2012) and Bremner et al. (1997) also showed significantly lower memory function scores, consistent with the hippocampal role in the brain. Similarly, Stein et al (1997) also reported observations of reduced volume in the left hippocampus amongst females with childhood sexual abuse. More recently, a meta-analysis conducted by Riem et al., (2015) also evidenced notable hippocampal volume reductions in victims of childhood trauma. Functional and structural changes have also been observed in the amygdala, an area of the brain responsible for emotional processing (Weissman et al., 2020). Mclaughlin et al. (2019) observed reduced amygdala volume in children who had been exposed to violence in comparison to children who hadn’t. Trauma-exposed children are also prone to increased amygdala reactivity in which they display heightened and intensified reactions to negative stimuli or threat cues (Teicher et al., 2016). If this trauma is chronic or frequent the risk of these neurobiological impacts are increased (Cowell et al., 2015).

Psychological Impacts

The consequential neurocognitive changes that occur following trauma-exposure in childhood have been significantly associated with a range of psychological consequences in later life (Zlotnicket al., 2008). Structural and functional changes to the amygdala impact the body's threat processing system and place increased stress on the brain's ability to emotionally regulate (Tottenham & Gabard-Durnam, 2017). Individuals with histories of childhood trauma exhibit increased “stress susceptibility” meaning daily stressors become overwhelming and difficult to navigate (Gerin et al., 2019). A critical issue in trauma responses is that children, particularly young children, are limited in their capacity to process overwhelming feelings of fear and anxiety. Strong bodies of research have associated childhood trauma with comorbid psychological issues such as substance abuse (Min et al., 2007), eating disorders (Tasca et al., 2013), depression (Heim et al., 2008), PTSD (Moser et al., 2020), obsessive-compulsive symptomology (Mathews et al., 2008), anxiety disorders (Kuzminskaite et al., 2022), suicidal ideation (Wang et al., 2022), and borderline personality disorder (Ball & Links, 2009). Behaviourally, childhood trauma is also associated with increased aggression (Sansone et al., 2012), self-harming behaviors (Serafini et al., 2017), low self-esteem (Downey & Crummy, 2022), sexual-deviancy (Levenson & Grady, 2016) and impulsivity (Roy, 2005). Childhood trauma can also be a mediating factor in treatment outcomes of comorbid disorders. A 2012 meta-analysis conducted by Nanni et al. (2012) found childhood trauma was significantly associated with poorer treatment responsiveness, symptom persistence and higher relapse risk among individuals with depression.

PTSD. Post-traumatic stress disorder (PTSD) is perhaps the most universally understood consequence of childhood trauma. PTSD is a psychiatric disorder characterised by the presence of on-going negative symptoms after witnessing or experiencing a traumatic event. Symptoms of PTSD include, but aren’t limited to, flashbacks, insomnia, prolonged psychological distress, dissociation, heightened anxiety and depressed mood (Miao et al., 2018). According to the WHO an estimated 3.9% of the population will meet the diagnostic criteria for PTSD at some stage in their lives (Koenen et al., 2017). However, not all individuals who experience childhood trauma will develop PTSD, as only an estimated 5.6% of trauma-exposed individuals go on to develop the disorder (Koenen et al., 2017). There is evidence to suggest that the risk of PTSD development is mitigated by the type of traumatic event experienced, with sexual violence and physical abuse carrying the highest risk (Kessler et al., 2017). Kessler et al. (2017) also suggest that prior trauma history is also significantly associated with PTSD development with subsequent traumas. This means that individuals with a history of childhood trauma are more likely to develop PTSD when re-exposed to the same trauma type in comparison to individuals with no prior trauma history.

Depression. A strong empirical relationship also exists between childhood trauma and depression. In their meta-analysis Mandelli et al. (2015) found that trauma-exposed children are between two to three times more likely to develop depression or depressive symptoms in adulthood in comparison to non trauma-exposed children. Another meta-analysis conducted by Nelson et al. (2017) found 46% of individuals with depression reported a history of childhood trauma. By trauma type, Mandelli et al. (2015) found emotional abuse to have the most significant association with depressive symptoms. Similarly, Humphreys et al. (2020) found that emotional abuse and neglect demonstrated the strongest association. This strong association between depression and emotional abuse has been corroborated by a number of studies (Martins-Monteverde et al., 2019; Maric et al., 2016). Moreover, research suggests that frequency of trauma is positively correlated with both the development of depression and severity of depressive symptoms, (Openshaw et al., 2015; Negele et al., 2015). This indicates that children who experience prolonged or chronic trauma are at a greater risk for developing depression over time.

Attachment & Social Development

There is strong empirical evidence to suggest that childhood trauma significantly impacts the development of a child's attachment style, which in turn shape a child's emotional and social development (Yilmaz et al., 2022; Lahousen et al., 2019). The earliest and most significant attachment we make as children is to our parents/caregiver, as this fundamental relationship informs how we go on to establish and maintain future interpersonal relationships (Bowlby, 1988). Originally proposed by John Bowlby in the 1951, attachment theory highlights the importance of the emotional bond between parent and child on the child's emotional well-being and development. How well our parent or caregiver can meet our needs informs the attachment style we develop, which then influences later interpersonal relationships (Bowlby, 1988). Overall, attachment styles can be categorized into two broad groups: secure and insecure. A secure attachment represents a relationship in which a child seeks and is able to receive comfort from a parent or caregiver when distressed. Secure attachment has been positively associated with increased social-emotional competence, cognitive functioning and mental health outcomes (Ranson & Urichuk, 2008). An insecure attachment style develops when a parent or caregiver fails to consistently meets the child's needs. Therefore, children raised in abusive or neglectful environments are more likely to develop an insecure attachment style due to consistently unmet needs, lack of protection, and lack of safety Erozkan (2016). Erozkan (2016) hypothesizes that over time, children exposed to trauma will come to expect these characteristics in all interpersonal relationships, contributing to difficulty with intimacy, affection, challenges sustaining friendships, distrust in others, and oppositional behaviour in adolescence and adulthood. However, recent studies have also presented evidence that secure attachment styles may act as a protective factor against negative outcomes associated with childhood trauma (Gause et al., 2022). Crouch et al. (2018) found that amongst adults with a history of four or more ACE's, those who reported secure childhood attachment with an adult who made them feel safe and protected, were less likely to report symptoms of mental distress or health concerns.

Physical Health

There is also a substantial body of literature evidencing strong relationships between childhood trauma and a plethora of negative health consequences in adulthood. Findings from the ACE study suggest that individuals with four or more ACE'S are 390% more likely to develop chronic obstructive pulmonary disease (COPD) than an individual with an ACE score of zero (Felitti et al., 1998). Lopes et al. (2020) attribute the increased rates of COPD amongst adults with childhood trauma to the high prevalence of smoking amongst this demographic, as previous literature suggests they are up to four times more likely to smoke cigarettes than those without a history of trauma Spratt et al. (2009). Childhood trauma has also been linked to metabolic dysfunction, particularly the development of Metabolic Syndrome which involves abdominal obesity, hypertension, hyperglycaemia and high cholesterol (Souama et al., 2024). There is some evidence to suggest that this relationship is mediated by trauma type, with sexual abuse, physical abuse and neglect demonstrate the strongest association (Souama et al., 2024). Individuals who have experienced trauma in childhood are also at an increased risk for obesity as maladaptive coping strategies, such as unhealthy relationships, often develop as a means of alleviating emotional distress following or during the traumatic period (Dye, 2018). This coping mechanism will often persist into adulthood, further contributing to obesity risk (Russell et al., 2016). In addition, findings from a cross-sectional observational study across a German sample, also evidenced significant association with an increased risk of diabetes, heart disease and stroke (Clemens et al., 2018). Moreover, recent findings also suggest that childhood traumatic experiences are significantly associated with an increased risk of cancer in adulthood, although this is dependent on the chronicity of the trauma (Holman et al., 2016; Hu et al., 2021).

Mental Healthcare in New Zealand

This section begins with an outline of the evolution of New Zealand’s mental healthcare system, followed by a summary of the current disparities facing the New Zealand’s psychology workforce. The various avenues of mental health support available in New Zealand will then be outlined in the following order; public mental health system, private mental healthcare, ACC, Helplines, Digital services and Employee Assistance Programmes.

The System

New Zealand’s mental health system has undergone radical changes over the past century. The New Zealand’s Mental Health Commission's 2012 publication “Blueprint II”, characterised these periods of marked change as “waves”. Williams et al. (2017) expanded on this framework, outlining three distinct waves in the history of New Zealand’s Mental Health System.

The first wave (1840’s to 1960’s) was one of mass institutionalisation, with mental health treatment occurring almost entirely in psychiatric facilities (Williams et al., 2017). In 1844 New Zealand Government authorities built its first ‘home for lunatics’, a small building attached to the pre-existing Wellington jail (Hamilton, 2019). Later that year, a similar structure was attached to another jail in Auckland. Other jails across the country quickly followed suit to house those suffering from mental disorders (Brunton, 2003). Inmates in these buildings received no form of treatment, as they were merely designed to separate the mentally ill from the rest of society (Brunton, 2003). Legislation released in 1846 allowed those with mental disorders to be housed in public hospitals, but overcrowding often made this challenging (Brunton, 2022). The 1860’s and 1870’s saw several asylums built across the country for longer term management of mentally ill people, however these were often staffed with individuals with little to no medical training (O’Brien & Kydd, 2013). The approach to mental illnesses in this period was one of practicality, rooted in an “out of sight out of mind” attitude as individuals struggling with psychological disorders were seen as burdensome, incurable and a danger to the community (Williams et al., 2017). As such, patient care within these facilities centred on long-term containment and behavioural management rather than medical treatment or psychological therapies (Brunton, 2003). By the early 1900’s, approaches and attitudes towards mental illness and care began to shift. The term “mental hospital” replaced “asylum” and new medical treatments gradually supplanted moral management as the dominant treatment approach (Brunton, 2022). Staff in mental hospitals also began to receive training, interest in psychiatry as a medical specialization grew, and out-patient clinics began to emerge in several regions across the country (Williams et al., 2017).

The late 1950’s marked the beginning of the second wave, characterised by a rapid movement toward deinstitutionalisation from psychiatric facilities (Williams et al., 2017). Growing awareness of the detrimental effects of involuntary and long-term institutionalisation such as loss of freedom and dignity, saw large numbers of patients in psychiatric facilities being moved into community care (Brunton, 2022). However, as Brunton (2003) states, this era focused more on ‘de-hospitalization’ than true deinstitutionalisation. The focus remained centred on moving individuals out of long-term in-patient psychiatric care, rather than addressing the on-going and deep-rooted effects of institutionalisation, such as loss of dignity and freedom (Williams et al, 2017). This led to large numbers of patients continuously returning to in-patient psychiatric care shortly after entering the community (Williams et al., 2017). The deinstitutionalisation movement is largely regarded as a failure and highlighted the need for mental illness to be treated through a more centralized public system. This prompted the government to work towards developing community-based mental health services and direct funding into publicly funded mental healthcare (Williams et al., 2017). During this time, the ‘recovery model’ became the dominant approach, in which the aim to “live well” in the presence or absence of mental illness was promoted (Ramalho et al. 2022). This approach optimized patient care over removal from society and ethics, respect, right to dignity and privacy became important principles (Ramalho et al. 2022).

The third wave, beginning in the mid-1990’s, further solidified the transition to community mental health services (Williams et al., 2017). By this time, nearly all psychiatric facilities across the country had been shut down, and patients had been transitioned into community-based care (Joseph & Kearns, 1996). Counselling and other social support services expanded, and general practitioners were given moderate training in mental illness and care (Brunton, 2003). Additionally, numerous non-government organisations (NGO) services began to emerge across the country, as mental healthcare was no longer exclusively state funded (Ramalho et al., 2022). However, the rapid expansion of these organizations, each offering different types of support across various regions, resulted in a fragmented system, lacking cohesion, communication and continuity of care (Williams et al., 2017). This fragmentation negatively impacted the quality of care provided, leading to the government re-strategize its approach to mental healthcare (Brunton, 2022). In response, a three-tiered mental health system was established, backed by a strong focus on appropriate mental health treatment and positive mental health. In this new system, services were categorized into primary (GP clinics, nursing services, private clinics), secondary care (Kaupapa Māori clinics, psychiatrists and other medical specialists) and tertiary care (in-patient psychiatric care or highly specialized referrals). Under this structure, patients are typically initially assessed at the primary level and referred to higher levels based on severity and complexity of their needs. While this tiered approach remains the foundation of New Zealand’s public mental healthcare system today, it has faced on-going criticism, particularly regarding inequities in funding distribution (Williams et al., 2017). The primary sector, despite representing the front-line of care for those within the community, has historically received reduced funding in favour of more specialized services within the secondary and tertiary levels (Dowell et al., 2009). However, recognition of the critical role of primary care began to increase as emerging research highlighted the prevalence of mental illness in New Zealand, inequities and mental health disparities facing Māori and Pasifika populations, and the strong interconnection between mental and physical health (Williams et al., 2017).

In 2017 the WHO collected global data on psychologists per 100,000 people. When equating clinician who worked in public mental health services the data estimates New Zealand to have 9 psychologists (of all practicing scopes) per 100,000 people (WHO, 2017). In comparison, Finland, which maintains a relatively similar population size, has 142 psychologists per 100,000 people (WHO, 2017). Rucklidge et al. (2018) further underscored this shortage, estimating that New Zealand had one practising clinical psychologist for every 312 individuals experiencing mental distress. For those suffering severe mental distress, the ratio was one clinical psychologist for every 142 individuals (Rucklidge et al., 2018). The 2016 Aotearoa New Zealand Psychology Workforce Survey reported additional workforce disparities, estimating that 90% of the psychology workforce in New Zealand was Caucasian while only 5% identified as Māori and 1% Pasifika (Psychology Workforce Task Group, 2016). In terms of gender, the survey found 77% of the psychology workforce was female and 23% are male.

Avenues of Support

Public Mental Health Services. The public sector is perhaps the most common access point for mental healthcare in New Zealand. Public mental health services are government funded and were previously managed by the 20 regional District Health Boards (DHB) until a major healthcare reform in July 2022 (Ramalho et al., 2022). This reform consolidated the DHB's into a single national agency, Te Whatu Ora (Health New Zealand), which now oversees all public mental healthcare services including in-patient hospital care, specialists, primary care and community based services. Access to care typically begins at the primary care level with General Practitioners (GP's) who are then able to make referrals for further support. Although varying by region, public mental healthcare services commonly include multidisciplinary outreach and inpatient teams, consisting of varying mental health and medical professionals. Treatment options typically include group therapy, talk therapy, medication prescribing, as well as a range of other individualized therapeutic interventions. Despite offering a number of comprehensive services, rising demand, staffing shortages and resource limitations have placed considerable pressure on the public mental health system, resulting in long wait-times for many New Zealanders (Paterson et al., 2018).

Treatment in the Private Sector. The private mental health sector refers to practices, clinics and services that do not receive government funding. Therefore, treatment in the private sector often occurs at full cost to the consumer with prices varying amongst different regions, clinics and practitioners. Collated data on treatment costs in the private sector are seemingly unavailable, but an online search across varying regions revealed an average $180 - $250 per session with a registered psychologist. Counselling sessions with a registered counsellor appear to be slightly cheaper at $120-$140. Mental health professionals working in the private sector have also been met with a significant increase in demand over the past decade. Whilst there is very limited data on psychologists in the private sector, A 2021 workforce survey found amongst 271 private clinical psychologists at least half reported having to turn away at least 10 new clients per month (New Zealand College of Clinical Psychologists, 2021). In some cases, this number was as high as 40.

ACC. The Accident Compensation Corporation (ACC) provides compulsory insurance cover for anyone in New Zealand who has suffered an accidental personal injury. Included in this scheme is initial cover for anyone in New Zealand (resident or visitor) who has suffered sexual assault or abuse whilst in the country (ACC, 2025). There is no time limit for claims of this nature and thus this pathway to care can be accessed regardless of when the assault occurred. Claims of this nature are called ‘sensitive claims’ and are typically lodged through a GP, who will document the relevant information and lodge this with ACC. Following policy changes in late 2024, the scheme now covers up to 14 hours of initial therapy with an ACC certified clinician, and 30 hours of additional support. Once assessed, the clinician will determine the length of care needed to achieve recovery, ranging from 8-100 hours of care. Unfortunately, due to both the large number of sensitive claims and low client in-take capacity, individuals seeking help through ACC sensitive claim schemes are often waiting months at a time for care (ACC, 2024). ACC reports that in the first quarter of 2024, 1,347 individuals remained on the waitlist with an average wait time of 15 weeks across regions (ACC, 2024). In this same period, 21,00 referrals were unable to be accepted due to capacity constraints (ACC, 2024). As well as therapeutic care, ACC also offers Loss of Potential Earnings (LOPE) payments in some circumstances. These regular payments are available to individuals who are unable to work due to a mental or physical injury that occurred prior to the age of 18 years, including those who have suffered from childhood trauma. However, ACC considers the date an individual first reports or seeks treatment for this mental injury as the date the injury occurred. Since many survivors of childhood trauma can take years to officially report traumatic events (Allnock & Miller, 2013), they can miss out on the full benefits of compensation.

Helplines. Helplines are an essential component of the mental healthcare system due to the accessibility, affordability, anonymity and confidentiality they provide (Mahmood et al., 2024). There are a variety of national and regional helplines available in New Zealand for mental health support and advice. The majority of these helplines are available, for free, 7 days a week 24 hours a day and can be accessed by text or call. Many of the helplines such as The Depression Helpline, Lifeline and 1737- Need to Talk? are staffed with trained mental health professionals. Helplines are particularly critical in areas of geographical isolation, individuals who are in need of immediate support or advice, or those who are hesitant to disclose their experiences face-to-face (Mahmood et al., 2024). The COVID-19 pandemic saw an uptake in demand on national helpline services (Scerri et al., 2021). In the first three months of the pandemic in 2020, national helplines in New Zealand saw a 12.4% increase in calls as lockdown restrictions reduced access to in-person services (Pavlova et al., 2022)

Digital Mental Health Services. The rise of technological advancement has also seen an increase in mental health services provided in the digital space. Therapists, clinicians and other mental health professionals are now able to offer sessions via video calls, chat sessions and online courses. The accessibility provided by these digital services has aided in expanding the reach of mental healthcare, particularly to individuals who are located in rural areas (Graham et al., 2021). The accessibility of these digital services may also serve to ease the significant demand that currently exists on more mainstream mental health services (Moock, 2014). Like helplines, the COVID-19 pandemic had a major impact on utilisation of digital mental health services (Mahoney et al., 2021). Mahoney et al. (2021) found that New Zealand based digital mental health service 'Just A Thought' saw over a 100% increase in registered service users during the first 3 months of the pandemic. In the 2020/2021 period, depression support website 'depression.org.nz' saw 515,036 visitors which, at that time, represented 1 in every 10 New Zealanders (Mahoney et al., 2021). Garrett et al. (2024) surveyed 1471 participants aged 15-30 across New Zealand, 641 of whom had previously accessed digital services, finding that despite positive access experiences, participants felt it couldn't replace face-to-face care.

Employee Assistance Programmes. Employee Assistance Programmes (EAP) provide confidential, short-term, counselling services for employees in the workplace. There are currently several EAP service providers in New Zealand that are utilised by a range of organizations and workplaces. EAP provide a range of short-term support for employees to access through their workplace, including mental health support, financial advice, legal advice and career guidance. Although employees access EAP through the workplace, counselling is not restricted to work-related concerns, employees can confidentiality access EAP for any mental health concerns or stressors in their personal or professional life. EAP is a short-term service, providing an initial 3-sessions with a registered counsellor or psychologist to each employee. All New Zealand based data is scarce, international research reports a steady increase in EAP service usage, particularly since the COVID-19 pandemic (Veldsman & van Aarde, 2021).

Seeking Treatment for Childhood Trauma

This section begins by examining trauma-informed care and its significance in treating trauma-exposed individuals. Following this, the available treatments and interventions currently utilized for treating childhood trauma are then explored. Concluding with a discussion on the limited literature that has investigated barriers and facilitators to mental healthcare for adult survivors of childhood trauma.

Trauma-Informed Care

Historically, mental healthcare approaches have maintained a strong focus on treating a person based on their presenting symptoms, typically aiming to 'fix' what was 'wrong' with a person (Butler et al., 2011). In contrast, a trauma-informed care (TIC) approach to care seeks to understand a person and their symptoms within their individual context and experiences (Butler et al., 2011). TIC represents an approach to mental health treatment that centralizes traumatic experiences (Mihelicova et al., 2018). On a foundational level, TIC views a traumatic experience as more than just a past event, but as a complex and formative experience with the potential to have multifaceted and on-going impacts on an individual's life and well-being (Reeves, 2015). Thus, TIC approaches emphasize safety, support and healing in the care environment. (Mihelicova et al., 2018). In the past three decades, trauma-informed care has become a fairly dominant care model across healthcare and mental health-care spaces (Butler et al., 2011). Butler et al. (2011) connects this shift toward trauma-informed care to the rapid expansion of literature on childhood trauma following the publication of the ACE study in 1998, signifying continued growth in social and academic interest in the impacts of early traumatic experiences.

