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Ko au te wahine Māori

**A phenomenological study of Maori women
diagnosed with a mental illness and their
experiences of pregnancy and childbirth**

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WHAKAPAPA

Ko Mamari toku waka
Ko Ruanui te tangata
Ko Oruphana toku maunga
Ko Herikino toku awa
Ko Whakamaharatanga toku marae
Ko Ngati Hine toku hapu
Ko Te Rarawa me Te Arawa oku iwi
Ko Putongaroa Pukeroa toku mama
Ko John Semmons toku papa
Ko Wendy Semmons toku ingoa
Ko Max raua Ko Harry oku tamaiti

ABSTRACT

To date there have been no specific studies undertaken about Maori women, diagnosed with a mental illness and their experiences of pregnancy and childbirth, and the services they accessed during this period. I look at the history of psychiatry and psychology and compare that with what it means for Maori to be well, and the differences in treatment approaches between the two. The research involved a review of the literature relative to the study. However, given the paucity of research written about this topic, a wide range of literature was used to form the backdrop to the study. Using a phenomenological approach following Colaizzi's method, seven Maori women diagnosed with a mental illness as described by the Diagnostic and Statistical Manual, fourth edition (DSM-IV) were interviewed and their narratives analysed.

The four criteria for inclusion in the study were that the women:

- I. identify as being Maori;
- II. have experienced pregnancy, and childbirth;
- III. had a diagnosis of mental illness, and considered stable enough to take part in the proposed study, as assessed by the Maternal Mental Health staff involved and;
- IV. there was no documented neurological illness, brain damage, or mental retardation,

Three major themes emerged which formed the basis for the analysis. Specifically, identity as a Maori, the treatment approaches participants encountered, and how and why tikanga Maori should be integrated into service delivery for Maori.

The results of the study indicate that the participants felt there was a lack of co-ordinated care between services, and that much needs to be done in order to provide appropriate health and mental health treatments for Maori. This includes further research and ongoing workforce development.

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This thesis is dedicated to the participants of this research study.

Ko au te wahine Maori – Here I am a Maori women.

GLOSSARY

haka	posture dance, war dance
hapu	pregnant, or subtribe
hinengaro	mental, emotional
iwi	tribe, people
kai	food
kaumatua	male elder
kaupapa	plan
koha	donation, gift, contribution
kuia	female elder
mana	power, prestige,
rangatira	respected, of high rank
rongo	herbal remedies, plants
tane	man
tangata whaiora	participant, patient
te ao Maori	maori society, maori world
tikanga	custom, rules
tino rangatiratanga	chieftainship, self-determination
tipuna	ancestor
tohunga	priest, expert
turangawaewae	a place to stand
wahine	woman
wairua	spirit
whakatauiki	proverb
whanau	family, to give birth
whakapapa	genealogy
whanaungatanga	extended family,
family oriented relationships	
whare	house, building
whenua	land, earth, afterbirth

CHAPTER ON INTRODUCTION

Locating the study

The focus for this study is Maori women and how they identify as Maori, and the stories of their experiences of pregnancy and childbirth, having been diagnosed with a mental illness. They have all had contact with obstetric health and mental health services, and subsequently have all been given a diagnosis of mental illness. This study looks in particular at the type of care they received from the various health services they accessed, and what they thought of them.

As a matter of course in New Zealand, the management of mental illness is accessed by way of Western assessment and treatment approaches. Typically, in circumstances where the illness is acute, this management will take place in a state funded and managed hospital environment (Sachdev, 1989) as part of the services provided by government funded District Health Boards (DHBs).

This research study explores the impact pregnancy and childbirth has had on Maori women diagnosed with a mental illness and the services and treatments they received from Mental and Obstetric Health Services of a typical New Zealand DHB. Whether, Western diagnoses and treatments and the provision of these interventions serves the well being of Maori women appropriately is discussed.

Why do it?

My initial interest in this research came about from the time that I spent at National Women's Hospital (1997-1999), where I was employed as a social work counsellor. As the only Maori employed in the social work department at that time, I had first hand knowledge of the services and treatment options available to Maori and Pakeha alike. In my opinion there was a paucity of resources based on principles of tikanga Maori. Throughout this time, I was also part of the Maternal Mental Health Team.

It was here, with the opportunity to support tangata whaiora (consumers), and their whanau that my interest in the provision of services more appropriate to Maori transpired.

Since 1999 I have been employed as a clinical social worker/key-worker for one of the District Health Boards, (DHB) Community Mental Health Centers. Concurrently, I am completing a Masters degree in Social Work, through Massey University. This undertaking has provided me the opportunity to investigate the provision of services to Maori women, in a way that will, give a clear and valid explanation about the needs of Maori mothers suffering from mental ill-health. By documenting the participants' experiences, illumination and a way forward for the provision of congruent, and appropriate mental health services and treatments for Maori will become clearer.

Ultimately, this study is being undertaken because I believe that not enough choice exists in the treatments offered to Maori in the name of 'good-health'. I am convinced that more can be done to understand what it means for Maori to be healthy. This essentially means taking an holistic (complete) view of the mental, physical and spiritual parts of a person, including the whanau, and how together they can support and sustain each other as described by Durie, through the model Te Whare Tapa Wha (Refer Appendix I).

Language

The language used in this thesis to describe participants diagnosed with a mental illness and their experiences of pregnancy and childbirth, inevitably uses 'medical jargon'. As much as possible this language has been diluted to allow the lay person ease of reading and understanding of what is being described. The thesis is also interspersed with Te reo Maori (Maori language). A glossary of Maori words has been provided to assist the reader in understanding what is being described.

Writing structure

This thesis provides an explanation of the diagnostic and treatment approach offered from a Western paradigm for the treatment of mental illness. It is also a narrative of the experiences of the participants of this study; who all identified as being Maori, and their experiences of the treatment and services they received, and how these impacted on their lives. An account of how Western treatment approaches differ from a Maori worldview of causes of mental illness is also given. Whether Western models of treatment are the most appropriate for Maori will be discussed.

CHAPTER OUTLINES

Chapter one – back ground

The background to this study is described in chapter one. It identifies how a typical District Health Board serves women accessing obstetric care, maternal mental health, and community mental health care. It also looks at the researcher's interest in this topic, and how the research came about. The language used is aimed at allowing the lay person to understand the environment and procedures of psychiatric and health services, first from a Western perspective and then from a Maori perspective. The writing structure describes the experiences of the participants of this study, who all identified as Maori and whether Western models of treatment are the most appropriate for Maori. A bicultural approach is discussed and the importance of tikanga Maori to Maori, in health settings. This chapter also discusses the history of public and maternity health services in Aotearoa including Lead Maternity Care (LMC).

Chapter two - Review of the literature

An historical exploration of psychiatry is presented in this chapter. There is also discussion about the perceived causes of mental illness and the various treatment approaches from a Western perspective, and how psychiatry shaped the classifications systems currently in use, including the power that it wields.

Chapter three – Te Ao Maori

Te Ao Maori or the Maori world and concepts of health and mental illness feature in this chapter. It also reflects the fact that nothing has been written specifically about Maori women diagnosed with a mental illness and their experiences of pregnancy and childbirth. I will argue that traditional Maori healing practices have all but disappeared from Maori society due to the impact of colonisation and assimilation.

Chapter four – Methodology

The methodology used in this study is qualitative. A phenomenological approach aims to provide an instrument that is best suited to the small participant numbers of this study. Phenomenology – A study of 'lived experience' began as a philosophical movement during the nineteenth century, which was known as the era of 'enlightenment'.

Chapter five – Research design

Chapter five describes the method used to recruit participants, and the procedure for data collection. Data is analyzed using Colaizzi's descriptive phenomenology, and includes seven steps for extracting and analysing the data.

Chapter six – Findings

This chapter looks at the findings of the interviews using thematic analysis. The three main themes that emerge from the interviews are Identity, treatment approach and tikanaga Maori. The gaps that exist for Maori women accessing health and mental health services in the community are also discussed.

Chapter seven – Discussion

The discussion chapter reflects the findings of the data collected in this study. It is an explanation of the participants' experiences of pregnancy and childbirth and the services they accessed. It also discusses what the participants thought of these services.

Chapter eight – Conclusion

The concluding chapter discusses the strengths and limitations of this research and recommendations including further research. It also includes how paradigms of Western treatment approaches and those of Te Ao Maori can be linked.

CHAPTER ONE: BACKGROUND

Identifying the gaps

This is a phenomenological study of seven Maori women diagnosed with a mental illness and their experiences of pregnancy and childbirth.