Therapies and Interventions

Childhood trauma itself is not a diagnosis, and as such, there is no ‘cure-all’ for treating traumatic experiences. The high degree of subjectivity surrounding what is considered to be traumatic means that treating childhood trauma occurs in a multitude of ways (Dye, 2018). There are observable gaps in current literature on treatment options for adults with childhood trauma. The majority of research appears to centre around individuals with symptoms of PTSD which, whilst a prominent outcome of experiencing trauma, is only one of many associated with trauma exposure in childhood. The other portion of literature appears to focus on treating trauma exposure shortly following the event itself. In saying this, there are several evidence-based treatments that are used to treat trauma symptoms in adults with childhood trauma.

Trauma-focused Cognitive Behavioural Therapy. Trauma focused cognitive behavioural therapy (TF-CBT) is a common treatment for PTSD (de Arellano et al., 2014). As a therapy it utilizes psychoeducation, exposure, trauma narrative, processing and relaxation skills to reduce symptoms of PTSD through a series of 12-16 sessions (Verma et al., 2021)., TF-CBT is mainly utilized for treating trauma symptoms in children and adolescents but it has also been evidenced as a successful psychological intervention for adults (Ehring et al., 2014). Whilst originally designed to address symptoms associated with sexual abuse, TF-CBT has since been adapted to treat various other forms of childhood trauma (Verma et al., 2021).

Cognitive Processing Therapy. Cognitive processing therapy (CPT) is a specialized form of Cognitive Behavioural Therapy and is also commonly used in trauma survivors with PTSD (Moring et al., 2020). Typically delivered over 12 one-on-one sessions, CPT aims to aid individuals in processing and conceptualising their traumatic event(s) as well as address, challenge, and modify any associated unhealthy or harmful behaviours (Moring et al., 2020).

CPT has strong empirical foundations and is a commonly recommended treatment option for trauma-based disorders such as PTSD (Asmundson et al., 2018). However, literature on the efficacy of CPT on treating trauma without a PTSD diagnosis is scarce. As is with most trauma-focused treatments, literature on the validity of CPT using New Zealand samples is virtually non-existent.

Eye Movement Desensitization and Reprocessing Therapy. Developed by Francine Shapiro in 1987, Eye Movement Desensitization and Reprocessing Therapy (EMDR) is an empirically validated structured psychotherapy often utilized in treating symptoms of traumatic stress (Shapiro, 2002). Rooted in the Adaptive Information Processing Model, EMDR posits that symptoms of traumatic stress originate from improperly processed memories of a traumatic event. When these unprocessed memories are triggered by an external event (often one that resembles elements of the original trauma), it causes the individual to re-experience the thoughts, emotions and sensations felt during the traumatic event. Unlike traditional trauma-focused therapies, EMDR is focused on addressing memory of the event, rather than the thoughts, emotions and beliefs surrounding the trauma (Perlini et al., 2020). The eight-phase treatment involves the client identifying a vivid visual image of the event as well as the negative self-beliefs, emotions and physical sensations related to the traumatic memory (Perlini et al., 2020). Clients will then be asked to recall the imagery, beliefs and sensations whilst moving their eyes in a rhythmic bilateral (side to side) pattern, other bilateral stimulations can also be used such as tonal taps or hand tapping. Through these structured eye movements and/or other bilateral stimulations, EMDR aims to restructure traumatic memories to reduce or eliminate symptoms of traumatic stress (Perlini et al., 2020). A vast body of literature has produced findings supporting EMDR as an effective treatment for reducing systems of childhood trauma such as dissociations, shame and guilt (Boterhoven de Haan et al., 2020) as well as associated comorbidities including PTSD, depression, anxiety (Chen et al., 2018), eating disorders, sexual dysfunctions, OCD, mood disorders, and addiction issues (Scelles & Bulnes, 2021). A 2005 randomised controlled trial, d found that in comparison to most traditional trauma-based therapies such as CBT, EDMR produces relative equal results whilst requiring minimal traumatic memory recall. Additionally, EMDR requires less of the client's time outside of therapy sessions (no at home tasks to complete), making it a potentially more favourable and accessible treatment option (Rothbaum et al., 2005).

Barriers to Care-Seeking

Despite the abundance of trauma-related research, only a limited number of studies have examined childhood trauma-related barriers to care. de Boer et al. (2022) investigated the barriers and facilitators to care amongst women with complex trauma histories in Australia. Through semi-structured interviews with 11 women, the study identified several systemic, treatment-related, and intrapersonal barriers to care. At a systemic level, participants highlighted the inadequacy of subsidized care within the public mental healthcare system. The women reported that available subsidized care was short-term, which they felt negatively impacted their ability to establish trust in the therapy space and did not provide sufficient time to address their trauma. Financial constraints restricted the woman from seeking alternative forms of support, such as private care, leaving them feeling stuck between ineffective short-term support or no care at all (de Boer et al., 2022). Additionally, the women also reported difficulties in finding providers that offered trauma-specialised care, with geographical distance or absence of referrals from healthcare providers making this even more challenging. A lack of trauma-informed care in the therapy space led to dissatisfaction with treatment and negative care experiences. In terms of intrapersonal barriers, de Boer et al, (2022) identified fear of stigma, distrust in providers, re-traumatisation in the therapy environment and low perceived need of care as key obstacles for the women. Ellinghaus et al. (2021) reported similar findings while exploring barriers to mental healthcare amongst trauma-exposed young people. Collecting data across five internet forums, the study found perceived ineffectiveness of treatment, difficulty navigating the mental health system, limited availability of practitioners and issues in the therapeutic relationship as key obstacles to care. Reflective of the findings of de Boer (2022), participants also felt the subsidized care they were offered through the public system was too brief to facilitate meaningful trauma recovery (Ellinghaus et al., 2021). Sivagurunathan et al. (2019) examined the barriers to help-seeking amongst adult male survivors of child sexual abuse from the perspective of Canadian service providers. Reflective of the findings of de Boer et al. (2022), service providers recognized that a lack of adequate trauma-specific services was a critical barrier to care as well as limited services for those living in rural areas, long wait times, lack of gender-specific services, lack of cultural sensitivity, limited referrals from healthcare providers (Sivagurunathan et al., 2019). Reflective of the previous findings, participants also reported that the length of care offered through the public mental health system was too limited to adequately deal with their trauma (Sivagurunathan et al., 2019). A systematic review conducted by Kantor et al. (2017) investigated barriers to care amongst adult trauma survivors, although not specifically focusing on childhood trauma survivors they included related terms in their search protocol. Frequently reported barriers included lack of available mental healthcare services, language barriers, geographical distance, time constraints, financial cost of care, previous negative experiences with professional support, and low mental health literacy (not able to recognise symptoms as mental health issues) (Kantor et al., 2017). Echoing de Boer et al. (2022), the study also found internal barriers such as concerns of stigma, shame, fear of social consequences, distrust and concerns for confidentiality, lack of treatment-related knowledge as a key obstacle. Kantor et al. (2022) also reported similar internal barriers among Austrian adults with histories of child maltreatment in foster care with lack of mental health literacy, stigma, shame and rejection all being significant barriers. Like Kantor et al., (2017), the study identified previous negative care experiences as a key obstacle to care.

Facilitators to Care-Seeking

Among the limited literature on barriers and facilitators to accessing and utilising mental healthcare for adults with childhood trauma, studies indicate that participants tend to provide less information on facilitators in comparison to barriers (Kantor et al., 2017; de Boer et al., 2022). In saying this, existing research has identified a number of factors that encourage and facilitate seeking and engaging in mental health services. Kantor et al. (2022) found that subsidised/free treatment, social support from significant others, and receiving personal recommendations for specific psychologists were all facilitators of care-seeking amongst adults with histories of child maltreatment. Additionally, the 2017 systematic review by Kantor et al. also found social support to be a facilitator amongst adult trauma survivors as well as reduced stigma, experiences of trust, and motivation to avoid burdening family members. The study also found that reaching a crisis point, in which symptoms or impacts of mental distress become overwhelming, motivated care-seeking (Kantor et al. (2017). Positive past experiences with care providers were also identified as a facilitator, indicating the quality of the therapeutic relationship to be an important facilitator to care access and engagement. The importance of the therapeutic relationship was further emphasized in the findings of Ellinghaus et al. (2021) who evidenced that trusting relationship between client and clinician was a significant facilitator to accessing care and disclosure of trauma amongst trauma-exposed young adults. Similarly, de Boer et al. (2022) found that supportive and empathetic relationships with mental healthcare providers were instrumental in maintaining continued engagement in therapy.

Summary and Observed Gaps in Literature

Prior research in the field of childhood trauma highlights several notable findings. Firstly, childhood trauma is an incredibly prevalent and pervasive issue faced globally. Secondly, childhood traumatic experiences are well evidenced to have significant causal relationships with a myriad of negative short-term and long-term outcomes. These outcomes impact all aspects of well-being including brain development and function, physiological and psychological well-being, and social development. Thirdly, whilst the mental health system in New Zealand has undergone radical changes in the past century, several issues still face the system including under-funding, under-staffing and long wait times. Lastly, there is a clear disconnect between the high rates of mental illness and distress and low levels of mental health service usage.

Significant gaps remain in literature on barriers and facilitators to care for adults with childhood trauma. Existing research investigating the barriers and facilitators to mental health service use for trauma-exposed individuals has primarily focused on adults who experienced trauma after the age of 18 or trauma-exposed children/adolescents. Research exploring the barriers to seeking and utilising mental health treatment in adult survivors of childhood trauma is scarce, and research in a New Zealand context is, to the best of my knowledge, non-existent. Given the extensive evidence on the long-term impacts of childhood trauma in addition to the clear disconnect between the high prevalence of childhood trauma and the low rates of mental healthcare service utilization in New Zealand, investigating the barriers and facilitators care for this population is crucial. Developing a deeper understanding of these challenges and supports will provide invaluable insights, enabling tailored and effective care, increasing mental healthcare utilisation and minimizing negative outcomes (Ellinghaus et al., 2021).

The Current Study

Through Interpretive Phenomenological Analysis (IPA), the current study aims to contribute to literature pertaining to the lived experiences of adults with histories of childhood trauma, investigating both the barriers and facilitators that exist to seeking and utilising mental healthcare. Research questions in IPA are purposefully broad and open as IPA does not aim to test predetermined hypotheses or create generalizations regarding populations of interest. The current study was therefore guided by the following research questions:

1. What are the perceived barriers to accessing and utilising mental healthcare in adults with childhood trauma?
2. What are the perceived facilitators to accessing and utilising mental healthcare in adults with childhood trauma?
3. What do adults with childhood trauma believe would best support them to access and utilize mental healthcare?

Chapter Three: Methodology

This chapter begins with an outline of Interpretive Phenomenological Analysis, the chosen methodology for the current study, as well as its philosophical and theoretical underpinnings. It will then provide detail on the study’s participants, followed by a discussion of data collection methods and an outline of participant interviews. The data analysis process will be described before concluding with an exploration of both the ethical and cultural considerations made in the design phase.

Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis is an increasingly popular methodological framework for qualitative psychological research. At its core IPA is concerned with meaning-making, methodologically centred in exploring the lived experiences of individuals and how they make sense of their reality in relation to a certain phenomenon or topic.

From a philosophical standpoint, IPA is underlined by phenomenology. First developed by Edmund Hursell in the early 20th century, phenomenology is a philosophical and qualitative approach to research that is concerned with investigating reality through the subjective lived experiences of individuals. From a phenomenological standpoint, research aims to produce accounts of lived experience rather than subscribing to pre-existing theories. In this way phenomenology can be seen as a “bottom-up” approach to research rather than “top-down” approaches seen in more traditional qualitative methodologies. In contrast to quantitative research approaches which aim to identify, categorize and generalize patterns of behaviour and thinking, phenomenology is concerned with the individual lived experience and how the individual makes sense of that experience or phenomenon.

Theoretically, IPA also draws from hermeneutics which can be understood as the “theory or practice or interpretation”. An IPA approach to research inherently acknowledges that analysis of data always involves interpretation (Eatough & Smith, 2017). IPA stipulates a requirement for double hermeneutics meaning that whilst the participant is engaging in sense-making of their own personal world, the researcher is simultaneously trying to make sense of the participant engaging in this sense-making (Eatough & Smith, 2017). Therefore, the success of analysis and the subsequent quality of interpretation is entirely dependent on the participants ability to make sense of their experiences and articulate them and for the researcher's ability to analyze and interpret this (Smith, Flowers & Larkin, 2009). A key epistemological assumption of IPA is that we, as humans, are self-interpretive beings and that reality exists in the subjective accounts of one's own experience (Eatough & Smith, 2017). In this sense, the researcher and the participant work together to transcribe the lived experiences of the participant and interpret and analyze this. Noon (2018) states that the two main commitments of IPA are "giving voice" and "making sense" with the researchers attempting to gain an insider perspective to a phenomenon by making sense of how individuals perceive their personal and social worlds.

IPA is also idiographic in its approach, representing a focus on individuals over groups. In comparison to nomothetic approaches that seek to investigate the group and make generalizations across large populations, IPA aims to produce rich and detailed accounts of an individual's unique experience. IPA is an appropriate methodological choice for the current study due to its suitability with topics that are "complex and emotionally laden" Smith & Osborn (2015). Additionally, IPA "invites participants to offer a rich, detailed, first-person account of their experiences" (Smith, Flowers & Larkin, 2009, p. 56) an approach that is critical in research of this nature.

Reflexivity

Within the context of IPA research, reflexivity represents active practices that involve purposeful reflection and awareness of one's own biases, assumptions, thoughts, and lived experiences that could potentially influence the research and subsequent research processes (Engward & Goldspink, 2020). Engaging in reflexivity is an essential requirement of IPA as stipulated by its theoretical underpinnings of hermeneutics (Pietkiewicz & Smith, 2014). A hermeneutic phenomenological approach to research inherently acknowledges that prior experiences and understandings cannot be eliminated or separated from the research experience

(Pietkiewicz & Smith, 2014). Therefore, researchers must actively engage in practices that reflect on these prior understandings to recognize and account for their potential influence on interpretation (Eatough & Smith, 2017). Given the importance of acknowledging one's own experiences, beliefs, and potential biases I was purposeful in engaging in consistent reflexivity throughout the duration of this project.

When I first started pondering potential research topics, I found myself hesitant to approach topics that I could engage with from personal experience, cautious that my own lived experiences may obstruct my ability to interpret others. I soon realized that engaging in a topic of which I was an insider, provided me with a unique perspective. In saying this, having had my own journey with childhood trauma and experienced subsequent barriers to seeking and utilising mental healthcare it was essential that I maintained constant reflexive practices. This ensured that, to the best of my ability, I was able to explore the lived experiences of my participants authentically and without interjection from my own personal biases. At the beginning stages of the project, once my topic had been decided, I began a reflexive journal to document both my research processes and any thoughts, feelings and beliefs that arose along the way. Additionally, Creswell (2013) advises that before engaging in data analysis researchers should "First describe [their own] personal experience with the phenomenon under study. The researcher [should] begin with a full description of his or her own experience of the phenomenon" (p. 193). In engaging in this practice, researchers maintain an awareness of their own personal experiences, beliefs and feelings towards the phenomenon of interest (Engward & Goldspink, 2020). In doing so, the researcher can better understand how their experiences can cause bias within the data analysis process and the researcher can better avoid mis-interpreting participant narratives and interjecting their own personal beliefs into the analysis process (Engward & Goldspink, 2020).

Due to my insider position in this topic, I found this to be a critical step in addition to maintenance of a reflexive journal.

Participants

In this project I aimed to meet with 3-5 adults who had experienced a traumatic event in their childhood and talk about their feelings, beliefs and experiences with mental healthcare. The selected sample size is typical of Interpretive Phenomenological Analysis, the chosen methodology for this project. Clarke (2010) suggests that three is the default, appropriate sample size for masters-level research. IPA is purposive in exploring the human lived experience and is typically interested in sampling a homogenous group to explore a particular phenomenon. Data collection in IPA based research involves the collection of rich and full detailed accounts of an individual's experience and thus sample sizes are typically on the smaller side. Typical IPA sample sizes range from 1-12 participants with anything larger running the risk of over saturation of data. Additionally large sample sizes also risk accumulating an overwhelming amount of data that could detract from the quality of analysis. Noon (2018) advises researchers to consider a sample size that will provide the project with sufficient data whilst also allowing the researcher to uphold their commitment to engaging in an in-depth analysis. For this reason, coupled with the time constraints of Master’s level research, a sample size of 3-5 participants was deemed appropriate for this project.

Eligibility Criteria

To be eligible to participate in this study participants had to meet the following criteria. Firstly, they must be adults (over the age of 18). Secondly, participants were required to have experienced at least one traumatic experience in their childhood (before the age of 18).

Participants were also required to be fluent English speakers, as the researcher is a native English speaker. Additionally, participants must not have experienced this traumatic event within the last five years. Including this in the eligibility criteria was important for several reasons. Firstly, it ensured that if there were any younger respondents (over the age of 18 but under the age of 23) that there was sufficient time between the event and participating to potentially seek and utilize mental healthcare. Secondly, it acted as a safeguarding measure for participants to ensure that recent events were not being discussed.

Recruitment

Participants were recruited via advertisement on two community pages on Facebook. Participant recruitment via social media has grown in popularity over the past decade with literature investigating the feasibility of social media as a recruitment medium identifying several advantages such as faster recruitment time, reduced costs and expanded reach in rural areas (Darko et al., 2022; Khatri et al., 2015 Benedict et al., 2019). As I am located in a semi-rural area in the Taranaki region, social media provided the widest and most effective medium to recruit potential participants. Both community pages were public in which advertisements of this kind did not violate any page guidelines. Even so, I reached out to the administrators on both pages for permission to post my advertisement, both of which were granted. The larger of the two pages, at the time the advertisement was posted, had 18,200 page-members, the other with 13,500. The advertisement had five respondents within the first 24 hours and after receiving the information packet, three retained continued interest in participating. The researcher completed interviews with all three of these participants. The original advertisement was then reshared by the researcher on the largest of the two community pages for further recruitment, in which the final and fourth participant was recruited and interviewed. The advertisement poster (Appendix

E) outlined the nature of the study, participant criteria and what participation involved. It directed participants to either scan a QR code for further information or to contact the researcher via email. When scanned, the QR code led participants to a copy of the Participant Information Sheet (Appendix B) which provided further detail on the project, participation and participant rights. The majority of participants reached out via email with one participant reaching out via Facebook messenger after having difficulty with the researchers email address. This participant was then redirected to the researcher's email address where further correspondence continued. After reaching out via email, all participants were provided with a copy of the participant information sheet and advised to read it through and before confirming their interest in participation. Getting potential participants to read through this information was important as it facilitated respondents to confirm their decision to participate with the most information possible.

Participants Descriptions

To protect the privacy and anonymity of all participants involved in the project, each was provided with a pseudonym. All participants were offered the choice between choosing their own pseudonym or being provided one by the researcher, with all four participants choosing the latter. Additionally, all participants were asked if there were any names that, unbeknownst to the researcher, would or could potentially identify them and thus should be avoided when later nominating pseudonyms. Demographic information collected on each participant was minimal with the researcher only asking for the participants age and gender. Other demographic information such as employment status, marital status etc. was deemed non-essential to the project. Of the four participants recruited for this study, three identified as female and one identified as male. Ages ranged from 34-57. All participants were recruited within the Taranaki region in New Zealand.

Table 1

Participant Information

Participant Number	Pseudonym	Gender	Age
P1 (n=1)	John	Male	57
P2 (n=2)	Emma	Female	34
P3 (n=3)	Alice	Female	37
P4 (n=4)	Sarah	Female	42

Data Collection

In regard to data collection, IPA best aligns with an approach that "invites participants to offer a rich, detailed, first-person account of their experiences" (Smith, Flowers & Larkin, 2009, p. 56). For this study, data was gathered through semi-structured interviews, the standard data collection method in IPA research (Smith & Nizza, 2022). Given that IPA is concerned with extracting rich and detailed narratives, semi-structured interviews allowed me to guide the conversation whilst also providing the time and flexibility for the participant to explain their narrative in a way that was most natural and authentic to them (Eatough & Smith, 2017). I opted for interviews to be conducted in-person rather than phone or video-calls due to the nature of the topic and the importance of building rapport and trust between researcher and participant.

Interview Guide

Smith and Osborn (2015) suggest that when formulating a schedule for IPA interviews, the researcher should view the schedule as a guide of how they would like the meeting to go. This then facilitates the space for the participant's narrative to have greater control over the interview (Alase, 2017). In research topics that are sensitive or emotionally difficult, preparing an interview guide also aids in navigating emotional conversations with minimal harm to participants (Dempsey et al., 2016). In preparation for the interviews, I created an interview guide (Appendix A) that reflected these suggestions. I created an initial opening statement that informed the participants briefly about the project, myself as the researcher and what to expect from the following conversation. I also prepared my Pepeha and a karakia to be delivered at the preference of the participant. I then categorized my questions into 8 broad topics that covered the information I was hoping to gather. Each of these eight topics had 2-4 questions. I also created a list of prompts and follow ups that would aid in gaining further information. Additionally, I included a list of prompted responses to utilize should the participant appear to become emotionally distressed at any point in the interview. An important aspect to IPA research is the natural flow of conversation, it was important that my questions could be asked in any order and in the ways that best fit the flow of each individual conversation.

The Interviews

Pre-Interview. After respondents had confirmed their interest in participating, I began to organize dates, times and locations for an interview. The date and time of each interview was selected at the preference and availability of each participant. Interview locations were for-hire community meeting rooms across the Taranaki region, each participant was informed of the available locations and selected what was most suitable. Once the interviews had been booked with the venue, a confirmation email was sent to the participant. A confirmation/reminder email of the appointment date/time and location was also sent to each participant approximately 24 hours before their respective interview. Prior to each interview introductions were conducted between researcher and participant. These pre-interview conversations were important to build rapport and trust between the researcher and participant as well as ease any nerves the participant may have been feeling. As stated by Smith et al. (2009) “The most important thing at the beginning of the interview is to establish a rapport with the participant. They need to be comfortable with you, to know what you want and to trust you. Unless you succeed in establishing this rapport, you are unlikely to obtain good data from your participant.” (p. 64). In general, each participant appeared to the researcher to be positive, engaged and invested in their involvement in the study. Three out of the four participants mentioned that their interest in childhood trauma research was a key factor in their willingness to participate. Following this introductory portion, I went through the participant information sheet and consent form with each participant, which was then signed. Participants were then provided with the time and the space to ask any questions or voice any concerns they may have.

During the Interviews. Following the introductory pre-interview portion, the audio recorder was switched on. I then read a brief statement reiterating the aim of the interview and the participants right to pause or end the interview at any given time with no reasoning needed. The researcher then asked each participant their age and gender (if they felt comfortable doing so). Each participant provided this information with no concerns. With the purpose of easing into the interview and establishing rapport, participants were first asked about their existing knowledge of the mental healthcare system as well as their current understanding of accessing mental healthcare in New Zealand. Following this, questions outlined in the Interview Guide (Appendix A) were asked in varying orders, adapting the sequence to participant responses to best serve the natural flow of each conversation. This technique proved effective in enabling participants to articulate their thoughts, beliefs and experiences in a way that was organic and authentic. Prompts outlined in the Interview Guide were implemented as needed to encourage deeper discussion or to gently guide conversation back to the central question. Minimal note taking was implemented during each interview to minimize disruptions and to maintain the natural flow of the interview. Three of the four interviews took place in the same community centre in which a playgroup was located next door. Whilst disruptions were minimal, background music was briefly audible during a portion of one interview. The researcher then paused the interview to see if the participant was comfortable continuing, and the participant voiced that they had no concerns and were happy to proceed. Interviews ranged in length, with the longest being 76 minutes and the shortest being 40 minutes, averaging approximately 60 minutes. Towards the end of each interview, each participant was asked if there was anything they wished to share or felt was important for me to know regarding any barriers, facilitators or their experiences with seeking and utilising mental healthcare, that we hadn’t covered in the previous questions. This gave the participants the opportunity to expand on and add anything to the conversation. Three out of the four participants used this opportunity to expand on previous statements, mention something forgotten in a previous answer, or provide additional/contextual information.

Post-Interview. Once the recorder had been switched off, I thanked each participant for their time and valuable contribution to the project. Each participant varied in the amount of time they stayed in the interview space following the completion of the interview. All four participants expressed some form of interest in childhood trauma research with two participants sharing that they felt participation in the project assisted them with their healing process. I reminded each participant that I would reach out again via email once the transcription had been completed. Due to delays with research funding, the first three participants were not provided with koha immediately following the interview. Once this had come through, I organised a preferred time and date with each participant to handover the supermarket voucher, each participant was happy with this arrangement. The fourth and final participant, who was interviewed several weeks later, was presented with the voucher at the conclusion of their interview.

Data Analysis

IPA outlines several phases in the data analysis process. As outlined by Pietkiewicz & Smith (2014) these phases are flexible and, for the most part, are able to be interpreted and adapted by each individual researcher. Subsequently, each researcher will vary slightly in the way they interpret and utilize the analysis phases in IPA. The current study is guided by the six-phase analysis framework outlined by Smith et al. (2009) analysis framework. Additionally, this study also adheres to the recent changes in terminology used in IPA data analysis. As outlined by Smith & Nizza (2022), what was previously referred to as ‘emergent themes’ are now termed ‘experiential statements’ (ES). The clustering of these experiential statements forms ‘personal experiential themes’ (PETs), while themes identified across cases, formerly known as ‘superordinate themes’, are now referred to as ‘group experiential themes’ (GETs)

The philosophical underpinnings of IPA inherently involve the researcher making sense of the participant’s sense-making (Smith & Osborn, 2015). Thus, it is critical that the researcher immerses themselves within the participant’s narratives and to the best of their ability, “step into the shoes” of the participant. An important aspect in IPA research is engaging with each transcript separately to ensure analysis is free from influence of other participant narratives. With this in mind, data analysis began with multiple listening’s of the audio recording to produce the verbatim transcription of each interview. I opted to transcribe each interview personally rather than utilising transcription software to facilitate deeper immersion into the participants narrative. Once this was completed the transcript was re-read multiple times and the audio recording re-listened to. Exploratory comments were noted in the right-hand margin and consisted of observational notes, thoughts of potential significance, initial interpretive comments and personal reflectivity. Language use was also noted in this phase regarding tonal changes, laughing, metaphors, pauses, stressors on particular phrases/words or any repetitions which provided further context to participants thoughts, feelings and emotions at the time of the interview. For the purpose of reflexivity, the researcher also personally noted any comments, thoughts, feelings or questions that arose during the reading of each transcription.

Exploratory comments were then refined and formulated into experiential statements. This involved creating concise statements at a higher level of abstraction, capturing the researcher’s interpretation of the participant’s experience within the context of the participant’s meaning-making. (Pietkiewicz & Smith, 2014). Creswell (2013) advises researchers to “treat each statement as having equal worth, and works to develop a list of non-repetitive non-overlapping statements” (p. 193). As such, experiential statements were formed for each section of the transcript. Some sections required minimal commentary, whilst others often overlapped with other statements. While engaging with each section of the transcript allowed for a more in-depth analysis of the participants experience it was essential these statements were compared to the transcript as a whole to ensure statements remained in context and the voice of the participant remained authentic (Smith & Nizza, 2022). Once experimental statements were created, these were moved to a separate document where they were analysed for conceptual similarities, patterns and relevancy to the research questions. Repeated statements were combined and ones that were not relevant to the research questions were excluded. Once experiential statements had been clustered, PETs were formed that encapsulated the essence of each cluster. Under each PET heading I placed both the relevant experiential statements and participant quotations to ensure each PET remained grounded in the participants narrative.

Following this, I moved on to the next case, repeating these steps for each of the four interviews. Once this was complete, a cross-case analysis was conducted which involved searching for themes across the four cases and clustering PETs by conceptual similarities to form group experiential themes. Throughout this process I continued to refer back to the clustered experiential statements and quotations under each PET as well as the full transcripts to ensure themes remained true to the context of each participant’s experience (Smith et al., 2021).

Ethics

This section will review several considerations that were made regarding the ethics of this project and how any potential concerns were mitigated. Full ethics approval for this project was given by the Massey University Human Ethics Committee. A copy of the approval letter can be found in Appendix D.

Informed Consent

Full and informed consent was an essential and on-going process throughout the recruitment and data collection phase of the project. All participants were provided with a digital copy of the participant information sheet following their expression of interest in participation. Prior to the interview commencing, participants were provided with a take-home physical copy of the information sheet and the time and space was provided for participants to ask any questions they may have had. Participants were informed of their participants rights including their right to pause or end the interview at any given point and withdraw consent to participate at any point up until the transcript release form was signed. Participants then were required to sign a consent form (Appendix C) that acknowledged their explicit informed consent and willingness to participate in the study. All four participants retained their interest and consent to participate in the study and all four signed the transcript release form.

Anonymity and Confidentiality

The anonymity and confidentiality of participants was upheld at all stages throughout this project. Participants were provided with a pseudonym that was used to label all recordings, transcripts and quotations following the interview. Any identifying information such as names, locations or references to other people were redacted during the transcript writing process to ensure anonymity was maintained. Interviews were recorded and initially stored on the password protected audio-recording application “SafeRecorder” and deleted immediately following completion of the transcription process. Participants' names as well as their email addresses were known to only the researcher and were not shared with anyone else. Transcripts were only accessible to the researcher and were provided to my supervisor for storage and eventual disposal following the completion of the study. All sensitive data including email correspondence, consent forms, release forms and transcripts were securely stored and only accessible to the researcher.

Avoidance of Harm

In projects involving sensitive topics, such as childhood trauma, it is critical to identify related ethical concerns to protect the well-being of the participants and minimize any potential harm. Careful considerations were made in the design process of this project regarding the wording and content of interview questions that participants were to be asked in the data collection process. Participants were informed of their right to stop/pause the interview at any given time with reasoning required, however this was not requested in any of the four interviews. Participants were also provided with a list of resources to contact should they feel in need of further support following the interview or at any point in their participation in the study.

Cultural Considerations

Adhering to Te Tiriti o Waitangi (Treaty of Waitangi) is essential when conducting any research in New Zealand (Hudson & Russell, 2009). As a researcher it is critical to not only understand the treaty principles of partnership, participation and protection, but how these principles apply when conducting research in New Zealand (Hudson & Russell, 2009). This first came with an understanding and acknowledgement of Māori as tangata whenua, New Zealand as a bi-cultural nation, as well as respect and understanding of mana, tikanga and Māori values. These understandings were critical to not only protect any Māori participants who potentially became involved in this research but to also protect the rights and interests of Māori communities. Although this project sampled mainstream New Zealand, it was important to recognise that Māori are over- represented in both negative mental health and child trauma statistics making this project of relevance to Māori communities (Theodore et al., 2022; Marie et al., 2009). As a Pākehā researcher it was essential that I engaged in my own research into relevant literature to ensure that I was upholding the treaty principles and providing a culturally safe and sensitive research environment. Firstly, it was essential that all participants (Māori and non-Māori) were given full information surrounding the project, what they were required to do and what their data will be used for and who it will be shared with. Additionally, each participant was provided the opportunity to review their transcript to ensure I captured their narrative in a way they feel is authentic and true. These were essential steps to address not only the historical distrust that exists between Māori communities and academic research but the fact that in any research scenario, a power imbalance exists between researcher and participant. I also prepared both my Pepeha and a karakia to be delivered at the preference of the participants. Of the four participants interviewed, three declined and one accepted. Lastly, it was essential that my chosen participants recruitment and data collection methods were culturally safe and provided an equitable opportunity for Māori participant engagement. Due to living in a rural area, advertising on this community page is the best and most equitable way of reaching the most members of my community. Reflection on these principles has occurred at all points in the design of this study and were discussed in several stages with my superviso

Chapter Four: Results and Analysis

This section will explore themes related to barriers and facilitators to accessing and utilising mental healthcare. Analysis of the four participant interviews revealed six group experiential themes, four of which encompass subthemes. The themes and subthemes for this section have been outlined in a thematic table which can be seen below. Throughout the analysis process it became clear that various passages often reflected more than one theme or subtheme. This highlights the interconnected nature of the lived experience and provides evidence that barriers and facilitators to accessing and utilising mental healthcare do not exist in isolation and mutual exclusivity.

Table 2

Thematic Table

Themes	**Subthemes**	**Participants**
Constraints of Living in a Small Town	*Limited Resources*	John, Sarah, Emma, Alice
	Finding the "Right Fit"	John, Sarah, Emma Alice
	Lack of Anonymity	John, Sarah
The Cost of Care	*Money Over Mind?*	John, Sarah, Emma, Alice
	Feelings of Injustice	Sarah, Emma
Confronting Internal Barriers	*The Stigma of it All*	John, Sarah, Alice
	Trust is a Gatekeeper	John, Sarah, Emma, Alice
Reaching a Breaking Point		John, Sarah, Emma, Alice
It Takes a Village	*Support from Friends & Family*	John, Sarah, Emma, Alice
	Positive Healthcare Relationships & Experiences	John, Sarah, Emma, Alice
A Need for a System that Cares		John, Sarah Emma Alice

Constraints of Living in a Small Town

Throughout the interviews it became clear that living in a small town/population had significant impacts on the participants ability to seek, engage with and sustain mental health support in their communities. The theme 'Constraints of living in a small town' captures these challenges, compassing three sub-themes: *Limited Resources, Finding the "Right Fit"* and *Lack of Anonymity*.

Limited Resources

Three of the four participants felt that living in a smaller town had, in some capacity, limited the mental healthcare resources that they had access to. Throughout her journey, Alice has had several mental healthcare experiences which she described as "mixed". She noted a significant lack of resources in Taranaki in comparison to larger urban areas, referring to a "small pool" of practitioners that were available in the region to choose from.

> **Alice:** *"I'm guessing probably in bigger cities and towns there is more resource, like more choice of therapists and things. So, I think part of the issues here is because it's regional and a small, small pool of people to choose from."*

The high cost of private mental healthcare restricted Alice's options for care, meaning she has only been able to access clinicians involved in workplace programs (EAP) or voucher-based systems through her GP. Alice felt like her already limited choice in clinician was further reduced by living in a smaller city.

> **Alice:** *"Generally, the people I've seen have been like, nice people (laughs), but I wonder if like being in Taranaki um, there's not, there's quite a small pool to choose from particularly ones that are registered with EAP or ones that your GP can send you to."*

Like Alice, John described how living in a small town equated to limited options for care. Throughout his interview John discussed the importance of having a clinician that specialized in dealing with his specific trauma type. He felt that being in a smaller region, the number of available practitioners was already limited and those specializing in male child sexual abuse was even fewer in number.

> **John:** *"it's pretty lean pickings in New Plymouth for counsellors who dealt with male sexual abuse"*

Having a practitioner that understood and was experienced in dealing with his trauma type was an important aspect in John's willingness to seek care.

> ***John:*** *"yeah I think if you had as a child particularly of serious sexual abuse um I think you're going to feel more comfortable disclosing that to someone who you know is well trained in that field"*

John was not able to find an available male clinician who dealt with male childhood sexual abuse. Discouraged, he concluded that finding a clinician with the specializations he needed was an impossible task in a small town.

> **John:** *"I'm sure that a lot of um, you know, there are psychologists and psychiatrists who are um but um in the smaller centers you never going to get that and yeah that's the way it is."*

After moving to Taranaki as a young adult, Emma accessed mental healthcare through the ACC sensitive claims scheme. She was initially matched with a therapist whom she saw regularly over a 3-to-4-year period. Several years later, Emma found herself in need of mental healthcare again and decided to seek support through the ACC pathway again. When she did so, Emma was informed that whilst she was still eligible to access free treatment, due to exceeding long waitlists she may have to wait upwards of a year before receiving care.

> **Emma:** *"The waitlist in the mental health system, here in Taranaki, is so long. So, they were thinking maybe even a year wait and I thought I can't wait a year. I'm crying out for help now, now is when it's most important so it's either, what, you go and admit yourself into the mental health ward in the hospital or, or what?"*

Being told she may have to wait up to a year to receive ACC covered care again left Emma feeling incredibly frustrated. Feeling limited in her options and understanding the urgency of her need for mental healthcare Emma felt like she was faced with a binary option, to wait or to pay for private care.

Finding the "Right Fit"

The limited availability of practitioners also meant reduced opportunity for participants to advocate for their preference in clinician. All participants discussed the importance of having a good connection with their clinician and how the presence or absence of this connection had contributed to previous positive and negative care experiences. Therapeutic relationships where participants felt there was a "right fit" was a key facilitator in their continued engagement and utilisation of care. For Emma, living in a small town with already limited mental healthcare options made finding the "right fit" a critical factor when seeking care.

> **Emma:** *"But also, because it's Taranaki, and it's a small place and you've only got slim pickings and if you don't connect with that right person then I don't think that it's worth your time."*

Emma spoke frequently about the importance of having the "right fit" with her practitioner and that she had experienced the right fit as well as the wrong fit within her previous mental health experiences. When asked about what having the “right fit” meant to her, she explained that to her it meant feeling seen and heard in the therapy space.

> **Emma:** *“Well, I think because you’re going to, you’re going to feel seen, you’re going to feel heard and you’re going to feel like they're doing their job, essentially. And I feel that way with the one that I just paid privately for, versus the one that I had ACC and unlimited visits for with my child psychologist. And to get that you have to go through a lot of stuff. I didn’t feel that with him.”*

Empathy and professionalism were important qualities for Emma when finding a clinician. Emma discussed how, at times, she felt that her ACC-provided psychologist became withdrawn and non-emotive within her sessions, leading her to question the validity of her feelings.

> **Emma:** *“…there were times where he would just sit there and vacantly stare and just be like, yeah. And like not even like a prompt to get you moving on or like “Oh, what about this?” you know, you just sit there and so you kind of felt after a while, like, what’s the point? Like I must be okay, I don’t know.”*

In comparison, during her second experience with mental healthcare Emma felt a strong fit with a clinician she had privately sourced.

> **Emma:** *“Oh, that was a game changer, she was the best. A whole different kind of um therapy thrown at me (laughs) she was super engaging.”*

Feeling seen, heard and engaged within her sessions was, as Emma puts it, a “game changer”. Lack of trust had been a significant barrier for Emma in terms of accessing mental healthcare and so having the right fit with her practitioner was a key facilitator in building trust and emotional openness within her session.

Sarah had a long and arduous journey to accessing affordable mental healthcare and so when she managed to access care through ACC, she felt fortunate to be receiving low-cost care. When asked about her experience with the clinician, Sarah responded that she felt he wasn't the best fit for her and often felt conscious of how he would react to what she was saying. Sarah noted through-out the interview that she was very perceptive of other people's reactions and body language and felt in a few of her mental healthcare experiences that the clinician's reaction/non-verbal responses left her feeling judged.

> **Sarah**: *"He was alright. I don't think he was probably the best suited to me, but he was still good. It still, you know, gave me... I still picked up on of things that he would react to, to what I was saying as well. Like, I've got this kind of etched in my memory of him just going like... I don't know (laughs). Like, come on guys, you're the professionals."*

Despite feeling like the clinician she was seeing was not the best fit for her, Sarah felt like she couldn't push for a different practitioner because she was concerned that there wouldn't be one available. Sarah's experience with accessing affordable mental healthcare was lengthy and so when she managed to access this form of care she did not want to risk losing her "spot" by attempting to switch clinicians.

> **Sarah:** *"I'll just say that I felt like I probably didn't push for another person because I didn't think that there would be one available. Like, I knew that I was lucky to have the spot that I had. So, I didn't push it."*

After struggling to find affordable mental healthcare in a small town where the availability of mental health practitioners is limited, Sarah decided to stick with her clinician to ensure that she would receive care. Sarah reflected further on this experience, stating given the choice, she would have preferred a female clinician.

> **Sarah:** *"I think because of the nature of, like, what we were talking about I probably would've been better with a female."*

Whilst ACC's sensitive claim system promotes the claimant's right to find a practitioner that best fits them, this is reliant on having a pool of available practitioners. With limited available practitioners, long waitlists and increasing mental health concerns, claimants like Sarah may feel pressured to stay with a clinician that they don't feel is a good match so as not to risk losing the available help and having to wait even longer for care. For individuals accessing free mental healthcare through GP voucher systems or EAP services, advocating for a suitable therapist match can also be challenging. Alice commented that although it was explained to her that she could find another clinician if she didn't feel the match was right, she found herself hesitating to make a change.

> **Alice:** *"…that initial match, I think, has to be quite strong. And normally they do say look, if I'm not the right person you can find someone else, but I'm kind of a bit of a people pleaser and I like to give people a second chance, a third chance, a fourth chance and I'm always like, oh maybe they were just having an off day and maybe it will be better next time."*

Each time Alice accessed care through EAP or the GP voucher system she was only allocated 3-6 sessions. Already finding it difficult to find an available clinician in her area due to the limited number of practitioners, she felt pressured into booking with whoever was available. Alice described the frustration she felt in circumstances where the clinician turned out to be a poor match for her, feeling that she had wasted her allocated sessions on care that wasn't that beneficial.

> **Alice:** *"I think just like, experience and the frustration of kind of um, feeling a bit, what's the word? Trapped, not trapped, that sounds a bit dramatic but yeah kind of that experience of being like right, I've got this opportunity for um three sessions of free healthcare which is great and then searching out someone and the frustrations of actually um, only finding like one practitioner who I can access and meeting with the practitioner and it's not a good match but then you're just kind of trapped and in hindsight feeling like that was a bit of a waste of my time."*

Despite experiencing the wrong fit with previous clinicians, Alice maintained an optimistic perspective. Choosing to view these 'failed matches' as an opportunity to learn more about the type of clinician and therapy that works best for her.

> **Alice:** *"I suppose with each failed match there is an opportunity for learning what does and doesn't suit me rather than like blaming the person."*

As mentioned, having a clinician that specialized in his trauma type was important for John in terms of seeking care. He voiced concerns that in going through the public mental health system he wouldn't have the capacity to advocate for himself in terms of the clinician.