Research question:

“What does the experience of pregnancy and childbirth mean to Maori women with a diagnosis of mental illness?”

Aims:

1. how pregnancy and childbirth affected women diagnosed with a mental illness
2. whether current mental health and obstetric services were appropriate to their recovery, and
3. if not, what interventions would have been more appropriate to meet their needs.

Healthcare in Aotearoa/New Zealand

The premise of healthcare for all is a basic tenet of past and present New Zealand governments. According to Stern (cited in Durie, 2002), indigenous peoples like Maori (tangata whenua or first peoples of New Zealand), live their day to day lives on the perimeter between the indigenous world, and a set of norms assembled by the dictates of wider society or the dominant culture. In New Zealand that culture is descended from the mostly Anglo-Saxon Caucasians who settled here approximately two hundred years ago, and now comprise the majority of the population (Sachdev, 1989).

Consequently in New Zealand, a ‘bicultural’ approach (implying partnership) was promoted, as the concept that would best accommodate the needs of Maori and Pakeha (non-Maori). The struggle to find and implement this utopian state continues in the political and social arenas. The impact of government policies and the provision of appropriate health, educational, and social services for Maori have resulted in a mishmash of service delivery.

Unfortunately, Maori attempts at self determination through parallel institutions – for example a radio station – are viewed with suspicion as inimical to the 'we are one people' ideology, which is a cover for social and political domination. Maoris are expected to be served by the same institutions as Pakehas, but with the Pakeha in control (Walker, 1987, p.156).

Possibly because biculturalism has proffered more of a prickly path, than a smooth solution, perceptions of what New Zealand society should look like has resulted in a shift of attitude. Consequently, over the past few decades a push to cater for all races by way of a multicultural approach has been seen as the only way forward, due in large part to the increased arrival of ethnicities other than the dominant white culture.

The landscape has changed, dramatically. Nonetheless, what continues to delineate Maori from others is tikanga Maori. Something that although vague, in particular to urban Maori, is not foreign to them. For Maori, this link to tikanga is often the only avenue open to determining their identity. "In fact, the Maori have largely resisted assimilative pressures and have maintained their own identity" (Walker, 1987 p.156). All in all, we need to take the time to preserve the ethos, of a bicultural partnership, which includes the integration of tikanga Maori into mainstream processes, otherwise, progress in all aspects of this society will falter, and the socio-economic disparities that currently exist, will continue for many Maori (Durie, 2001a).

During the 19th century administration of public health in New Zealand was at "...best haphazard, and at worst non-existent" (New Zealand Year Book, 1990, p.221). Local authorities did the best they could, without any support or direction from the government. In 1900 the Public Health Act allowed for the establishment of the Department of Public Health, and was staffed by specially trained medical officers, who wielded far-reaching powers. This mandate occurred only after the threat of bubonic plague spreading throughout the country was eminent. From there New Zealand was divided into health districts, and healthcare was largely centralised. This was in order to control infectious diseases that were

prevalent and directly attributable to the appalling sanitation and health risks that existed. Eventually, hospital boards took over from local authorities and government officers were responsible for inspecting all hospitals (New Zealand Year Book, 1990).

Public Health; and Maternity Health Service Planning in New Zealand

Public maternity hospitals were only established in the early 1900's. Prior to this a network of small, local private hospitals had provided maternity care. Change came about with the Midwives Registration Act of 1904. Soon after, public maternity hospitals were set up to train midwives and also to provide a service to women who could not afford private care. In 1905 the first maternity hospital was opened in Wellington; over the next two years hospitals in Auckland, Christchurch and Dunedin were established. They were all called St Helen's Hospital, named for the town in Lancashire where Premier, Seddon was born (New Zealand Year Book, 1990).

Currently, maternal health services offer some choice in terms of ante-natal, birthing, and post-natal care based on Western treatment approaches. Maternity services in New Zealand have evolved spectacularly over time, due in large part to the change in societal attitudes and technological advances. The birthing regimes of the 30's and 40's were regimented, clinical procedures, and women laboured alone. Despite the inference that maternity services would provide women with support this support looks rather different today than it did then (Smythe, 1998).

In Aotearoa/New Zealand there are a number of options available to women regarding antenatal, delivery and postnatal care. The Ministry of Health (MoH) affected a notice on July 2002, pursuant to section 88 of the New Zealand Health & Disability Act 2002. The notice specifies what an authorised practitioner must provide in order to be entitled to claim payment under the notice. Its vision reads as follows.