> **John:** *"I'd have to find the right person to be comfortable to speak. And I think if I went through the mental health system you get given what you're given um you don't you have the option to choose the person or the type of person or you don't know their background as it were."*

In summary, finding the "right fit" with a clinician and the subsequent quality of the therapeutic relationship was a critical aspect in the participants' care-seeking journey. In circumstances where participants felt a good fit with their clinician, they felt supported, validated and listened to. In addition, they also experienced a greater sense of security, trust and emotional openness in their sessions which facilitated further engagement in treatment. The lack of ability to advocate for their preference in clinician was something participants felt was associated with living in a small town due to the limited number of practitioners available to choose from.

Lack of Anonymity

Maintaining privacy in a small town can be challenging, as smaller population sizes inevitably increase the likelihood of frequent interaction with those within the community. John and Sarah discussed how the lack of anonymity they felt, particularly in relation to their professions, created a barrier to accessing care. John felt that he was unable to seek any public mental healthcare services due to his employment at the hospital.

> **John:** "*But for me I've not used the hospital system. Uh, again because once I sort of became involved here again and once the shit came out and I had my little breakdown I didn't feel that I wanted to deal with people that I knew at the hospital.*"

During the interview, John described a breakdown that he experienced approximately five years previously, triggered by a Facebook post acknowledging the 10-year anniversary of his offender's death. John describes how seeing the offender's name caused traumatic memories to come "flooding back". Despite being in significant mental distress, John that seeking care through the public hospital system was not an option. Knowing many of the staff, he feared being "found out" or having to receive care from someone that he knew, a concern rooted in feelings of embarrassment and fear of judgement. Despite his reluctance to seek formal care services, John was able to tell both his GP and his wife about his traumatic experiences during this period, the first time he had spoken about his abuse to someone else.

Like John, Sarah's employment role was also connected to her concerns around anonymity with her role in the education sector made her feel especially visible within her small community. The lack of anonymity Sarah felt within her day-to-day life led her to feel that she was unable to access mental healthcare confidentially.

> **Sarah:** "*I was living in a small town, so I was living in [redacted town name] at the time and I was teaching. So, I just felt really like I didn't have any um anonymity, I really felt like I was being watched, you know, like I couldn't go to the supermarket without a student (laughs) being there. So um, really I felt I couldn't…"*

Several years later, Sarah had moved to a slightly larger town within the Taranaki region and had started the therapy process through ACC. Sarah describes how she was required to do a supported assessment with a separate clinician. Prior to December 2024, all claimants through the ACC sensitive claims were required to complete a supported assessment, which can be described as a comprehensive evaluation of a client's psychological, cognitive, and behavioural functioning to determine the nature of any clinical dysfunction and its link to sexual abuse. Essentially, this assessment is used to identify and diagnose issues that may relate directly to the traumatic event. It typically involves a two-hour session in which the claimant is extensively questioned about their health, history, mental health and current issues. Unbeknownst to Sarah, her supported assessment was completed by a parent of one of the children at her school.

> **C:** "*Okay, and how did you find that experience, accessing mental healthcare through ACC?"*
>
> **Sarah:** *"…mostly good, except there were still a few barriers, like, in the fact that so now, I didn't click straight away but um the psychologist that I was given didn't like to do the two hour, like, you know, summary thing. So, I was like, oh whatever, and um I had to with somebody else. So that somebody else ends up being a parent at the same school that I'm now at. So, there's that, you know, small, well not as small as [redacted town*

> *name] but it's still Taranaki, you know. So, I didn't kind of work that out until a few days after, it was actually after our kids had a playdate together, you know, yeah."*

This situation was confronting for Sarah as it confirmed her earlier fears of being "found out". Like John, Sarah's apprehension to access care for fear of being discovered by those in her community was also intrinsically linked to the stigma she had internalized about mental illness. Sarah felt that despite the supported assessment occurring within a professional setting it was something that impacted her relationship with the parent from school.

> **Sarah:** *"Yeah, and even though, like, I completely trust a professional not going to... you know what I mean? But I don't think as a human being you can unhear that and then carry on having like a, um, like a natural relationship. I think it can – Yeah, I just don't think that's possible."*

Despite trusting that the parent would remain professional Sarah felt concerned that their relationship would be irreversibly changed. Sarah commented that due to living in a smaller town, the likelihood of interacting with mental health professionals in a social manner outside of the therapy space is far greater than in larger urban areas.

> **Sarah**: "*Because who says that it's not in the future that you would have something to do with that person, yeah. Yeah, definitely living in a smaller population.*"

Following this interaction with the parent from school Sarah felt further apprehension about accessing any future care, stating that she is now cautious about who she chooses to see. Sarah even considered online-based therapy to mitigate a repeated situation in the future.

> **Sarah: "***I would have to choose very carefully the person now, just through those experiences. Just through having, you know... as much as you'd like to think that it didn't affect me in those like two-hour sessions just blurting everything out, I think it did. You*

> *know as much as he probably hoped to think that it didn't, I don't think subconsciously it couldn't of. Yeah, so I think living in a place like this, I probably feel more comfortable. Like I've considered Talkspace or something like that…"*

The Cost of Care

Money over Mind?

Participants discussed feelings of conflict when trying to financially prioritise their mental health. In New Zealand, sessions with a private psychologist or psychotherapist can range from $150-$250 per session. Without any subsidies, this is a high cost that many New Zealanders cannot afford to shoulder for long term care. Despite being covered for long-term mental healthcare under ACC, Emma was confronted by the high cost of private mental healthcare when she attempted to re-access her ACC covered therapy for a second time, being told that although she was still eligible to access free care, she may have to wait up to a year to do so.

> **Emma:** *"I asked to be seen again but was told "No, you have to wait, or you have to pay privately."*
>
> **C:** "Yeah"
>
> **Emma:** "*And when you are in that need like that, that dark dark place and crying out for help and you are told sorry like the waitlist is just far too long um yeah, it's pretty devastating. And it's either you have to pay or otherwise you have to find some other coping mechanisms which I guess only adds to the statistics of those that suffer, right?"*

Emma felt that the cost to her mental health would be too great if she continued to wait to access care. Although frustrated with having to pay despite being covered by ACC Emma was aware of the mental distress she was in and felt she had no choice but to go private.

> **Emma: "***So, I ended up having to pay. I thought, my mental health, our family's mental health is worth so much more and if it's going to cost me a hundred and eighty dollars a pop, I'm going to do it, I'll find a way. So, I did, I ended up going private."*

Despite feeling the financial burden of having to pay for private mental healthcare, Emma felt fortunate that both her and her family were in a position to cover the cost of private care. Emma was determined that if she was required to pay to be seen she was going to find someone who suited her personality and needs.

> **Emma:** *I read through a few people and their um profiles (laughs) 'cause I was adamant that if I'm having to pay, I want someone that's actually going to suit my kind of vibe and figure out how they can help me, holistically.*

After searching for a clinician Emma found a private therapist that she felt she really connected with. Although the financial cost was significant for Emma, she felt that she was at least getting a lot out of her sessions.

> **Emma:** *"I am lucky that I have an income where I can prioritize my mental health, at a cost, but I mean at least I was getting a lot out of it and worked it through."*

Cost was also a significant barrier for Sarah when it came to accessing mental healthcare. Her previous experiences with mental healthcare had been through her GP where she was given vouchers for six free sessions with a clinician. Although these sessions were better than nothing, Sarah felt in need of longer-term care. Whilst she was aware that private mental healthcare was an option, she did not feel that she could justify the cost.

> **Sarah:** "*Yeah, I mean I always knew that it was there but there's always a massive cost to it, it's not cheap. Um, yeah and I mean there's nothing left over anyway, like, how can you prioritize that?"*

Sarah felt conflicted with justifying the high cost of private mental healthcare, knowing that she needed to prioritize her mental health to be at her "best" for her children but hesitant to place financial strain on the family knowing that the money could be used elsewhere.

> **Sarah: "***There's always something more important when you have kids, I think."*
>
> **C: "***In terms of things that are more important than accessing care for yourself?"*
>
> **Sarah:** "*Yeah. Even though I know that me being at my best is the best from them, there's just always somewhere else the money can go."*

Like Emma, Sarah's motivations to seek care revolved around her children. Despite knowing that she needed longer term mental healthcare Sarah felt she could not justify the cost and thus ultimately decided not to seek private care. It wasn't until Sarah was later informed that she qualified for free care under ACC sensitive claims that she was able to access free long-term care.

Alice identified cost as the most significant biggest barrier that had prevented her from previously accessing mental healthcare. Like Sarah, Alice felt a strong need for longer-term care options beyond what she was getting through the EAP and GP voucher system. Alice looked at several private therapists within her region and whilst they looked to be a great fit for her, she knew that she could not afford to access them.

> **Alice:** "*I know there's heaps others out there, but financially I can't, you know, you look at people's website and they look amazing and you're like, that would be such a good match for me but then I can't actually afford the sessions because they are so expensive."*

Throughout her experiences with therapy, Alice came to feel that traditional approaches such as cognitive behavioural therapy were perhaps no longer the right fit for her and that different therapy methods would be more beneficial. In particular she was interested in EMDR, an established treatment approach to trauma. However, when she began searching for practitioners in her region that offered EMDR, she found very minimal availability and prices that were entirely unaffordable.

> ***Alice:*** *"I was looking into EMDR and stuff like that but there's not very many practitioners here and if they bother to get back you when you email them, then they are either unaffordable or their availability doesn't match yours because you work full-time. So yeah, and then if you look into like psychotherapy here, I think there's one and she's all the way out around the coast so it's like the extra time and the petrol and the money on top of the cost of the session themselves."*

Alice emphasized that the cost of accessing mental healthcare extends beyond the price of the sessions themselves as she also had to account for cost of transport to and from the sessions and the time lost from the work week. These additional costs became obstacles for Alice when it came to her searching for a more specialised form of care. With most therapists in the country working standard business hours (Monday to Friday, 8am-5pm), full-time workers like Alice can find it difficult to find time to attend sessions, particularly if the clinician is located a fair distance away.

John was also confronted by the high cost of private healthcare when he disclosed his childhood abuse to his GP. When John informed his GP of his trauma, he was advised to seek private care despite qualifying for covered care under ACC's sensitive claims.

> **John:** "*...I spoke to my GP about what to do and he unfortunately wasn't great (laughs) he, he suggested not to go through the ACC line um even though the event certainly um would've (long pause).*"
>
> **C:** "*Qualified?*"
>
> **John:** "*Yeah absolutely. Um, so I took his word and then I said "well, you know, can I talk to someone?" and because I had private health insurance he said yeah well just find yourself a counsellor and away you go. So, I um didn't go through the mental health system, the hospital system per se, I used a private counsellor.*"

John trusted the advice of his GP and did not make a claim through ACC, instead finding a private counsellor. John did not clarify whether this was claimed through his private health insurance or if he paid out-of-pocket but either option would have been at a financial cost to him and his family.

Feelings of Injustice

In addition to the challenge of financially prioritising mental healthcare, both Emma and Sarah expressed a deep sense of injustice over having to pay for their treatment. As survivors of childhood trauma, they both felt that it shouldn't be their responsibility to bear the financial burden.

> ***Emma:*** *"I should not have to pay after all the stuff that you endure and I find that is the most ridiculous thing, because as children we didn't wish this. I didn't wish to be born to*

> *my stupid parents, I wish it was different, and yet here we are suffering all the consequences, here I am forking out all this money and they don't care, they get away with it."*

Emma's frustration of having to pay for care is rooted in a deep sense of injustice that she didn't choose to endure her traumatic experiences and the plethora of consequences they brought, yet she is expected to bear the cost of her recovery. These feelings were further compounded by the fact that the people that failed to keep her safe, remained unaccountable. Like Emma, Sarah also believed the responsibility of paying for care should not fall on her, but on those who failed to protect her.

> ***Sarah:*** *"I've just always felt like I shouldn't have to pay for it, like my parents should have to pay for it (laughs). Like before ACC, I just felt like why should I? Why should I be taking money out of my family when this happened to me as a child, and you're supposed to protect me? Pay for it. That's how I felt about it."*

For both Emma and Sarah, bearing the financial responsibility was another reminder that they had been let down by those around them as well the systems meant to protect them. Only to be faced with another system that required them to pay for the care to heal from the trauma inflicted on them. Knowing that those who inflicted these traumatic experiences, or at least failed to protect them from it, did not suffer any similar consequences only deepened their sense of frustration and injustice.

Confronting Internal Barriers

The Stigma of it All

Stigma can be described as a negative attitude or belief surrounding or towards a person or group of people for a distinguishing trait or characteristic (Thornicroft, 2008). Stigmas surrounding mental health and illness are rife and deeply rooted in misinformation and fear. For John, stigma was a significant barrier in his journey with accessing and utilising mental healthcare. After a rejected attempt to inform his father of the abuse that he had suffered, John remembers burying his trauma and all feelings associated with the event. It wasn't until he had returned to New Zealand and was at university where he first considered reaching out for help. During this time John made an appointment with his university counsellor, but then later cancelled the appointment stating he "couldn't face it".

> **John:** *"I personally didn't really seek any help um I tried at university after we came back from Australia, I had one year of high school um then went to uni and I tried there but I made an appointment and chickened out I just couldn't face it and I think through embarrassment."*

Despite feeling a desire to disclose his abuse to someone and receive support, John's internalized embarrassment inhibited him from going through with the appointment. In fact, it wasn't until many years later following his retirement from the police force that John accessed mental healthcare for the first time.

> **John:** "*I saw a private psychologist at the time. Psychologist one. A wonderful lady and uh she was great she helped me deal with those things."*
>
> **C**: "*And that was following the retirement?*"

> **John:** "*The police issues yeah. Never really thought to talk about the other event because you know again it wasn't an issue per se. It was always there but you know I… I buried it enough in my head. I didn't want to deal with it.*"

At this point in time, John had not disclosed his child trauma to anyone and so these sessions with the psychologist revolved around his traumatic experiences whilst in the police force. John felt at this point his childhood traumatic experiences were deeply buried and whilst they were always present, he did not want to face them. For John, it was easier to disclose his recent experiences whilst in the police force as they weren't attached to the stigma that he had attached to his childhood experiences. After a treatment plan was established with his psychologist, John was required to see a psychiatrist to sign off on his medication. John recalled feeling hesitant leading up to this appointment.

> **John**: "*I think I was worried about having a psychiatric history attached to my name again maybe a little bit of stigma um and then having come out of the police um the last thing I wanted was to be known as a mental health patient.*"

John's career in the police force involved him dealing with a myriad of individuals who were in severe mental distress. His experiences within this role, as well as his own internal feelings of embarrassment further informed his own stigma surrounding mental illness and mental healthcare.

> **John**: *"I was very stressed and unwell and um I think and then having the stigma of being labelled with a mental health history was, was not... you know, it was a stigma for me."*

John stated that he has come to realize that these feelings are not true but recalls how these experiences made him feel incredibly hesitant when he found himself in mental distress. John attributes the overcoming of this stigma, in part, to his work in the psychiatric ward at his local hospital following the end of his police career.

> **John**: "*...before I worked in the psych unit you know I did have a lot of stigma about mental health patients and people with mental health problems um and it opened my eyes and you know you get to learn that most of them, it's not their fault."*

When asked about barriers that had inhibited her from accessing care in the past, Sarah recalled the critical role that her own stigma played in her willingness to access mental healthcare.

> **Sarah***: "Yeah. So probably first - probably, first of all, it was my own thoughts about people who needed mental healthcare and seeing that as, you know, a weakness if you needed that. So, first of all, my own stigma. but I mean that's come from somewhere, you know, that's come from family, society, you know, TV, whatever it's come from. That belief had come from somewhere."*

Like John, Sarah's internalized stigma was informed by previous beliefs she had attributed to mental illness and healthcare. Sarah recalled how her prior perceptions of those who sought mental healthcare became a considerable barrier when it came to needing to access care for herself.

> **Sarah:** *"I think that I still had a lot of um stigma attached to other people finding help. So, why would other people not think of that for myself, you know, about me?"*

The stigma that Sarah internalized in combination with the lack of anonymity she felt living within her small town, led to a fear of judgement and discrimination. Sarah became concerned that her capability and competence in regards to her job would be questioned if she was seen accessing mental healthcare. With what Sarah believed about people needing mental health treatment she felt it was only logical that others would think the same about her.

> **Sarah:** *"I feel like you've got that little bit of public scrutiny. Well, you know, if people thought that I wasn't up to the job or, you know, had questioned that um yeah... I just never wanted to be seen, certainly going into a psychologist's room, never."*

Sarah also reflected on how her parents' beliefs and attitudes towards mental healthcare and illness, in particular her father's, had influenced how she had previously viewed mental healthcare.

> **Sarah:** "*…That stigma that I had to break down for myself would have come from Dad. And I guess to a lesser extent them both, you know, where you just didn't talk about anything. You did something and then you got punished but there was no chat around why you had done something…"*

Sarah continued, stating that past comments from other members of her support system, such as her husband, had also reaffirmed her internal stigma towards seeking mental healthcare.

> **Sarah:** "*But also, like, that's come through from my husband too. Because I've had like some pretty scary um, I don't really know how to describe it... Like at one point I was pretty worried that I was going to hurt myself, it was before we had kids, and I said I really need some help. I just can't, I don't think I should be here. And I said I really think I need to go to the hospital. And he said to me, I really don't think anyone else needs to be involved, you know, so that... It just really needs to be kept in the house. And so that was probably, It might of been 15 years ago."*
>
> **C:** *"How did that make you feel?"*
>
> **Sarah:** *"Like I just needed to sort it out."*
>
> **C:** *"So it reaffirmed that feeling, that stigma?"*

> **Sarah: "***Yeah, don't bring shame. Don't bring shame to us, you know, because then there's going to be a problem with everybody. You know, if you're down, you can't sort it out... yeah absolutely."*

Unfortunately, this wasn't the first or only scenario where Sarah would learn to associate help-seeking with shame. Situations such as this only further contributed to Sarah's internal stigma and her fear of stigmatization from others was only further reinforced. Like Sarah, Alice also discussed how the stigmas held by those within her support system have also impacted her own beliefs and attitudes about the mental healthcare system.

> **Alice**: "*I suppose the biggest one that stands out to me would be my parents, who don't believe in it. Well, my dad, like if I mention that I'm seeing a psychologist or something he - I don't know if it's a generational thing, but just, you know, there's still that stigma of like why do you need a headshrinker and it's not a real thing just, you know?"*

When asked how she believes her fathers stigmatized view of mental healthcare has impacted her own thoughts and beliefs about mental healthcare Alice commented that although she believes mental healthcare is an important and necessary tool for those who need it, it has contributed to doubts she has about her worthiness of care and a drive to "deal with it" herself.

> **Alice:** "*...like, I really strongly believe that mental healthcare is um really necessary for people but then I'm like, you know, I'm not willing to spend - well I don't have the money, but you know, it's not always a priority for me because maybe I'm just like, oh I can deal with it myself. Like, I'm sick of going through all of it again. I'm just going to deal with it myself, probably from my dad."*

Like Sarah and John, stigma was a two-faceted barrier for Alice as she experienced both internalized stigma and fear of stigmatization from others. For Alice, fear of stigmatization centred around her diagnosis of PTSD. Following a set of six voucher sessions provided by her GP Alice was assessed for and diagnosed with PTSD. Through her own preconceptions about PTSD Alice struggled to identify with her diagnosis

> **Alice:** *"I kind of was like, I don't have PTSD, that's ridiculous, that's just for people who have been in wars or, you know, that kind of thing."*

PTSD diagnoses are not uncommon amongst those with childhood trauma but coming to terms with her diagnosis is something that Alice still struggles with today.

> **Alice:** *"I think it took me a long time to come to terms with the fact that I may have PTSD. I still don't know if I agree with that diagnosis for myself. Um, but maybe because I'm not ready to."*

She recalled feeling concerned about the implications of her new diagnosis and attributed these concerns, at least in part, to fear of stigmatization from others. She felt concerned that the stereotypes and stigmas associated with trauma-related diagnoses, such as PTSD, would lead to future health concerns being trivialized and/or entirely contributed to her traumatic experience and subsequent diagnosis.

> **Alice***: "So, it's like the practicality of things and also um, maybe like fear of stigma, like I don't want to be treated any differently by anyone and particularly like having it on my record, if I were to have any medical health problems, I worry that I'd then be lumped into "oh it's all because of your trauma" it's all because you've got this PTSD diagnosis and my physical symptoms will be discounted in the future. Because unfortunately that does happen and it happens all the time, so I think I'm quite fearful of that as well.".*

Being labelled with a diagnosis can have complex and sometimes harmful implications for those with childhood trauma. For Alice, being diagnosed at the very end of her six sessions meant she had little time to process within the therapy space and received minimal guidance and education from her clinician in adjusting to her diagnosis, making it feel even more confronting. With no structured follow-up or education about her diagnosis, Alice felt she was left to manage the emotional and practical implications on her own. Whilst Alice's clinician did offer to continue seeing her privately, this was not something Alice could afford. As Alice navigated life with her new diagnosis, she became aware of the broader ways in which it would impact her life.

> **Alice:** *"I recently brought a house, and you need to get like life insurance, and you have to disclose stuff, and there's heaps of types of insurance that aren't available to me now because of that diagnosis. Like my life insurance premiums are higher, I couldn't get income protection, and I couldn't get another type and travel insurance is now more expensive, things like that."*

Although the timing of her diagnosis was at no fault of the clinician, it still left Alice feeling confused and isolated. Without professional guidance, she struggled to acclimatize to her diagnosis. Grappling with the future implications it may have on her life and well-being only further contributed to Alice's difficulty identifying with her new diagnosis.

Trust is a Gatekeeper

Trust, or lack thereof, was another central component to the internal barriers faced by participants. Lack of trust was a significant barrier of Emma's journey with accessing and utilising mental healthcare. As a teenager she was presented with several opportunities to confide in school staff but felt that disclosing her experiences would have jeopardized her ability to escape her living circumstances.

> **Emma:** *"the school counsellor, came and took me out of class and they said to me "We've heard that you're going through some heavy stuff at home" you know they labelled it and I denied it because I had to get out and I did not trust telling them and I did not want anything to effect the plan of me getting out of that environment safely."*

Being stuck in a traumatic home environment, Emma felt that she couldn't rely on anyone else to assist her in leaving home. For Emma, disclosing her experiences to a third party was an unknown variable and represented a risk to her well-being that she did not want to take.

> **Emma:** *"Like if one person found out it would have changed my entire life. So, there were opportunities, but I did not have any faith or trust in those, when in personally you're being affected directly from those that you love, you know, or are meant to love you. So, yeah it's about that lack of trust."*

As for many victims of childhood trauma, one's ability to trust others can be deeply affected by traumatic experiences. This is especially true when the perpetrator is a family member, the child will develop a strong sense of distrust as a protection factor but also as a result of unmet expectations of parents, caregivers or other authority figures within their life that are meant to provide them with safety. For Emma this led to a fundamental sense of distrust in others that continued to adulthood.

> **Emma:** *"So, there's a little bit of um, questioning everybody around you, questioning society and how you grow up knowing that they are meant to be there for you but when you're young, and you're learning, and you're in that immediate fear, you know, you just think I need to do what I need to do to get through and that's what I had done."*

Once Emma had moved back to New Zealand, she found herself once again living in a toxic and neglectful home environment. Her father's partner, who Emma likened to an "Evil Stepmother", contacted Emma’s school to report her concerns for Emma’s mental well-being, which Emma felt was a control and manipulation tactic. When she was confronted by a school dean, Emma once again denied that anything was wrong.

> **Emma:** “*I was like “Oh no, everything’s fine” you know because you’re putting yourself, your putting your health and safety and your own mental wellbeing as a priority and I did not want to go into that, and yes that's another person coming in but they don’t live what I live, they don’t know the ins and outs and they don’t know what I had to go home to and I'm not going to play into that.”*

Having spent the majority of her childhood surrounded by adults she could not rely on for safety, Emma found it difficult to trust the motivations and intentions of those offering her support. At the time, she felt keeping her experiences private was the only way to protect herself and maintain control over her escape from her unsafe living circumstances.

> **Emma:** *“I'm going to do that because I have to put my holistic, you know, my everything, my whole being, at the forefront, where these people do not know me and do they really have my best interests at heart? No. Do I want to go through police and other services and go through trials, and courts, ‘cause all of that we going through my head since before fourteen, I didn’t want that for myself , I don’t want to be placed on, you know, in front of everyone, I don’t want to be putting that out there, having those confrontations with um services that you just have no clue about.”*

The fear of being forced into legal proceedings or losing control over own narrative reinforced Emma’s reluctance to seek support. As she states, these intense feelings of distrust in her family and in the system were deep-rooted and persisted into her late teenage years. Consequently, it wasn’t until she was an adult and far removed from the toxic environments of her childhood that Emma was able to form independent healthy relationships of which trust became a central factor.

> **Emma:** "*Because those that are suffering from trauma, they already distrust everybody, mostly and so to have someone very close to them, that will say, you know, I feel like this might be the right fit, you know it's having those close*-knit *conversations with those that you trust."*

Establishing trust in the relationships was significant for Emma, as it allowed her to have confidence in the sincerity of their encouragement to seek care. This sense of trust and safety ultimately empowered her to voluntarily seek mental healthcare for the first time.

For Sarah, lack of trust was a barrier for her within her therapy sessions. Following her initial experience with the university counsellor, Sarah's first experience with therapy was when she accessed a psychologist through her GP via a voucher system in which she was given six free sessions. During these sessions she felt a noticeable disconnect with her psychologist, commenting that she felt judged by the clinician. This led Sarah to question if she should trust the clinician with her story.

> **Sarah:** *"…there were times when I picked up on her reactions to what I was saying and I just thought, you're judging me, you know all these sorts of um, yeah. I just, even just the way... just in her body language even, you know, when I would say things. I just thought, how can I tell you these things when your reaction is, yeah, what it was*."

Sarah's fear of stigma and judgement from others was a critical barrier she had to overcome to access therapy in the first place, feeling judged by the clinician in the therapy space only further reinforced this fear. For Sarah, this fostered a lack of trust in the therapeutic relationship leading Sarah to withdraw emotionally in the sessions.

> **Sarah: "***Yeah. I guess there was a lack of trust, you know."*

> **C:** *"Okay, how do you feel that impacted your experience with care?"*

> **Sarah:** *"Well, I just thought what's the point? You know, why put myself out there, why be vulnerable and open up to other people's thoughts of me when it doesn't help anyway. And what can you really do in six sessions? let's be honest, you know, that's deep childhood trauma."*

Trust is directly connected to Sarah's willingness and ability to be vulnerable. The lack of trust Sarah felt in the therapy space effectively led to a reluctance to share openly with her clinician. Sarah began to doubt the purpose of the therapy as well as question if healing could even be achieved within the allotted time frame. Following these sessions, it was another 3-4 years before Sarah accessed mental healthcare again, through a second set of GP appointed voucher sessions. Similarly to Sarah, John also alluded to a lack of trust in the benefits of mental healthcare, questioning if the deep and extensive impacts of his traumatic experiences were even able to be remedied in therapy.

> **John:** *"... you can chat away about it that it doesn't really change anything you know you can tell a psychologist "this is what's happened" he goes "that's terrible" but you know breathe deep and you know try and sleep well but it didn't, it doesn't really change anything um because unless you can change the whole wiring of your brain from the traumatic things that have happened to you um it's a tick box thing."*

John's view that talking with a psychologist doesn't "change anything" indicates a clear lack of trust and confidence in the mental health system. John's lack of trust in the benefits of mental healthcare are arguably founded in his previous care experiences. His first experience being a mandated appointment with a psychologist as part of his medical retirement and the second being with a counsellor that John found unhelpful as she was the “wrong fit”. Having had both care experiences be unhelpful, it is unsurprising that John maintains a level of distrust in the benefits of care.

Like Emma, Alice’s difficulties with trust were directly informed by her traumatic experiences. Alice explains how for those who have experienced trauma, trust can take far longer to build in the therapy space.

> **Alice:** *“I think probably common for lots of people but for me anyway if you’ve been through trauma then it can take a bit more time to like, trust people”.*

Being financially limited to voucher systems, Alice’s care experiences were always short-term making it incredibly difficult for her to build trust in the therapeutic relationship.

Reaching a Breaking Point

Three of the four participants described how reaching a breaking point was a pivotal moment in their decision to access care. When Sarah was asked about things that would need to happen for her to consider accessing mental healthcare in the future, she commented on how moments of crisis have been a consistent motivation for her to seek care.

> ***Sarah:*** *“I guess the motivations not there either because there’s no crisis, you know, because that has been a major motivator in the past.”*

The instances where Sarah had reached out to access care had always followed a period of decline in her mental health. Sarah described how she would reach a point where her mental distress began to encroach so heavily on her life that she would feel an urgency to reach out for help.

> **Sarah:** “*My decline, it’s always been at a time when I felt like it was impacting my life so much that if I didn’t do something about it, it was going to get even worse.”*

Sarah described the cyclical nature of her mental health; she would be okay managing day-to-day and then an external factor such as work stress would serve as a catalyst that would trigger her mental decline. Sarah had also developed unhealthy coping strategies that ultimately contributed to the severity of her mental distress.

> **Sarah:** *"Because I just... (sighs). I would just go through these cycles, you know, of everything being okay handling it, handling it, handling it, and then just I guess probably work being too much and then it just all come crumbling down. Yeah, and I was, you know, drinking too much and all those things, you know, recipe for disaster."*

Sarah would reach this breaking point and acknowledge that she needed to get help but then find that a few days later she would start to feel better again and the urgency she had originally felt to seek help would dissipate.

> **Sarah:** *"I think I just knew that I would get to this point where I would feel like I knew that I needed to do something. But then say like a few days later I would be okay, you know."*

What ultimately broke this cycle for Sarah was her eldest child starting school. This transition represented a loss of control for Sarah in regard to the people who were around her child. This loss of control as well as her feelings of distrust in others, formulated from her own childhood traumatic experiences, made this transition particularly difficult for Sarah and she once again found herself declining mentally. During this time Sarah began to observe how these implications of her childhood experiences were impacting her family. Acknowledging that she was in a state of mental decline and aware of how her unresolved trauma was impacting her family motivated Sarah to advocate for herself and seek healthcare.

> **Sarah:** "*So my child started school and things didn't go well. So, yeah because up until then there was very limited people that I trusted with him. Um, and then so he was at school and, you know, I don't have control over that (laughs). Um, yeah that's when I rang and was just finally like, this is just, you know, impacting them so much now, that I've got to sort myself out. Whether it costs us or not, because the impacts on them are so great.*"

Similarly, Emma mentioned the periods in her life when she had reached a period of noticeable mental distress which she referred to as a "dark place". Emma elaborated on her most recent experience of being in this dark place, triggered by her young daughter becoming more inquisitive about Emma's family and childhood.

> **Emma:** "*...that brought up the trauma, trauma from my childhood therefore I was at a dark place again to try and seek help to figure this scenario out.*"

Stepping back into the therapy space to access care was important to Emma and like Sarah, she was motivated by wanting to address her mental health for the well-being of her child.

> **Emma:** *"I really want to deal with and have the right tools and skills from a qualified and experienced person 'cause this is our family, and I just want nothing but the best for her and it's delicate."*

Like Sarah and Emma, John had accessed care following periods of deep mental distress. John's police career involved a plethora of accumulative traumatic experiences, John suggests that because he hadn't addressed his childhood trauma, these more recent traumas became increasingly detrimental to his mental well-being. After 15 years in the police force, John had reached a breaking point. Feeling both physically and mentally unwell with a growing concern that he may become a danger to himself or others, John approached his doctor to begin the process of medical retirement. As part of the medical retirement process John was required to see a psychologist and a psychiatrist and he was put on medication to manage his mental health.

> **John:** "*unfortunately why my police career kind of came to an end um through trauma basically and maybe the fact I hadn't properly dealt with my childhood trauma maybe that's the reason why I wasn't dealing with the trauma in the police. It just all.... stress is a killer you know I could tell that physically I was kind of unwell and mentally and I… I knew that if I didn't leave the police I would've done something that would have got me arrested."*

Following his retirement John had an extended period of time off work, managing his mental health by keeping a fairly low-stress lifestyle, John hadn't disclosed his childhood trauma at this point stating that it was still deeply buried. Then, as mentioned previously, roughly five years ago John saw a post regarding his offender which then triggered a breakdown for John. This breakdown led to John accessing mental healthcare for the second time. This breakdown also led to John disclosing his abuse for the first time to both his GP and his wife.

It Takes a Village

Support from Family & Friends

Support from friends and family was a crucial contributor to the participants willingness to seek care. Emma, John and Alice recognised how the lack of support from those closest to them in the past had contributed as a barrier to accessing mental healthcare. Emma recalled feeling isolated and unsupported during her teenage years and how this lack of support contributed to the difficulty of facing the impacts of her trauma.

> **Emma:** *"…you're, you know, facing a really long journey ahead and the completely unknown because you've got no one in your, your corner."*

In discussing his daughter's mental healthcare experiences John reflected on how pivotal support would have been if had received it as a teenager.

John feels that if he had access to support during the time of his trauma, he wouldn't have faced such significant mental health struggles later in life.

> **John:** "*if I was able to get decent help when it happened um I would have been an a lot happier person in my life."*

Like John, Alice acknowledged that having access to mental healthcare as a child would have mitigated many of the long-term impacts of her traumatic experiences.

> **Alice:** *"…now I feel like it is a shame, and it would of made a massive difference to me as a child and as an adult um, but I try not to feel kind of annoyed about it 'cause it's not going to get me anywhere (laughs)."*

When Emma moved to Taranaki as an adult, she was tasked with building her own support network, something she found challenging.

> **Emma:** *"So, when I left them and came to Taranaki, I managed to find a way out and came to Taranaki and then I had to develop my own support network, that was really tricky."*

When Emma met her now husband, she initially struggled with entering a family that almost reflected the total opposite of what she grew up surrounded by.

> **Emma:** *"When you're not used to it, especially with meeting my husband, we were best friends at the time, then I got to know his family and then I remember sitting in the corner in their lounge, because I wasn't used to it, they – all his family got along, they have*

family reunion days, I'm like what is this? Like there's so many of them and no one is arguing. Like they are all just banter, what?"

Throughout the interview Emma emphasized the deep support of her husband and how it had been a key facilitator to her accessing care. Emma acknowledged that it can be difficult to recognize within herself that she is struggling mentally. In these periods, her husband's awareness of her mental health, validation of her struggles and encouragement to seek help have been instrumental in her accessing the care she needs.

Emma: *"…my husband and I have a thing where he knows that if I'm not, 'cause it happens so, I don't want to say so suddenly, because you don't really know within yourself, but people close to you can see a difference and you're withdrawing or becoming quiet or something like that and then he will pick up on that and then he will say to me, we need to sort this out and that's okay."*

Her husband's support extended beyond encouraging her to access care; he also alleviates other responsibilities in Emma's life to assist her with accessing care. She mentioned that they have a safe word that works to instantly communicate to him that she isn't feeling great after a session.

Emma:" *my husband knows and he has the house sorted, he has my bed heated up, he has, you know, we have a safe word, if I just get overwhelmed with everything I just type in the safe word (clicks fingers) and it doesn't matter. Like, we just work. "*

In addition to her husband, Emma recognized that support came from a variety of different people in her life. Emma comments that support to access care does not come from a singular conversation but the continued encouragement from her support network. Having this "village" of support not only facilitated Emma in accessing and utilising mental healthcare it also facilitated healing beyond the therapy space.

> **Emma:** *"Like it's not just a one-on-one conversation obviously, it's a, it is quite a village, like for me it was my doctor, it was my husband's family, it was having understanding friends and having those um, being gifted those strategies in how to cope when you're triggered unexpectedly."*

John had struggled for many years with disclosing his abuse and like Emma, the support of his spouse has been a key facilitator for John in accessing care.

> **John:** *"…my wife has been my rock as it were."*

John struggled for a long-time with internalized stigma, shame and embarrassment regarding his trauma. He recalls a lengthy battle with self-blame and how the support of his wife was pivotal in recognizing that he wasn't at fault.

> **John:** "*Yeah, kept me going you know and learning about you know whose fault it was you know and for years I blamed myself."*

Alice shared that whilst her partner and friends are supportive of her seeking care, it can be challenging when those within her support network can't comprehend the barriers that she faces.

> **Alice: "***And probably like my partner and some of my closest friends would be very very optimistic about me seeking support and kind of almost pushing me into it, whereas they don't really understand some of the barriers that I've talked about. And it's easy for them to say "Oh yeah, great. Go and get some help, go and talk to someone" but they don't really understand the realities of the barriers."*

Positive Healthcare Relationships & Experiences

Participants described the impact that positive healthcare relationships and experiences had in supporting them to access care. Once she had graduated from university and had some much-needed distance from her childhood experiences, Emma felt ready to begin dealing with her trauma. Emma described the strong and trusting relationship she established with her GP who was able to recognise that she needed further mental healthcare and began making referrals for her to do so.

> **Emma:** *"after I finished university I was twenty one and I realized uh oh I have a whole lot of stuff that I need to deal with so my GP and I had a conversation and she got me on to this child psychologist and sadly qualified for um free counselling for the rest of my life."*

Because Emma had already established a strong relationship with her GP, she was able to trust her recommendation for further care. The supportive and gentle approach to her mental health concerns made her feel both understood and reassured. Given Emma's historical distrust in mental healthcare services, this support from her GP was especially critical in her accessing the help she needed.

> **Emma:** *"Like I had that conversation with my GP and I trusted my GP with my life and she said this person, I think, would be a really good fit for you, let's give it a go and if you don't want to – so it was gentle. Um so i think just having that foundation of having someone that was good, and I can recognize that, amazing for this, not for this, but for this I need something else to help me."*

Similarly to Emma, Alice did not go into her appointment with her GP with the intention of accessing further mental healthcare. Alice's GP was able to recognise that she needed further care and provide Alice with vouchers for six free sessions.

> **Alice:** "*I didn't actually ask the GP for it at that time, she suggested it because she was going to put me on some medication, you know, best practice is to do both at once."*

Like Alice and Emma, John did initially disclose his trauma and sought care from his GP. However, as previously established, his GP's failure to refer him to ACC left John finding this experience unhelpful. When asked about what has influenced his beliefs about the mental healthcare system, John emphasized the impact of witnessing his daughter's positive mental healthcare experience on his own attitude towards care.

> **John:** *"I've since learned um you know my own experiences with my daughter that the system is there and it was great you know."*

Reflecting on his own childhood, he emphasized how life-changing it would have been to receive the same level of care at the time of his own trauma.

> **John:** *"I know if I could've got treatment like my daughter received, I would've been a completely different person. I wouldn't of had the issues and the et cetera that I had and still have to a point."*

Through his daughter's experience John was able to witness the positive impact of care and the role a strong therapeutic relationship plays in recovery. John felt this created a positive shift in his perceptions of mental healthcare, leaving him confident that it would be beneficial in his own journey if he chooses to seek it in the future.

> **John:** *I'm feeling pretty confident that um knowing what I know now that if I engaged in the mental health service that they would be helpful.*

A Need for a System that Cares

Participants discussed several systematic changes that they felt would better support themselves and others with childhood trauma in accessing and utilising mental healthcare. When asked about what could better support her to access mental healthcare in the future, Sarah emphasized the importance of continuity of care. She expressed frustration with the idea that mental health and trauma recovery follows a fixed timeline, stating that there wasn't a set list of issues that could be resolved within a set timeframe. Under ACC, Sarah's sensitive claim entitled her to 100 hours of care over a 24-month period, the maximum allocation under ACC's well-being package. However, she felt this timeframe did not account for the ongoing and long-lasting mental health impacts of her trauma.

> **Sarah:** *"Well, I think it's pretty well known that you just don't have a list of stuff and then you're fixed, you know. So why, if you've had two years and you've had the maximum amount of ACC, if you qualified enough for that, why would you not then qualify for some maintenance."*

Sarah felt strongly that if her experiences were severe enough to qualify for ACC-funded care, she should be eligible for continued care and support beyond the allotted two-year period.

> **Sarah:** *"Just not um "oh your two years is up, the funding is gone, we're done now". Um just on-going... yeah that maintenance. I think that would be really helpful."*

Throughout her experience in the healthcare system, Sarah encountered multiple instances where she felt her mental health struggles were dismissed, minimized or ignored by healthcare professionals. Sarah stressed the importance of appropriate communication regarding mental health issues and trauma-informed care in all healthcare spaces, extending beyond those that work in mental healthcare.

> **Sarah:** *"I think that it would be really useful for... almost how to deal with patients who need mental health services which, to be honest, is probably most of the population. For all practitioners, like GP's, people in the maternity ward, everybody, to just watch their words, just to know how to speak. Like, yeah there are a few. Like I remember being booked in for my second child and the doctor looking at my thing going like, oh why were*

> *mental health services called? Like um... okay? I don't know. I just think surely it should be a component of- you know that midwife, that was a really damaging comment to minimize that. For all medical staff to have some type of training in how to speak to patients."*

Similarly, Alice emphasized how important it is for healthcare staff to recognize, understand and validate mental health issues. Additionally, recognizing the importance of mental healthcare amongst healthcare professionals was also crucial as GP's referrals are often the difference between accessing care or remaining without support. Although grateful that her own GP took her concerns seriously, Alice felt it was crucial that healthcare professionals look at the whole person rather than just physical symptoms.

> **Alice: "***I think I've been quite lucky with my GP's but possibly like GP's and other doctors just having more of an awareness of the importance of mental healthcare as well, not just looking at physical problems"*

Emma, John and Alice all shared the perspective that New Zealand's public mental healthcare system was in desperate need of more funding.

> **Emma:** *"We need better, the children need better, our society needs better, we all know that if the i.e. government or funding was provided more than you would like you would see the statistics fall at the other end."*
>
> **Alice:** *"I feel passionate that it needs more funding. Because there are people much worse off than me that can't get the help they need as well, which is really sad."*
>
> **John:** "*I mean it's always a money thing, particularly these days the money's not there. The government's really um turned the tap off."*

Both Emma and Alice discussed the importance of early intervention in supporting those with childhood trauma. Emma emphasized the importance of integrated mental healthcare in schools and the value of creating welcoming and supportive environments for children to disclosure their trauma.