Each woman, and her whanau and family will have every opportunity to have a fulfilling outcome to her pregnancy and childbirth, through the provision of services that are safe and based on partnership, information and choice. Pregnancy and childbirth are a normal life-stage for most women, with appropriate additional care available to those women who require it. A lead Maternity Carer chosen by the woman with responsibility for assessment of her needs, planning her care with her and the care of her baby being responsible for ensuring provision of Maternity services, is the cornerstone of maternity care in New Zealand Health (Ministry of Health, 2002, p.11).

An authorised practitioner encompasses a raft of disciplines including anaesthetist, general practitioner (GP), midwife, obstetrician, paediatrician and radiologist. They need to have completed the Ministry of Health's (MoH) application form for authorisation of practitioner, and to have received authorisation from the MoH, to provide maternity services. An authorised practitioner can offer their services in an individual capacity, or be employed by, or affiliated to an organisation (Ministry of Health, 2002).

Usually a woman will go to her GP to have her pregnancy confirmed. However, the management of maternity care – provided by the Lead Maternity Carer (LMC) is not restricted to GP's. Midwives increasingly are managing the care of pregnant women. In 1990 the Nurses Amendment Act gave midwives the legal right to work as independent practitioners, regardless of setting or philosophy of practice (Calvert, 1998). This allows midwives to develop their own caseload and to provide care on a one-to-one basis. Importantly, maternity care in New Zealand is free to New Zealand citizens, women with permanent residency, and those who have a permit that allows them to stay two or more years in New Zealand.

CHAPTER TWO: REVIEW OF THE LITERATURE

Due to the fact that nothing has been written about Maori women diagnosed with a mental illness, and their experiences of pregnancy and childhood, the literature review reflects past and contemporary approaches of the care of women who experience the journey that is

pregnancy and childbirth, and all that brings, as well as the added experience that is labeled 'mental illness'.

Paradigms of Mental Illness

Paradigms of mental illness are as many and varied as there are causes of mental illness and subsequent treatment approaches. This chapter will endeavor to cast some light on some of these approaches. In particular, that of Western culture. Subsequent chapters will highlight a Te Ao Maori viewpoint (the Maori world). Differences and similarities will be evident.

Psychiatry and the power of diagnosis

Power comes in a variety of forms, often disguised. The assumption that psychiatry is a specialist area of wisdom immediately implies that it conveys some expert knowledge; and knowledge signifies power (Barker, 2000). Difficulties arise however, when trying to interpret and evaluate present-day theories and practices in mental health with reference to the past (Coppock, 2000). Various authorities and multiple 'histories' – of psychiatry have rendered the notion of a unified history of mental health theory and practice a vagary. Nevertheless, individual social attitudes endure in a particular culture, and an even wider divergence of attitudes exists between cultures (Sainsbury, 1976). This is true of the term mental illness.

Through the ages, causes of mental illness and those afflicted have been perceived in various ways - from possession by demons through to enlightened beings, vilified or venerated depending on the belief systems of the culture and times. One of the most illustrious writers of mental illness was Michel Foucault, whose pioneering work *Madness and Civilisation* (Foucault, 1965), laid the foundations for a critical appraisal of psychiatric history. His descriptive re-creation of mental illness derived from original documents portrays madness, folly and unreason in the context of time, place and social perspective - for example he believed there was a correlation between attitudes to insanity and the disappearance between the 1200s and 1400s of leprosy. The role lepers

had in society was that of abandoned non-human, creatures who represented disease and death and invoked rites of purification and exclusion. Thus their demise, Foucault supposed, left a gap that would be filled by felons and the deranged.

One of the earliest recorded histories of classification of mental disorders comes from Hippocratic School, who arrived at a system of classification (460-377BC) after observing patients and their symptoms. By grouping similar symptoms together, Hippocrates and his students arrived at a form of classification that can be called a descriptive system, comparable to today's current nosology (classification systems); that of the International Classification of Diseases (ICD), and the Diagnostic and Statistical Manual of Mental Disorders (DSM). Hippocrates divided these groupings into six types of mental disorders.

1. Phrenitis (acute mental disturbance and confusion)
2. Mania (acute mental disturbance without fever)
3. Melancholia (all chronic mental disturbance)
4. Epilepsy (which has survived unchanged)
5. Hysteria (paroxysmic dyspnoea, pain and convulsions)
6. Scythian disease (transvestism).