> **Emma:** *"I think that would be really cool to have, I guess, I'm looking at it future wise for my daughter in my mind, just a welcoming place that you're not going to be judged, and it should be kind of in partnership".*

Similarly, Alice discussed how vital early invention is in minimizing the harmful impacts of traumatic experiences in childhood. She expanded on this further stating early intervention would ultimately save the system money by reducing the number of adults seeking care for unresolved trauma.

> **Alice:** "*But I do feel that the system does let down people that really need it and it's a little bit, um almost like shortsighted because if problems were treated uh early on, they could prevent bigger problems later on and actually in terms of like actually costing the healthcare system then actually, you can prevent a lot of unnecessary stress and trauma to people but cost to the healthcare system as well."*

Expanding the mental healthcare services offered in Taranaki was another much-needed systematic change discussed by participants. For Emma, this meant increasing the number of mental healthcare professionals with a variety of specializations.

> **Emma:** "*Can they just have more people in Taranaki, please. Like a whole variety of people, that would be amazing."*

Having had experienced being unable to access care when she needed it most, Emma felt it was imperative that the system do better to support individuals immediately following disclosure.

> **Emma:** "*we need to lessen the wait times, and we need it now, when people have the courage to speak out they needed it like yesterday.*"

Similarly, John reflected on his own struggles in accessing a mental healthcare provider that specialized in male child sexual abuse and felt an increase in the number of clinicians trained in trauma-related areas would be invaluable.

> **John:** *"it would be nice if there were more specialists in each area um I know child um teenage sexual assault has gone through the roof."*

Given that affordability had been a significant barrier for Alice she stressed a need not only for more experienced clinicians, but an increase in accessibility to care by introducing affordable low-cost mental healthcare options.

> **Alice:** "*Um, more options, particularly locally and um cost-wise potentially more free or really low-cost options. And um somehow getting more people to move to Taranaki with great experience and um availability.*"

In introducing more affordable mental healthcare services people, like Alice, who are not entitled to subsidized care through ACC would have the opportunity to access long-term care and build a sustained relationship with their clinician.

> **Alice**: "*Like you've either got the free people who are on the EAP or voucher scheme or the really really expensive ones. You know, like, I'd be willing to pay like eighty dollars for a session but not two hundred dollars, it's quite a leap. So maybe more of that like middle cost option, where you could make it more of a sustainable relationship. But like two hundred dollars a week for years, I mean I can't afford that, I don't know who can. But maybe like fifty to eighty dollars a week would be something that I could afford, yeah.*"

Alice also suggested that growth in the online therapy space could also address the issue of affordability as well as the limited number of practitioners in smaller regions. An increase in digital mental health services would also help mitigate scheduling issues, travel costs that had been a barrier for her previously.

> **Alice:** *"I guess with online it could be more affordable, and there would be more choice of practitioners and then you may have more flexibility with your work schedule as well"*

Ultimately, participants shared the perception that in many ways the current mental health system is failing to adequately support those with childhood trauma. Whilst participants acknowledged the positive impacts of mental healthcare, they felt strongly that systematic barriers stood in the way of their access to care. Amongst their suggestions for systematic changes, it became clear that participants desired a system that put people first when it comes to funding, resource allocations and patient interaction. The desire for empathy, compassion and understanding in all healthcare spaces regarding mental illness and trauma was strongly expressed by participants.

Chapter 5: Discussion

The aim of the current study was to explore the lived experiences of adults with childhood trauma and develop an in-depth understanding of the barriers and facilitators they have encountered when accessing and utilising mental healthcare. To the best of my knowledge this is the first study to explore the barriers and facilitators to accessing and utilising mental healthcare in adults with childhood trauma in New Zealand. Whilst international studies have thoroughly investigated barriers and facilitators to mental healthcare, those with a trauma-specific focus typically centre on individuals who experienced trauma in adulthood. Given the limited research on this topic, the following discussion will draw on this broader literature as well as other research on mental healthcare access and engagement, comparing these findings with the results of the current study to identify barriers and facilitators to accessing and utilising mental healthcare that exist for adults with childhood trauma. There were three key areas of focus in the current study. Firstly, to investigate the perceived barriers to accessing and utilising mental healthcare. Secondly, to investigate the perceived facilitators to accessing and utilising mental healthcare. Lastly, to explore the perceived future supports needed to access and utilize mental healthcare. The current chapter will begin with a summary of the six themes explored in the previous chapter. This will be followed by a discussion of barriers and facilitators identified within these themes and its relation to prior literature. The implications of the study's findings will then be discussed before concluding with a reflection on the study's limitations and recommendations for future research.

Summary of Themes

Data Analysis identified six key themes relating to the participants' experiences and the barriers and facilitators they encountered in their journeys with accessing and utilising mental healthcare. *Constraints of Living in a Small Town* encapsulated the challenges faced by participants when pursuing mental healthcare in a small town. The limited availability of practitioners, difficulty in finding a well-matched therapeutic relationship and concerns about anonymity all contributed to difficulty in accessing and utilising mental healthcare. *The Cost of Care* reflected the financial obstacles faced by participants when seeking care. Limited options for care often forced participants to face long waiting lists, take on a significant financial burden or remain without care. Financial burdens were compounded by travel costs and loss of work hours. Frustration and feelings of injustice were also expressed regarding the financial responsibility of paying for care as survivors of childhood trauma. *Confronting Internal Barriers*, encompassed the participants struggles with internal barriers to accessing care. Both internalized stigma and fear of stigmatization from others emerged significant obstacles, often informed by the negative perceptions of mental illness and care-seeking within support networks. Lack of trust in others, often developed as a result of childhood trauma and was a significant barrier to care-seeking, disclosure and establishing therapeutic relationships. The presence of trusting relationships facilitated access to care and contributed to positive care experiences and healing. *Reaching a Breaking Point*, highlighted the role that crisis plays in the motivation to seek care. Periods of significant mental distress, in combination with witnessing its negative impact on loved ones, often overshadowed existing barriers and motivated participants to seek care. *It Takes a Village*, encapsulated the significant role that support networks have in encouraging care-seeking. Emotional and practical support from family, friends, and partners were pivotal in encouraging participants to access and utilise care. Positive relationships with healthcare providers, such as GP's, were also central in facilitating access to care through referrals and encouragement.

Lastly, *A Need for a System that Cares* highlighted an overarching need for empathy and understanding within all healthcare spaces. Several systematic changes such as increased funding, resource allocation, affordable care options and early intervention were suggested to further facilitate access to care amongst participants and others with childhood trauma.

Barriers to Accessing and Utilising Mental Healthcare

From the themes identified in this study, several barriers to accessing and utilising mental healthcare amongst adults with childhood trauma were highlighted. The barriers identified in this research include Limited Resources, Finding the "Right Fit", Lack of Anonymity, Financial Constraints, Stigma, and Lack of Trust. It should be noted that although this research did not aim to explore barriers to care associated with living in smaller towns/communities, it became evident that geographical location had a significant influence on participants' experiences and contributed to many of the obstacles they faced in accessing and utilising mental healthcare.

Limited Resources.

As outlined by Williams et al. (2017) and the Mental Health Commission (2012), New Zealand has historically experienced a nationwide deficit in mental healthcare resources. More recent findings of the 2018 Government Inquiry into Mental Health and Addiction evidence that current resources are unable to meet the demands of the population (Paterson et al., 2018). Those living in smaller towns experience an even deeper lack of mental healthcare resources in comparison to larger urban areas (Ferris-Day et al., 2024). Participants consistently reported that the limited resources, as a consequence of living in a small town, was a significant barrier to accessing and utilising mental healthcare services. For some participants, limited care resources meant facing long wait times, a finding supported in previous research investigating systemic barriers to care (Kulshrestha & Shahid, 2022). Literature has associated long wait times with a number of negative outcomes such as increased severity of symptoms (Punton et al., 2022) and reduced treatment engagement (Westin et al., 2014). Similarly, one participant in the current study reported how facing a waitlist of up to a year exacerbated her mental distress, forcing her to pay out of pocket for care despite full coverage under ACC. Echoing the findings of de Boer et al (2022), two participants also reported a scarcity of practitioners who specialized in specific trauma-types or trauma-focused therapies. Although participants were able to find clinicians with appropriate scopes of practice, these were either geographically distant or too expensive. The inability to find clinicians providing this specialised care was discouraging for participants and was highlighted as a notable barrier to care (Sivagurunathan et al., 2019).

Incompatibility in the Therapeutic Relationship

Alliance and compatibility in the therapeutic relationship was of clear importance amongst participants. Therapeutic alliance can be defined as a positive collaborative relationship in which client and clinician work together to meet the client's needs (Grad, 2022). Previous literature has associated strong therapeutic alliance with increased treatment engagement and positive therapeutic outcomes in those with childhood trauma (Koole & Tschacher, 2016). In agreement with this, findings of the current study highlighted that in therapy experiences where a therapeutic alliance was apparent, participants felt emotionally open and engaged in treatment. Alternatively, in scenarios where participants felt an incorrect fit with their clinician, they often felt judged, unheard and disengaged in the therapy space. A myriad of factors contribute to establishing a strong therapeutic relationship (Grad, 2022). For those with childhood trauma, pre-existing distrust in others as a result of early traumatic experiences can make establishing this relationship difficult (Simpson, 2013). Reflective of findings from Boterhoven de Haan et al. (2021), who investigated valued characteristics of the therapeutic relationship amongst adults with childhood trauma, participants in the current study valued empathy, knowledgeability in working with childhood-trauma, and professionalism as qualities in their clinician. Participants looked back positively on therapy experiences where these qualities were present, and expressed dissatisfaction in experiences where they weren't.

Having the ability and autonomy to advocate for their choice in clinician was an important aspect in the participants willingness to seek care. However, the limited availability of clinicians in their region made it difficult to exercise this. Regarding clinician gender, one participant expressed they would be more comfortable discussing their trauma with a clinician of the same gender. Existing literature on clinical gender preference is limited but has yielded mixed results. Aligning with the results of the current study, Landes et al. (2013) found gender matches between client and clinician to be associated with higher levels of anticipated comfort and increased likelihood of self-disclosure. In contrast, findings from Seidler et al. (2022) suggest that men typically do not have a preference for either gender, but rather, having their preference met, regardless of gender, was predictive of positive treatment. Similarly, Turchik et al. (2013) reported that male trauma survivors typically varied in their gender preference, influenced by factors such as sex of the offender, past care experiences, sexual orientation and internalized beliefs about male sexual assault. However, men who preferred female clinicians did so due to higher perceived comfortability and concerns about the provider questioning their sexuality (Turchik et al., 2013).

Anonymity

In agreement with previous literature, some participants highlighted a lack of anonymity as a barrier to accessing mental healthcare services (Heron & Eisma, 2021). However, participants' concerns for anonymity did not centre around a fear of service providers disclosing their information, as indicated previously, but rather that they would be seen by others in their community accessing care. Participants described feeling particularly visible within their small communities and maintaining privacy became especially challenging due to their professions. Existing research indicates that lack of anonymity remains a salient barrier in smaller communities where mental illness and care-seeking is often attached to prejudice (Graves et al., 2024). In agreement with this, two participants in the current study expressed a concern that others would find out about their care-seeking, fearing judgement and stigmatization from those in their community. For one participant in particular, the need to keep her mental distress as private as possible was reinforced by her family's belief that such matters should be kept private so as not to bring shame on the family. Ultimately, concerns for anonymity created a psychological barrier, discouraging participants from pursuing mental healthcare even when they were in mental distress. Fear of judgement and discrimination as a consequence of being seen accessing care indicate a clear prevalence of stigma within smaller community settings making concerns for anonymity a clear barrier to accessing mental healthcare.

Financial Constraints

Financial cost is a well-documented barrier to accessing and utilising mental healthcare amongst trauma-exposed and non-trauma exposed populations (de Boer et al., 2022; Coombs et al., 2021). Therefore, it was unsurprising that financial cost was identified as a significant barrier to accessing and utilising care amongst participants in this study. In New Zealand, several avenues exist in New Zealand for free or low-cost mental healthcare, including GP-issued vouchers, EAP programs, and ACC sensitive claims. Many regions also offer low-cost services through local Women's/Men's centres, tertiary institutes and youth centres. Additionally, individuals can also apply for up to 10 free counselling sessions under the disability allowance provided by Work and Income New Zealand, with the possibility for additional sessions if recommended by a health practitioner. However, many of these avenues only provide short- term care, typically offering between 3-10 sessions.

Reflective of previous literature, participants felt that although short-term services were better than nothing, they often found the limited sessions did not provide adequate time to address trauma and achieve meaningful healing (de Boer et al., 2022; Ellinghaus et al., 2021) Additionally, participants who were financially restricted to only accessing this short-term care found establishing trust in the therapeutic relationship incredibly difficult within the short time frame (Ellinghaus et al., 2021). Although ACC does provide extensive cover longer-term care under their sensitive claims scheme, these are restricted to sexual abuse cases only. Participants with childhood traumatic experiences that don't fit within these criteria are often forced to pay privately or avoid accessing care altogether.

Findings of this study also highlighted that the financial cost of care expands beyond the cost of the sessions themselves. In agreement with previous literature, Participants highlighted travel expenses, loss of work hours and childcare as additional financial considerations that had to be made when accessing care (Kantor et al., 2017). Travel costs associated with accessing mental healthcare is a barrier that has been previously highlighted in research investigating barriers to accessing care for those living in rural communities (Ferris-Day et al., 2021).

Interestingly, two participants discussed feelings of injustice in regard to being financially responsible for paying for mental healthcare. This was a particularly interesting finding given that, to the best of my knowledge, it is an aspect of financial barriers to care that has not been identified in previous literature. Bearing the financial responsibility of paying for care was a source of frustration for some participants as it was yet another on-going consequence of their trauma. The fact that those responsible for their trauma, or at least failed to protect them from it, faced no such consequences only furthered this frustration.

Stigma

Stigma was identified as a significant barrier to accessing and utilising mental healthcare for three of the four participants in this study, a finding consistent amongst research on trauma-related barriers to care-seeking. (Sayer et al., 2009; Kantor et al., 2017). Corrigan (2014) outlines two facets of stigma, public and self, that impact care-seeking. Public stigma refers to the negative societal perceptions of mental illness and mental healthcare, while self-stigma refers to the internalization of these negative beliefs. Corrigan (2014) suggests that self-stigma metastasizes in four stages; awareness of public stigma towards mental illness, agreement with perceived public stigma, application of these negative beliefs to the self which is then followed by a decrease in self-esteem and self-efficacy. This can ultimately lead to self-discrimination and what Corrigan (2014) states is the “why try” effect, where individuals will question whether they are worth receiving care at all. Alice’s experience illustrates this, her internalized stigma, predominantly informed by her father’s negative perceptions of mental health, led her to question her own worthiness of receiving care. Corrigan et al (2014) reports that in families that associate shame with mental illness and seek to keep mental distress a secret will worsen the individual’s ability to cope with said distress and can alienate the individual and inhibit care-seeking

More broadly, stigma and fear of being stigmatized, fostered a fear of being judged, discriminated against, and socially excluded amongst participants. Previous literature suggests that this is particularly pronounced in cultures that value self-reliance and stoicism. Therefore, stigma becomes a particularly prevalent barrier in smaller towns and rural settings who generally hold more stoic and rigid mindsets towards mental health (Ferris-Day et al., 2021). This was reflected in the current study with participants citing negative generational attitudes and parental emphasis on self-reliance as key contributors to their stigmatized perception of care-seeking. Hoyt et al. (1997) found that amongst those living within rural settings, not only was internal stigma a predictor of willingness to seek mental healthcare, but fear of stigmatization from others was equally impactful. Whilst the ways in which stigma impeded access to care varied amongst participants these two facets of stigma, public-stigma and self-stigma, were discussed as barriers by three of the four participants. Stigmatised views held by family members also had a profound impact on participants and was particularly influential on their own attitudes towards seeking care.

As established earlier, childhood traumatic experiences can lead to a range of trauma-related diagnoses, many of which have been attached to negative societal stereotypes (Gronholm et al., 2024). Participants in this study not only highlighted the effects of being labelled with a diagnosis, but expressed fear of receiving a label and the consequences it may have. For those with childhood trauma, receiving a mental health diagnosis can give rise to a number of complex challenges, often exacerbating existing fears of stigma (McCormack & Thomson, 2017). Consistent with previous literature, participants also indicated a fear of unintended social or professional consequences as a result of seeking care and being labelled (Sims et al., 2021). Link's (1987) modified labelling theory of mental illness suggests that individuals will unconsciously internalize cultural and societal stereotypes associated with psychiatric labels/disorders and come to inherently expect rejection and discrimination. For those with childhood trauma, labelling may also compound pre-existing self-protective behaviours that further inhibit care-seeking and recovery (McCormack & Thomson, 2017). Findings of McCormack & Thomson (2017) indicate that although diagnosis can be a validating experience, this is mitigated by the extent to which an individual identifies with the given diagnosis. This was evident in Alice's experience, as she struggled to identify with her PTSD diagnosis, perceiving it as an inaccurate reflection of her symptoms. Rather than fostering validation or clarity, the label felt somewhat disabling and heightened a fear of future stigmatization. Additionally, the current study highlights that the way in which the diagnosis is delivered plays a critical role in mitigating its impacts. Individuals who are not given adequate support or education surrounding their diagnoses are at further risk of internalized stigma, shame, embarrassment and feelings of isolation (Perkins et al., 2018). Regarding treatment in healthcare settings, receiving a mental health diagnosis can also foster a fear of being perceived solely through the lens of their diagnosis/label rather than as a whole person, leading to trivialisation or dismissal of other separate health concerns (Eldal et al., 2019). One participant in the current study expressed this apprehension, fearing future health concerns may be invalidated or grouped-in her with her diagnosis.

Lack of Trust

Trust is fundamental when seeking any form of healthcare, as it inherently involves some level of vulnerability of the seeker (Brown et al., 2009). Willingness to seek and utilize care is often reliant on the seeker trusting that the provider is knowledgeable, professional and safe to confide in with the relevant issue (Lawson et al., 2017). For those with childhood trauma, establishing trust in the therapeutic relationship can become particularly challenging, as early violations of security and safety inform a strong sense of distrust in others (Beaton & Thielking, 2020). Consistent with this, lack of trust was identified as a central internal barrier amongst participants in this study. Previous literature has often identified systematic distrust in mental healthcare services as a prevalent barrier to care amongst trauma-exposed individuals, with concerns mainly centred around breaches of confidentiality (Kantor et al., 2017). However, this was not entirely reflected in the findings of the current study. Although one participant did report systematic distrust as a significant barrier, this was primarily in her teenage years rather than adulthood. Instead, participants commonly cited lack of trust as an issue within individual therapeutic relationships. Pre-existing apprehension and general difficulty in establishing trust were exacerbated when met with unhelpful or negative comments and/or actions of the clinician, leading to an emotional withdrawal in the therapy space.

Prior research indicates that lack of trust within the therapeutic relationship is common when clients are limited to a set number of sessions (Ellinghaus, 2021). Beaton & Thielking

(2020) similarly found a lack of trust to be prevalent in therapeutic relationships with a predetermined end (i.e. a set number of sessions) amongst women with complex trauma. This was true even when participants reported a positive therapeutic relationship with their clinician, as they remained reluctant to disclose their trauma, subsequently halting recovery (Beaton & Thielking, 2020). In concurrence with these findings, participants in the current study who accessed short-term care through GP vouchers or EAP services shared a perspective that they found trust difficult to establish within the set number of sessions. In consequence, participants reported emotionally withdrawing within these sessions, questioning the possibility of healing in such short-term care. Conversely, both Ellinghaus et al. (2021) and Beaton and Thielking (2020) reported that consistent long-term care fostered positive therapeutic relationships, facilitating trust and disclosure. Although this wasn't directly expressed by participants in the current study, one participant did report a perception that access to long-term care would aid in facilitating trust in the therapy environment. Given the importance of trust in trauma recovery, this finding highlights a critical need for an increase in long-term care options for those with childhood trauma.

Facilitators of Accessing and Utilising Mental Healthcare

Although participants were asked equally about both challenges and supports to accessing and utilising care, barriers to care were mentioned more frequently and more in-depth. Interestingly this reflects findings of de Boer et al. (2022) who found similar results when investigating barriers and facilitators to treatment seeking and engagement amongst women with complex trauma histories in Australia. In saying this, several key facilitators were identified from the experiences of the participants including Crisis is a Motivator, Support and Positive Healthcare Relationships. The last facilitator, A Need for a System that Cares, discusses the systematic changes and supports that participants felt would encourage mental healthcare access and utilisation in the future.

Crisis is a Motivator

Participants in the current study reported a motivation to seek and access mental health care following a period of significant mental distress. Reaching a point of crisis is a key enabler to care seeking that has been highlighted in previous literature (Mellotte et al., 2017), particularly amongst adults with PTSD (Murphy et al., 2014). Consistent with previous research, this highlighted a reactive rather than proactive approach towards seeking mental healthcare amongst participants. (Spengler et al., 2023). A reactive approach describes motivation to seek care once symptoms have become perceptible and unmanageable, in comparison a proactive approach describes seeking care to address potential mental distress before symptoms become disruptive (Spengler et al., 2023). Childhood traumatic experiences have been significantly associated with the development of a myriad of unhealthy coping mechanisms (Koçak & Çağatay, 2024. When trauma remains unresolved these coping mechanisms can become ingrained, leading individuals to rely on them until a crisis (such as a period of significant mental distress) renders them insufficient, prompting an urgent need to seek care. Existing literature on barriers to care for adult trauma survivors has identified low perceived need of care as an obstacle to seeking support (de Boer et al., 2022). However, this was not entirely reflected in the current study. While all participants were able to recognize their need for care, the perceived weight of the barriers they faced made seeking care challenging. During periods of significant mental distress, the urgency to receive support outweighed these barriers, enabling them to seek care. Findings from Bance et al. (2014) suggest that during these periods of crisis, witnessing the impact on one's family serves as a strong motivator to seek care. Echoing this, participants in the current study reported a motivation to seek care upon recognizing or fearing the impact of their mental distress on their families. This was particularly evident among participants with children, who were particularly concerned about the long-term impact of their distress on their children's well-being.

Support

Support was identified as a key facilitator in participant's accessing and utilising mental healthcare. Participants described receiving support from a variety of different sources, including significant others, family members, friends, work colleagues, and external healthcare professionals such as GP's. Support from informal social support networks, such as significant others, family and friends has been a well-documented facilitator in previous literature investigating care-seeking (Kantor et al., 2022; Bance et al., 2014). Evans et al. (2014) identified spousal support as a key protective factor in buffering on-going psychological symptoms of childhood trauma in adulthood. However, the authors only found this true in men, postulating this may be because women seek and access support from a wider range of sources, such as family and friends (Evans et al., 2014). In contrast, both male and female participants in the current study reported active and positive support from their spouses, which contributed greatly to their recovery.

Participants in this study highlighted three key ways that support from family and friends enabled them to access care. Firstly, support played a crucial role in facilitating disclosure. The stigma, shame and lack of trust associated with their childhood traumatic experiences made disclosure a difficult task for some participants. Strong support networks provided a safe space for participants to disclose their trauma without shame or judgement and in John's case, helped dismantle the self-blame he had associated with his experience. Secondly, support systems provided active emotional support and encouragement regarding mental healthcare access (Kantor et al., 2017). Reflective of the findings of Kantor et al. (2022), support from significant others was particularly influential, as they were able to recognize signs of mental distress and encouraging care-seeking. Additionally, positive attitudes towards mental healthcare within support networks worked to break down internalized stigmas associated with care-seeking. Lastly, participants highlighted the practical ways in which their support systems assisted them in engaging in treatment such as taking over domestic duties and managing childcare. This practical support not only assisted with continued engagement in care but facilitated continued healing beyond the therapy space.

Positive Healthcare Relationships

Positive healthcare relationships also emerged as a key facilitator to accessing and utilising mental healthcare. For three of the four participants, their General Practitioner (GP) was the initial point of contact when starting to seek care. This aligns with the findings of Harding and Fox (2015) who suggest GPs are the gatekeepers to mental healthcare, with referrals often being the difference between accessing care or going without support. Given that GPs are the usual first port-of-call it is crucial that they are knowledgeable, supportive and proactive when approaching mental health concerns. A meta-analysis conducted by Jackson et al. (2007) found that amongst those living in rural areas, seeking help via a GP was generally the most acceptable form of care-seeking. However, willingness to seek care from the GP was mitigated by the quality of the doctor-patient relationship. This finding was echoed in the current study where established trusting relationship with a GP was pivotal in facilitating initial treatment-seeking and disclosure.

Looking to the Future

Participants clearly expressed several supports that they believed would facilitate access and utilisation of mental healthcare in the future. Interestingly, although participants were only asked about what would better support *them* in accessing mental healthcare in the future, all participants spoke about changes that would positively impact all people who have suffered with childhood trauma. Participant responses reflected a strong sense of advocacy for trauma survivors as a group, underlined by a deep concern for the continued challenges that future generations will face if barriers to care are not addressed.

A primary concern amongst participants was the need for an increase in funding for public mental health services. The necessity for increased funding has been widely recognized in previous mental healthcare research and was a key recognition in the Government Inquiry into Mental Health and Addiction (Paterson et al., 2018). Similarly, commentary by Kulshrestha and Shahid (2022) identified that a nationwide lack of resources was a general barrier to mental healthcare across New Zealand. In agreement with this, participants emphasized a clear need for an increase in resources which they felt would assist with other systematic barriers such as long wait times and wider choice in clinician. Given the significance of financial barriers, it was unsurprising some participants advocated for an increase in affordable mental healthcare options. Increasing affordable private mental healthcare would not only provide access to a wider range of clinicians but assist individuals in building long-term and sustained relationships with providers, a factor that is essential in building trust and facilitating recovery for those with childhood trauma (Beaton & Thielking, 2020). Beyond addressing structural and financial barriers, participants also discussed the importance of parents, caregivers and other adults of authority providing the necessary support and intervention following a traumatic event.

Reflecting on their own experiences, participants emphasized how significant and life-changing this support would have been for them had they received it closer to the time of their trauma. One specific suggestion was creating and integrating more comprehensive mental health support in schools, which may facilitate earlier disclosure and care-seeking.

Lastly, participants stressed the importance of how clients/patients are treated in healthcare settings. A lack of empathy, sensitivity and the minimization of mental health concerns in healthcare spaces was a consistent theme among some participants' experiences, while others acknowledged these issues even if they hadn't personally experienced it themselves. This reinforces the need for trauma-informed care across all healthcare spaces. Ensuring that all care providers are trained to provide effective support for those with mental health concerns is crucial to facilitate care-seeking, particularly for individuals with childhood trauma who may struggle with additional challenges such as stigma and distrust (Ellinghaus et al., 2021).

Implications

There are several notable implications of the current study. Firstly, and most importantly, it amplifies the voices of adults who have experienced childhood trauma, a noticeably under-researched population, particularly in New Zealand. The opportunity to discuss their experiences was valued amongst participants, who felt strongly that this research was important and worthy of exploration. As established, to the best of my knowledge, this is the first study to examine the topic in New Zealand, making it a valuable contribution to our understanding of the lived experiences of adults with childhood trauma in New Zealand. The significant impact of internalized stigma and fear of stigmatisation from others on willingness to seek care is a finding supported in previous literature, but it suggests a strong prevalence of stigmatised attitudes towards care-seeking in smaller New Zealand towns.

More broadly, the current study deepens our understanding of how the long-term impacts of childhood trauma, such as difficulties establishing trust, shame, and embarrassment, make accessing and utilising care a challenging process. Additionally, the feelings of injustice described by participants in regard to bearing the financial responsibility of paying for care was a unique finding that, to the best of my knowledge, has not been identified in previous literature on this population. In support of previous literature, findings of the current study further demonstrate the importance of alliance and compatibility in the therapeutic relationship in facilitating access and recovery. This finding highlights the need for an increase in longer-term subsidised care to facilitate trust-building, alliance and treatment engagement in the therapy space. Lastly, this study demonstrates that access and utilisation of care is facilitated beyond the care-seeking stage and continues within the therapy space and other external healthcare environments. This highlights the interconnectedness between mental and physical healthcare experiences and further emphasizes the need for trauma-informed care in all healthcare spaces.

Limitations

In line with the aims of IPA research, the current study aimed to explore the lived experiences of adults with childhood trauma rather than produce generalizable findings. However, given that all four participants in this study were recruited within the Taranaki region, all data gathered undoubtedly reflects barriers and facilitators that are contextual to living within this region. Consequently, given that this study did not aim to explore these experiences in the context of living in a small town, a notable limitation of the study is the lack of diversity of experiences explored.

As stated by Pietkiewicz and Smith (2014), interviewing skills are critical in IPA research and a significant determining factor in the quality and quantity of information gathered. As a novice researcher, this study was my first experience with formal research interviewing. Although I thoroughly familiarised myself with my interview guide and conducted practice interviews prior to the participant interviews, it is feasible that my lack of experience in formal research interviewing reflected in the data that I was or was not able to gather. For example, upon reviewing my transcripts I noted instances where I could have continued further questioning and I did not. Additionally, I noted that on a few occasions I asked closed questions where open ended ones would have been more appropriate. Whilst the information provided by each participant appeared to me to be rich and detailed, it is inevitable that some information remained unintentionally undiscovered.

In terms of my chosen recruitment method, there were two noticeable limitations. Firstly, participant recruitment via Facebook relies on potential participants having both internet access and a Facebook profile. Secondly, some literature suggests that social media recruitment methods can be exclusive to elderly people (Darko et al., 2022). In saying this, the Taranaki Regional Research Report concluded that 88% of households in the Taranaki region currently have access to the internet (Heyes, 2025). Additionally, whilst regional statistics regarding Facebook usage aren’t available, the 2023 New Zealand's Internet Insight Report estimates that 58% of New Zealanders over the age of 70 use Facebook at least once per week(REF). Although the limitations of my chosen methodology were notable, given that I was attempting to recruit in a semi-rural/rural region, social media recruitment provided the most effective recruitment method available.

Lastly, with the initial aim of gaining further contextual information, participants were informed via the participant information sheet (Appendix B) that they would be asked to identify their relevant trauma-type (i.e. physical abuse, neglect etc.) and the age(s) at which these event(s) occurred. Literature on the ethics of asking trauma-related questions in research interviews suggests that although questions of this nature risk participant distress/discomfort this risk is far outweighed by the positive benefits produced by research of this nature (Legerski & Bunnell, 2010; Cromer et al., 2006; Jaffe et al., 2015). However, given the focus of the study was to investigate experiences with seeking and utilising mental healthcare it was decided that any benefits provided by asking trauma-related questions would be outweighed by the potential harm it risked causing. Given this decision was made after participants had viewed the information sheet, I informed all participants at the pre-interview stage that they would no longer be asked these questions and provided the reasoning as to why. Participants were also informed that they were free to disclose information about their experiences in whatever way felt most appropriate, contextually relevant and comfortable to them. Although free to self-disclose, there is a possibility that the forewarning may have inadvertently influenced and limited the information participants chose to provide, particularly any trauma-specific barriers and facilitators they encountered.

Recommendations for Future Research

Whilst the current study contributes to existing literature on the lived experiences of adults with childhood trauma, there remain numerous avenues for future investigation. Given the very limited existing literature on barriers and facilitators that exist for adults with childhood trauma in accessing mental healthcare, continued exploration of this topic is critical to further develop our understanding. Given that stigma was identified as a critical barrier to accessing and utilising care, it would be beneficial to further investigate the barriers and facilitators that exist within a New Zealand cultural context. Future research would also benefit from exploring the experiences of Māori adults with childhood-trauma and the barriers and facilitators they face in accessing mental healthcare. Research has highlighted the inequities that exist within the New Zealand mental healthcare system for Māori, particularly regarding treatment outcomes and overrepresentation of mental health disorders (Theodore et al., 2022). Additionally, of all children in New Zealand, Māori children are at the greatest risk of exposure to physical, emotional and sexual abuse as well as neglect (Marie et al., 2009). Subsequently, this indicates that Māori communities are disproportionately affected by the long-term consequences of childhood trauma, making this critical avenue for further exploration.

The results of the current study have highlighted the significant impact in which living within a small town has on one's ability to access and utilize mental healthcare. Whilst the study did not set out to explore the barriers and facilitators specific to this context, these findings are worthy of further exploration with a focus on rural/semi-rural populations. Alternatively, expanding the geographical scope of the participant sample would provide a wider variety of urban and rural perspectives. Additionally, whilst the number of participants recruited in the current study is in line with IPA recommendations for master's level research (Pietkiewicz & Smith, 2014), a larger sample size would provide even further insight into the experiences of accessing and utilising care amongst adults with childhood trauma. Lastly, it was outside of the scope of the current study to explore the variations in barriers and facilitators based amongst different demographic populations, but further investigation would assist in highlighting more specialised and targeted supports and interventions for those with childhood trauma.

Conclusion

This study aimed to explore the lived experiences of adults with childhood trauma and identify the barriers and facilitators that impact their access and utilisation of mental healthcare. Employing Interpretive Phenomenological Analysis, the study utilised semi-structured interviews to explore the experiences of four adult participants in the Taranaki Region. The study identified six key themes encompassing various barriers, facilitators and suggested future supports. Consistent with previous literature, limited resources, lack of anonymity, incompatibility in the therapeutic relationship, stigma, lack of trust and financial constraints were identified as significant barriers to care. Aligning with the findings of rural mental healthcare research, these barriers were often further exacerbated by living in a small town with particular regard to anonymity, resource limitations, and stigmatised community attitudes towards seeking care. The facilitators identified in the study included crisis as a motivator, social support and positive healthcare relationships, reinforcing existing findings. All four participants faced complex journeys to accessing mental healthcare and although they experienced significant challenges, all remained optimistic about the benefits of care in healing from their childhood experiences. Participants highlighted the need for several systematic changes to improve mental healthcare access, including increased funding, trauma-specific care options, longer-term subsidized care and earlier intervention. A recurring theme was the urgent need for a more empathetic system that employs trauma-informed care in all healthcare spaces. Given that this is the first study to explore this topic within a New Zealand context, further investigation is needed to continue to develop our understanding of the barriers and facilitators that impact mental healthcare access for this population.

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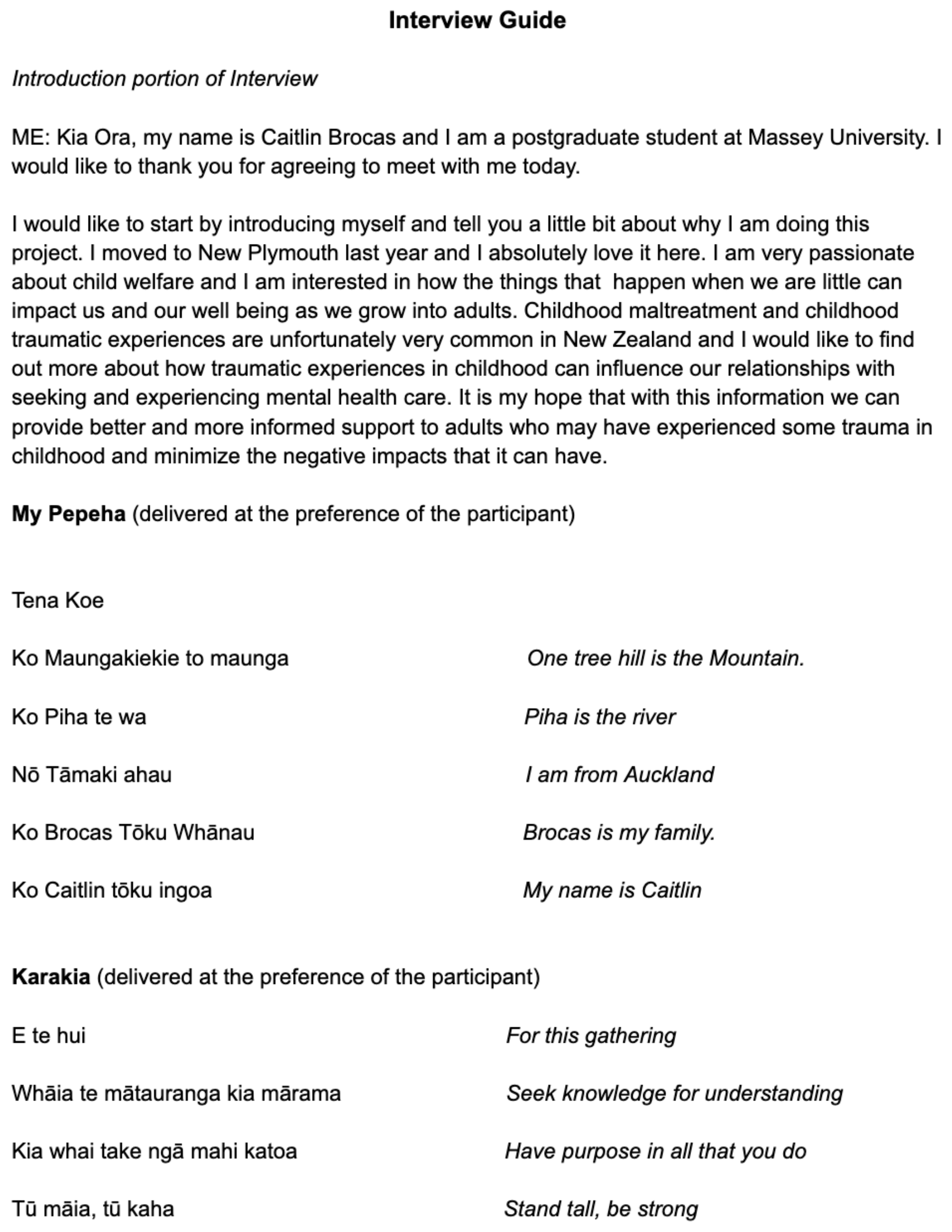
Appendices

Appendix A: Interview Guide



Interview Guide

Introduction portion of Interview

ME: Kia Ora, my name is Caitlin Brocas and I am a postgraduate student at Massey University. I would like to thank you for agreeing to meet with me today.

I would like to start by introducing myself and tell you a little bit about why I am doing this project. I moved to New Plymouth last year and I absolutely love it here. I am very passionate about child welfare and I am interested in how the things that happen when we are little can impact us and our well being as we grow into adults. Childhood maltreatment and childhood traumatic experiences are unfortunately very common in New Zealand and I would like to find out more about how traumatic experiences in childhood can influence our relationships with seeking and experiencing mental health care. It is my hope that with this information we can provide better and more informed support to adults who may have experienced some trauma in childhood and minimize the negative impacts that it can have.

My Pepeha (delivered at the preference of the participant)

Tena Koe

Ko Maungakiekie to maunga	*One tree hill is the Mountain.*
Ko Piha te wa	*Piha is the river*
Nō Tāmaki ahau	*I am from Auckland*
Ko Brocas Tōku Whānau	*Brocas is my family.*
Ko Caitlin tōku ingoa	*My name is Caitlin*

Karakia (delivered at the preference of the participant)

E te hui	*For this gathering*
Whāia te mātauranga kia mārama	*Seek knowledge for understanding*
Kia whai take ngā mahi katoa	*Have purpose in all that you do*
Tū māia, tū kaha	*Stand tall, be strong*

Aroha atu, aroha mai	*Let us show respect*
Tātou i a tātou katoa	*For each other*

Me: Remember in this study any identifying information will not be included and for this reason you will be given a fake name. Would you prefer to choose a fake name now or would you like me to assign you one later?

`*Go over information sheet, and consent form, get written consent*

ME: I am now going to turn on the audio recorder, is that okay?
Okay great.

So the aim of today is to talk about your personal experience with mental health care. I am interested in your story and the stories of other people who have had a traumatic experience as a child and how this has impacted the relationship you have with mental health care as an adult. I am interested in finding out the things that have maybe stopped you in the past from seeking mental health treatment, things that might still stop you, and what has supported or could support you in seeking mental health care in the future. I am also interested in talking about any previous experience you have had with mental healthcare and what that experience was like for you.

- It is important to note that none of the questions I ask you today will require you to talk about your traumatic experience(s) in any way. In saying this, this topic has the potential to be emotionally distressing and so if you need to take a break or end the interview at any point let me know. I have provided you with a list of resources should you feel the need for some support following this interview.

Start Questions

Interview Question Guide

Q1. Existing knowledge of the mental healthcare system in New Zealand
- Talk me through what you know about accessing mental health care in New Zealand?
- Repeat end of answer - how would you go about this?

Q2. Experience with mental healthcare system in NZ
- At the time of your traumatic event were you ever provided mental health care?
    - **If so**, what was this experience like? (what type, public or private sector)

  - **If not**, how do you feel about that?

- Tell me about your experience with mental healthcare services in New Zealand as an adult, have you sought/received mental health care at any point in your adult life?
  - **If so**, what was this experience like?
  - **If not**, how come?

Q3. Attitudes and beliefs

- How would you describe your current feelings towards the mental healthcare system in NZ?
- What do you believe has influenced how you feel about mental healthcare?
- What do you think the benefits of mental health care are (if any)?
- Do you believe that mental health treatment would benefit you? In what way?/Why not?

Q4. Barriers

- What do you believe has stopped you in the past from accessing mental healthcare?
- What do you believe is stopping you from seeking out mental health care currently?

Q5. Facilitators

- Tell me about what led to your decision to access mental healthcare (**If they have accessed mental healthcare).**
- What do you believe would encourage you to access mental healthcare **(if they haven't).**
- Tell me about the sort of support you would need to access mental healthcare? This could be support from friends/family, wider community or the healthcare system.

Q6. Support Network

- Who would you consider to be your support network? (friends, family etc)
- How would you describe their (support network) attitudes towards mental healthcare?
- In what way (if any) do you believe how those around you feel about mental healthcare has impacted how you feel?

Q7. Future

- What do you think you would need to happen in order for you to consider accessing mental healthcare?
- What do you believe the mental health care system could do better to support you?