(Mack, Forman, Brown & Frances, 1994. p.98).

Contemporary classification of mental illness could be said to be underpinned by the concept of positivism, an approach which had its beginnings in eighteenth century France. Positivism is a scientific formula where certain implicit and explicit beliefs are held. Sydenham describes it as a "...classification system based upon the hypothesis that diseases are distinct and produce discrete and classifiable pathology and symptoms" (Sydenham, 1979, p.56). Positivism is historically associated with the nineteenth century French philosopher, Auguste Comte. Comte's theory the law of three stages is about theological, metaphysical and the positive stage. The first two stages try to define human behaviour as obscure, ethereal or intangible manifestations. "The final positive stage dispenses with theological and metaphysical concepts and turns to observation and reason as means of understanding behaviour" (Cohen,

1989, p.10). The positivist view is objectivist and demands a solid, more tangible approach to research methodology. Subsequently, scientific evidence differs greatly from that which is acceptable to the lay person. The scientist on the one hand operates so that whatever theories he formulates have to be tested empirically so that his explanations have a firm foundation in fact (Cohen, 1989), whereas, the lay person is quite selective in choosing evidence that coincides with his/her hunches and ignoring that which is counter to them. This method of seeking truth is referred to as experiential as it is based on experience in one form or another.

It has been argued that categorising mental illness imposes a 'treatment barrier' thus, removing responsibility for certain situations from a person, in turn facilitating a procedure of converting political and social difficulties into those now requiring medical treatment (Bowers, 1998). Consequently, issues could be ignored. Thomas Szasz was most vociferous about the term 'mental illness' and charges that it could conceal difficult moral and social problems (Szasz, 1977). Nonetheless, categorisation of mental illnesses or psychiatric disorders exists in a Western diagnostic form, and is defined by two main texts; the International Classification of Diseases (ICD), and the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Reference in this paper will be made to the latter and specifically to the 4th edition (American Psychiatric Association, 1994). "New Zealand clinicians typically use DSM-IV criteria for symptom classification..." (Read, Agar, Argyle, & Alderhold, 2003, p.22).

The DSM IV has a specific medical model approach to diagnosis and the treatment of mental disorders. This is reflected in the current nosology that emphasises the incomparable role played by systemically collected, replicable empirical data. Like other sectors of medicine, psychiatric classification is perpetually evolving as a mixture of etiologic theory and

symptomatic description, with the comparative contribution of each shifting as knowledge has accumulated (Kupfer, 2002).

The DSM-IV defines a mental disorder as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability or an Important loss of freedom. (American Psychiatric Association, 1994, p.262).

Diagnosis is pivotal to the practice of psychiatry and has the ability to continually impact on people's lives. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental disorders, maintains that this does not categorise people, just the mental disorders that they may have. This claim has created the impression that naturally occurring mental disorders abound, and that the diagnostician's function is simply to recognise and record their occurrence. Clinical psychologist Mary Boyle notes that although there is acknowledgement that individual clinicians differ in their diagnostic proficiency, and that 'misdiagnosis' occurs, there is no recognition of the fact that diagnosis is a systematic practice of power Boyle, 1996 (cited in Barker & Stevenson, 2000). Foucault's description of the term 'bio-power' describes the notion of power over minds and bodies. Furthermore, Sawicki (1991) observed that bio-power emerges as a seemingly magnanimous, but oddly invasive and effective form of social control. Foucault describes two forms of bio-power. The first is related to politics of the population, such as social and economic laws and policies affecting reproduction, birth, marriage, health and death. The second form of power relates to disciplinary power, and is significant in the practice of psychiatric diagnosis

This disciplinary power can be observed in three major areas. Initially, it can be observed through language, and its links to social practice. Language in this framework does not reflect reality; it constructs it. Language elucidates for us, insisting that we see people and the world in certain ways, successfully dismissing and banishing alternative

paradigms. The second way in which disciplinary power controls is through the construction of certain identities that are categories or types of people. The rate at which these identities have evolved is unsettling. Since its inception in 1952, the DSM has gone from 106 listed diagnostic categories in DSM-I; DSM-II had 182; DSM-III had 205; DSM-III-R had 292, and DSM-IV has 390 (Sarbin, 1996).