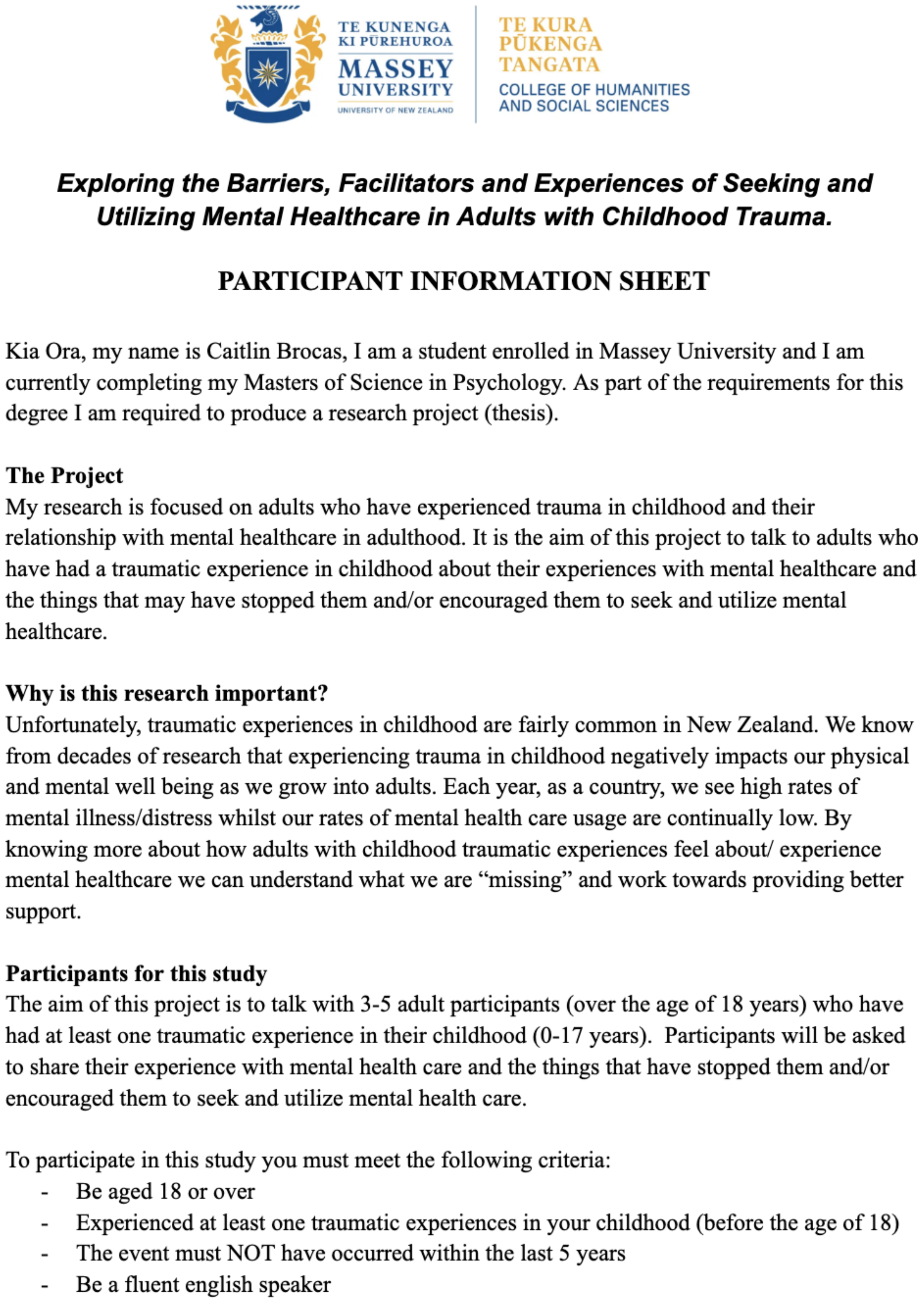
Prompts/Follow ups:

- Tell me more about that?
- Could you explain that further?
- What do you mean when you say…
- (Repeat answer) So what you are saying is…
- How did you feel about that?

Prompts to guide back on topic/ if participant appears distressed:

- You mentioned earlier that (insert statement). Could you tell me more about this?
- That sounds like it was really difficult for you
- Would you like to take a break?
- I can see that question has upset you, would you like to take a break?
- Would you like to stop?

Appendix B: Participant Information Sheet



TE KUNENGA KI PŪREHUROA
MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

TE KURA PŪKENGA TANGATA
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Exploring the Barriers, Facilitators and Experiences of Seeking and Utilizing Mental Healthcare in Adults with Childhood Trauma.

PARTICIPANT INFORMATION SHEET

Kia Ora, my name is Caitlin Brocas, I am a student enrolled in Massey University and I am currently completing my Masters of Science in Psychology. As part of the requirements for this degree I am required to produce a research project (thesis).

The Project

My research is focused on adults who have experienced trauma in childhood and their relationship with mental healthcare in adulthood. It is the aim of this project to talk to adults who have had a traumatic experience in childhood about their experiences with mental healthcare and the things that may have stopped them and/or encouraged them to seek and utilize mental healthcare.

Why is this research important?

Unfortunately, traumatic experiences in childhood are fairly common in New Zealand. We know from decades of research that experiencing trauma in childhood negatively impacts our physical and mental well being as we grow into adults. Each year, as a country, we see high rates of mental illness/distress whilst our rates of mental health care usage are continually low. By knowing more about how adults with childhood traumatic experiences feel about/ experience mental healthcare we can understand what we are “missing” and work towards providing better support.

Participants for this study

The aim of this project is to talk with 3-5 adult participants (over the age of 18 years) who have had at least one traumatic experience in their childhood (0-17 years). Participants will be asked to share their experience with mental health care and the things that have stopped them and/or encouraged them to seek and utilize mental health care.

To participate in this study you must meet the following criteria:

- Be aged 18 or over
- Experienced at least one traumatic experiences in your childhood (before the age of 18)
- The event must NOT have occurred within the last 5 years
- Be a fluent english speaker

Childhood Traumatic Experiences

Trauma is deeply personal and is unique to every individual. What may be perceived as traumatic to some may not to another. Because of this it has been hard for academics to reach a universal agreement on what "counts" as a traumatic experience. For the purposes of this study, a list has been compiled of various categories of childhood traumatic events. If you choose to participate in this research you will be asked to identify which category best reflects your experience. Please note you will not be asked to give any more detail on your experience

What will be required of me if I choose to participate?

If you agree to participate in this study you will be asked to meet with me for an in-person interview. This interview will occur at a time that is most convenient for you and will take approximately 50-60 minutes. You will be provided with a consent form that will need to be signed before our interview begins. With your consent this interview will be audio recorded. Audio-recording is an essential part of this project. It allows me, the researcher, to accurately capture what you are saying throughout our conversation with minimal disruption. It also allows me to refer back to our conversation through-out the write-up process. You do not have to consent to being audio recorded. If you feel uneasy about being audio recorded at any point before or during our interview it is absolutely your right to decline. Please note due to the importance of audio recording in this project, if you do choose to decline to be audio recorded your participation in this study will end.

Following our interview I will personally transcribe our conversation into a written digital format. During this process all identifying information will be removed. Once this has been completed, the audio recording will be destroyed. Following this, you will be provided with a copy of your transcript via email. You will then have the opportunity to look over your transcript to ensure that I have captured your voice and your experience in a way that you feel is authentic and true. This is expected to take no longer than 20 minutes. Once you are happy with this you will sign a transcript release form. We can either meet in person for this or this can occur over email, whatever works best for you. Once the study is complete, I will provide you with a summary of the studies findings. Again, this can occur via email or we can meet in person, whatever works best for you.

What will I have to talk about?

I am interested talking with you about the following:

- Your experiences with mental health care
- Your feelings and beliefs about mental health care in New Zealand
- What you believe has stopped you from seeking mental health care (previously or currently)
- What you believe has encouraged you to seek mental health care (previously or currently)
- Your support system
- Things that you feel could support you in seeking mental health care in the future

It is important to note that participation in this project will **not** require you to discuss your traumatic experience(s) in **any way.** I will ask you to identify which category (one or more) of childhood trauma best reflects your experience and the age(s) this event occurred. Trauma is a deeply personal experience and can be distressing to discuss. Even though we will not be discussing your trauma directly, it is important to keep in mind that participation in this project has the potential to be emotionally distressing. You are under no obligation to participate in this study and you retain the right to withdraw your participation in the study at any time up to and until you have signed a transcript release form (following the interview).

Koha

If you choose to participate in this study you will receive a $50 supermarket voucher as an appreciation for your time and valuable contribution to the study.

Your Privacy

Your privacy is important. All of your information and data will be entirely confidential and will be securely stored via password protection. Any identifying information such as your name and contact details will only be known to the researcher and will not be shared or discussed with anyone. Once I have transcribed our conversation, the audio recording will be destroyed, you will be provided a copy of the transcript of our conversation. You will have the opportunity to amend, add or remove any information you have provided to ensure that I am accurately capturing your narrative. You will also be provided a fake name (pseudonym) during the writing process to ensure your privacy is maintained.

Participant Rights

You are under no obligation to participate in this project. If you do decide to participate it is important that you understand your rights. These include:

- Right to withdraw your participation at any point in the study up until you have signed the transcript release form.
- Right to decline to answer any question asked.
- Right to ask any questions you may have at any given time.
- Right to decline to be audio-recorded or for audio-recording to cease at any given point during the interview. Please note that in this case your participation in the project will end.
- Right to have access to project findings once the project has concluded, these will be sent to you via email.
- Right to privacy and confidentiality, your name and any other identifying information will not be included in this study.

If you are interested in participating in this project: Please contact me via email at [redacted]

Research Contacts:

Researcher	*Supervisor*
Caitlin Brocas	Dr. Matthew Shepherd
[redacted]	09 414 0800 ETN. 430094
[redacted]	M.Sherpherd1@massey.ac.nz

Please contact either Caitlin or Matthew if you have any questions or concerns about this project at any time.

If you need some support before, during or after your participation in this study:

Helplines:

1737 - Text or call 1737 for confidential support from a trained counselor. This service is available anytime and is completely free.

Lifeline - 0800 543 354 (0800 LIFELINE) or free text 4357 (HELP). This service is available anytime, entirely confidential and is completely free.

Manaaki Tāngata | Victim Support - Call 0800 842 846. Provides nationwide support for people affected by crime, suicide or traumatic events. This service is available anytime and is completely free.

Te Puna Oranga - Call 0800 222 042 - Whanau crisis helpline. Provides 24/7 Kaupapa Maori support for individuals & Whanau

Assessment & Brief Care Team (ABC Team) in Taranaki

The ABC team provides support for individuals suffering from urgent and distressing mental health concerns across the Taranaki region. The team is available 24 hours a day, 7 days a week. The team is made up of mental healthcare nurses, social workers and support workers spread across the region. The ABC team can be contacted for free by calling 0508 292 467 and following the voice prompts.

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 24/43. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email humanethics1@massey.ac.nz.

Appendix C: Consent Form

TE KUNENGA KI PŪREHUROA
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TE KURA PŪKENGA TANGATA
COLLEGE OF HUMANITIES AND SOCIAL SCIENCES

Written Consent Form

I have read and understood the Information Sheet attached. I have had the details explained to me and have had any questions about this study and my participation in it answered to my satisfaction. I understand that I am allowed to ask any further questions at any time during my participation. I understand that participation in this study requires the audio recording of my interview. I understand that I can decline to be audio recorded at which point my participation in this study will end. I understand that my participation in this study is completely voluntary and that I may withdraw my participation from this study at any time up until I have signed my transcript release form.

Declaration by Participant

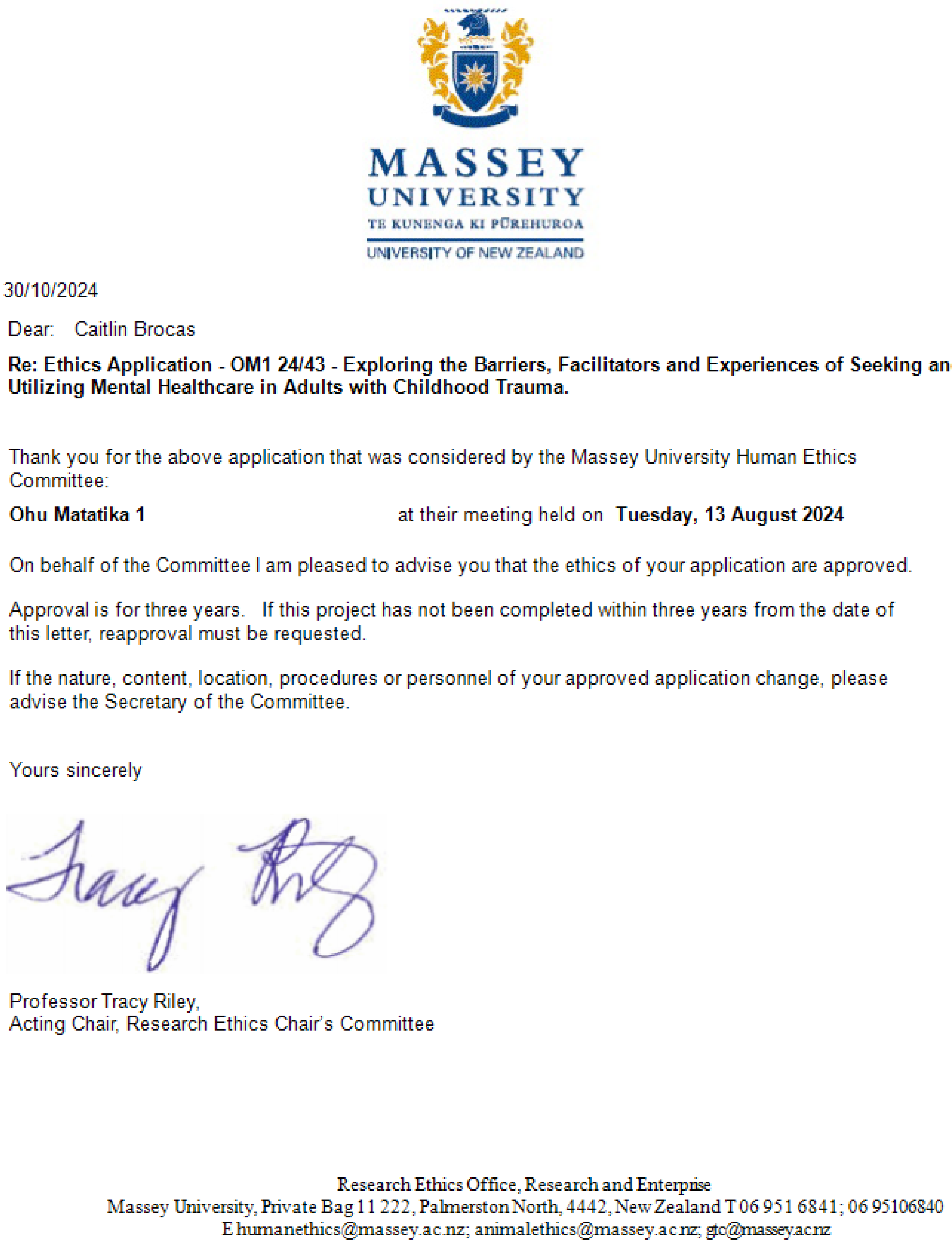
[Please Print Full name]

I ____ hereby consent to take part in this study.

I ____ hereby consent to being audio recorded.

Signature___________________________ Date______________________________

Appendix D: Ethics Application Approval Letter



MASSEY
UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

30/10/2024

Dear: Caitlin Brocas

Re: Ethics Application - OM1 24/43 - Exploring the Barriers, Facilitators and Experiences of Seeking and Utilizing Mental Healthcare in Adults with Childhood Trauma.

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

Ohu Matatika 1 at their meeting held on **Tuesday, 13 August 2024**

On behalf of the Committee I am pleased to advise you that 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, reapproval must be requested.

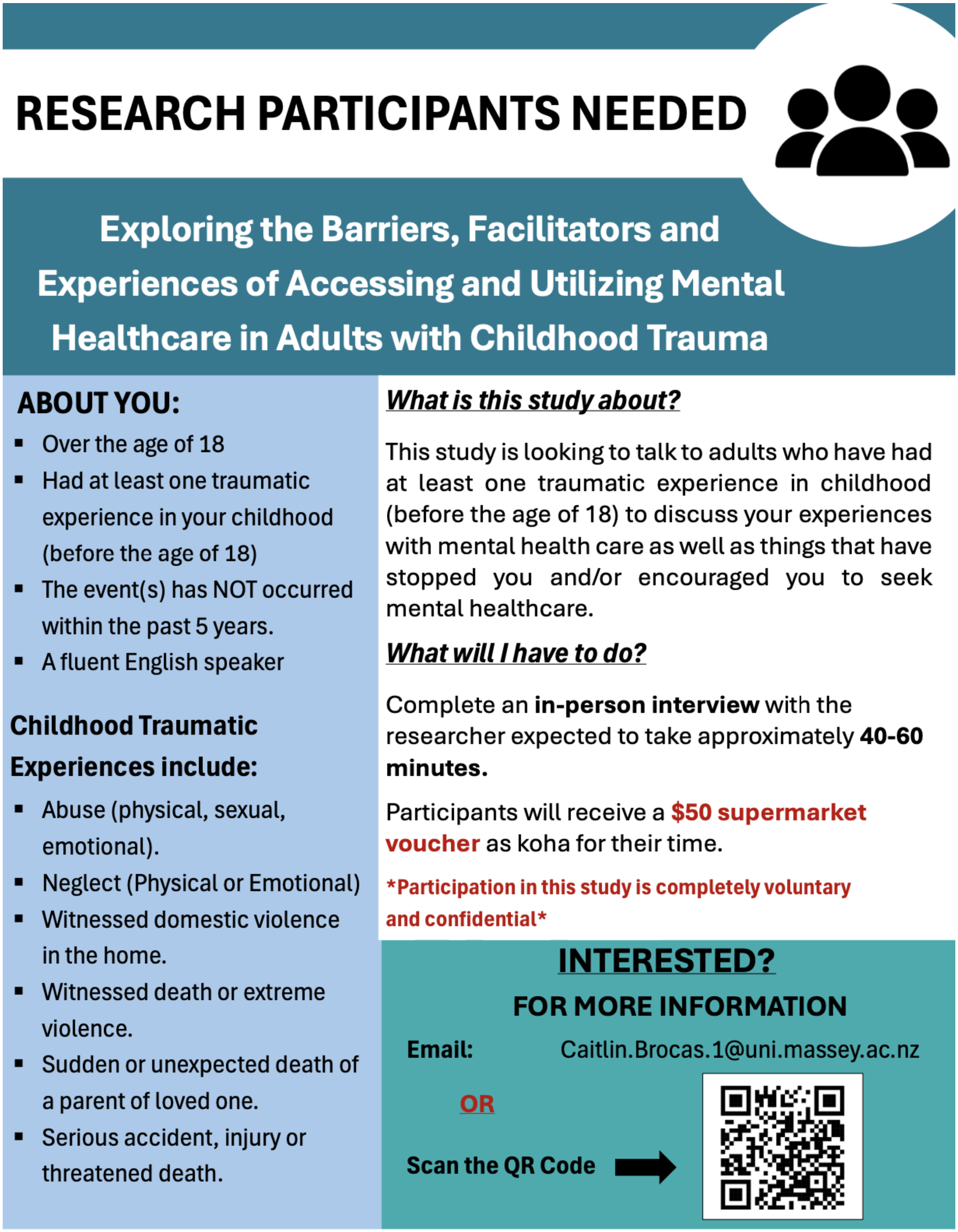
If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Tracy Riley,
Acting Chair, Research Ethics Chair's Committee

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 951 6841; 06 95106840
E humanethics@massey.ac.nz; animalethics@massey.ac.nz; gtc@massey.ac.nz

Appendix E: Advertisement



RESEARCH PARTICIPANTS NEEDED

Exploring the Barriers, Facilitators and Experiences of Accessing and Utilizing Mental Healthcare in Adults with Childhood Trauma

ABOUT YOU:

- Over the age of 18
- Had at least one traumatic experience in your childhood (before the age of 18)
- The event(s) has NOT occurred within the past 5 years.
- A fluent English speaker

Childhood Traumatic Experiences include:

- Abuse (physical, sexual, emotional).
- Neglect (Physical or Emotional)
- Witnessed domestic violence in the home.
- Witnessed death or extreme violence.
- Sudden or unexpected death of a parent of loved one.
- Serious accident, injury or threatened death.

What is this study about?

This study is looking to talk to adults who have had at least one traumatic experience in childhood (before the age of 18) to discuss your experiences with mental health care as well as things that have stopped you and/or encouraged you to seek mental healthcare.

What will I have to do?

Complete an **in-person interview** with the researcher expected to take approximately **40-60 minutes.**

Participants will receive a **$50 supermarket voucher** as koha for their time.

Participation in this study is completely voluntary and confidential

INTERESTED?

FOR MORE INFORMATION

Email: Caitlin.Brocas.1@uni.massey.ac.nz

OR

Scan the QR Code ➡

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 24/43. If you have any concerns about the conduct of this research, please contact the Chairperson, Massey University Human Ethics Ohu Matatika 1, email humanethics1@massey.ac.nz.