The final approach of disciplinary power in this framework is through the creation of advantaged ways of talking and writing about particular phenomena. The privileged languages of science and medicine create a powerful impression of both care and concern and present an impression of impartiality and neutrality, which effectively deflects any criticism or disagreement. This sets the scene for an imbalance of power between the mental-health professional as the expert diagnostician, and the recipient of the applied diagnosis, a power difference that is difficult to challenge. The power of diagnosis therefore would appear to have two main functions. First in the form of disciplinary power, by creating types of people who it would seem exemplify 'natural' categories of mental disorder; and by defining social norms of behaviour and experience. By telling us how to define people (or at least the personalities they present) according to considered 'norms' any deviation from this makes certain forms of management appear desirable and appropriate (Boyle, 1996).

The paradigmatic exercise of psychiatric coercion is the imposition of an ostensibly diagnostic or therapeutic intervention on subjects against their will, legitimized by the state as protection of the subjects from madness and protection of the public from the mad (Szasz, 1977, p.76).

The problem with assigning a person a diagnosis is that the person is a person no longer but a label. Schizophrenia for instance is purportedly rooted in the family or biology. But according to Ron Coleman (a consumer activist), schizophrenia or any other mental illness 'label' is rooted in society. He maintains that society needs people like Adolph Hitler to be mad; so too, Idi Amin, or any number of historical or

contemporary despots. Why? Because if we say they're not mad, then we all have the potential to be exactly the same. Society he asserts needs madness, the construct of psychiatric authority lies in society's need (Coleman, 2000). He emphasises his point by quoting the poet Nathaniel Lee.

"They said I was mad.
I said they were mad.
Bastards. They outnumbered me"
(Coleman, 2000, p.60)

Psychiatry and scientific evidence

So what is it that psychiatry has to offer the mentally ill that has given it such impetus? Moreover, is there any logical reason not to accept psychiatry as a solution to treating mental illness? According to the previous authors there are a number of reasons. However, as with any topic that engenders such intense debate as mental illness does, an exploration of both sides of the argument is necessary.

Psychiatrists and psychologists, to make sense of a person's presenting symptoms and complaints, regularly use diagnosis and classification. Classification is used broadly in all sciences. The purpose of classification is to communicate the meaning of a given construct; this is done in order to avoid the need to repeat a detailed description of an object that is referred to. For instance, there is no need to describe in great detail (to most people) what an apple is. Generally a person would know without seeing an apple what its shape, texture, colour, taste and smell is likely to be. Classification in psychiatry attempts to determine some sort of order and meaning, using (debatably) objective observation on the diasporas of psychiatric symptomatology. The symptoms of a mental illness are considered through the mirror of a person's personality, experience and perception (Mack, Forman, Brown & Frances, 1994).

A view that has remained central to DSM-IV and ICD-10 is that held by Krapelin, 1986 (cited in Barker, 2000) who theorised those patients whose symptoms advanced along the same course, invariably had the

same disease. Kraepelin's textbook on psychiatry, drawn from earlier works of Sydenham and Charcot's descriptive methods, described disorders based upon descriptions of symptoms, and produced the foundation of modern psychiatric classification.

His views were not however, universally accepted, and other researchers argued for an aetiological system. In trying to address the need for statistical and epidemiological information, the American Medico-Psychological Association and the National Committee for Mental Hygiene developed a list of twenty-two psychiatric diseases that was to be used across US institutions. Throughout the 1920s and 1930s this classification evolved into 'The Standard Classification'. This standard was nevertheless surpassed by the US military classifications that had developed during the Second World War and included the post traumatic stress disorders. Subsequently, the American Psychiatric Association (APA) reviewed existing classifications and published in 1952, DSM-I. This had the result of elevating the importance of diagnosis to the status of being fundamental to psychiatric medicine. The APA committee has gone on to produce a diagnostic system that takes account of descriptions of symptoms which are atheoretical in nature in order to aid research and to augment communication across disciplines with different philosophical bases (Mack, Forman, Brown & Frances, 1994). Based upon the empirical findings, symptoms were consigned to diagnostic categories in the form of descriptive operational criteria. These criteria were open to further research and validity and reliability testing. Because of this, the trend has required classification to be necessarily revised up to and including today's present DSM-IV-TR. This history of classification (referred to as realism) does nothing to convince those like Szasz and Boyle who hold what is known as a nominalist view, to change their standpoint.

Nominalism versus Realism

Importantly, the nominalist position maintains that nothing, in particular psychiatric disorder exists, except as it is generated in the minds of

people (Frances, Mack, First, Widiger, Ross, Forman, 1994). This can be interpreted as meaning that psychiatric diagnoses are social constructions concocted to serve political, social and professional interests. Furthermore, such 'disorders' are constructs derived by flawed scientific method and are not based upon actual phenomena. On the other hand the realist point of view is reductionism. Realists argue that the classification, for example, of schizophrenia has a biological substrate, in much the same way that the signs and symptoms of something like measles represents an underlying viral infection. This realist view is dependent on finding a causal pathology to the symptomology described in the classification. The nominalist argues that in psychiatry the observable phenomena are fitted into constructs, which have been previously determined, and therefore lack reliability and validity. It is clear that there is no middle ground between the nominalist and the realist and the point could be wrangled interminably.

The APA argues for a middle way, but admits that these issues remain unresolved (Frances, et al, 1994). However, it maintains that DSM-IV is a heuristic and pragmatic classification system that attempts to form a middle ground between realism and nominalism. Moreover, arguing that the clinical and research value of heuristic diagnostic concepts in predicting course, family history, treatment response and future health trends provides a legitimate structure, as long as the results are used to continually test validity and usefulness of diagnosis.

Cultural difference

If Western concepts of mental illness remain at loggerheads, how then can psychiatry accommodate cultures other than those descended from a Eurocentric paradigm? Historically there is a racist component attached to psychiatry. Social Darwinism placed different races at varying positions on the evolution ladder, so it is unsurprising that the culture of psychiatry and psychology included a racist ideology. These disciplines were developed at a time when the persuasive myths of racism were being cultivated and integrated into European culture. Suman, (cited in, Barker

& Stevenson, 2000) suggests that by placing matters to do with white people in a position superior to those people of a black, brown, red or yellow hue, the promotion of 'scientific racism' as established knowledge maintained its position. Although the language has changed, the ideology of racism remains the same.

British racism in the late 20th Century often operated without any explicit reference to 'race' itself or the biological perceptions of difference. It still infers however its common-sense meaning by the use of the word culture. "Culture, as an immutable fixed property of social groups, has become confounded with 'race', and racism is articulated in cultural terms" Suman, (cited in Barker & Stevenson 2000, 21, p.84). An example of this is evident in the area of healing. Western medicine has been imposed and venerated (and psychiatry is part of that), while indigenous healing systems were suppressed, (and if necessary, mandated by law) and always underdeveloped. By demonising native healers as 'black magicians', or 'witch doctors' a host of stereotypes, myths and fictitious stories were and are structured and embedded in what we assume to be knowledge. This allows for the continuation of racism in psychiatry and psychology to centre on dangerousness, submissiveness, and lack of intelligence thus perpetuating under-development and demonization. Suman (cited in, Barker & Stevenson, 2000).

In New Zealand this was evidenced by the legal barriers that were imposed on Maori. This included land confiscation, the prohibition of the Maori language in schools, and the restriction of Maori adoption practices, which had previously always been based on the collective responsibility of the whanau, hapu and iwi, to care for children. However, the most callous impediment to Maori knowledge and traditions was the passing of the statute known as the Tohunga Suppression Act in 1907. This effectively outlawed the role of traditional healers, and halted their practices including their knowledge of healing, the arts, and environment. In particular, the Act sought the dissolution of the spiritual links that tikanga Maori is based on (Durie, 2001a). However, what the Pakeha

underestimated was the ability of Maori to retain a strong sense of whanaungatanga (family ties) and this mainstay has been the impetus for the renaissance that occurred in the 1960s and 1970s and subsequent advance of Maori culture. The repeal of the Tohunga Suppression Act in 1964 was instrumental in forging a pathway back to traditional practices for Maori (Durie, 2001a)

...attitudes towards one's ethnicity are central to the psychological functioning of those who live in societies where their group and culture are at best poorly represented (politically, economically and in the media) and are at worst discriminated against, even attacked verbally and physically; the concept of ethnic identity provides a way of understanding the need to assert oneself in the face of threats to one's identity (Phinney, 1990, p.499).

Cultural unawareness is feasibly responsible for misapplication of diagnostic criteria. Where the medical workforce is predominantly Western, it is conceivable that interpretation of clients' verbal and body language will be based on their own values and beliefs. The DSM-IV allows for cultural bias by describing cultural divergence in relation to clinical presentations. Nonetheless, schizophrenia in particular has been over-diagnosed, especially with patients who meet the criteria for an affective disorder with psychotic features. This is evident in data collected on Hispanics and African Americans in the United States of America. African-Americans with bipolar disorder or psychotic depression are often misdiagnosed as having schizophrenia (Herrera, Lawson & Sramek, 1999). In New Zealand similarities exist, evidenced by the high committal rates which emerge to suggest that health professionals are apprehensive about less rigid forms of treatment for Maori, and have a propensity to commit disturbed Maori, more often than any other groups, of disturbed patients (Durie, 2001a). Trying to accommodate Western classifications of mental and behavioural states of indigenous cultures can lead to misdiagnosis. However, incorporating the influences of culture bound syndromes can provide a much more accurate diagnosis and subsequently a more appropriate treatment approach; although culture bound syndromes as such are not readily recognised by Maori (Durie, 2001a).

What is interpreted as pathological behaviour in one culture can be deemed normal and even appropriate in another. For example, by using a judgmental standard - that of society and psychiatry - pathology can be classified within the 'criterion of result'. This rests on the premise that a person strives to attain a certain goal by behaving in an organised manner. When this behaviour becomes dysfunctional or disorganised, when it prevents someone from reaching their goal, disrupts the group, causes self-harm or harm to others, this behaviour and the mental condition associated with it, is labelled pathological. The opposite of this state is referred to as 'normal' (Wittkower, 1970).

Culture-free certainties are rare in psychiatry. Organic brain syndromes, such as psychotic delirium and psychotic hallucinations are pathological by definition. There was once collective agreement defining disorders trans-culturally from a biological viewpoint, thus reflecting the medical model of the profession (Rinder, 1964). Furthermore, this belief has brought about a climate in which the major form of treatment (and often, the only one offered) has been medication (British Psychological Society, 2000). However, this pattern is changing. There is a trend toward focusing on social issues and the examination of psychological causes (shaped by psychology) of a person's distress, which is now seen as truly relevant (British Psychological Society, 2000). However, whether either school of thought seriously considers the impact of a person's culture a valid variable in terms of appropriate management, is doubtful (Durie, 2001a).

Traditional practitioners often go into the healing vocation by way of a culture-specific calling experience. This may also include entry as a consequence of inheritance, disposition or aptitude (Sartorius, DeGirolamo, Andrews, German, Eisenberg, 1986). In traditional medicine (as opposed to Western scientific medicine), practitioners share, or at least have some familiarity with the cultural value system of their clientele. They generally integrate the physical, psychological, social, and spiritual aspects of healing. Traditional procedures also tend to be relational,

involving the interface of several people, and can include the afflicted person, healing practitioner, family, community members and ancestral spirits, thereby anchoring the person within the community of people from whom he or she may have become alienated (Sartorius, et al; 1986). Western medicine and psychiatry rely on the processes of diagnosis and classification of physical and mental disorders, thus reflecting the cultural and historical influences of Western culture. However, when trying to separate cultural contents and processes from pathology, the task becomes formidable, although not insurmountable. By being sensitive to cultural variables, and attempting some understanding of alternative paradigms, and the invaluable contributions they can make, a way forward is possible.

Spirituality

Spirituality has been described as the 'essence' of all human experience. It is however, a word that evokes skepticism and suspicion, principally for those aligned to a more academically or scientifically weighted environment. During the latter part of the 19th century the scientific progress that modernised and intellectualised thinking, saw the dissolution of our spiritual core (Schermer, 2003). Spirituality is often equated with para-normal phenomena, and spiritual-ism, and generally regarded as 'erroneous'. Moreover, the general perception of the scientific community is that a belief in God and metaphysical speculation has no place in a scientific approach. These logical positivists also argue that psychology should be distinct from religious beliefs, and offer the democratic principle that contends that anyone, irrespective of his/her faith or lack thereof, should have equal access to assessment and treatment, free of religious and cultural influences (Schermer, 2003).

A combined psychological and spiritual perspective is offered in the works of Carl Jung, William James, Martin Buber, Viktor Frankly and Erich Fromm. Jung in particular emphasised the spiritual aspect of the self, the mystical and archetypal within the psyche. This difference of opinion, and subsequent delay in incorporating spirituality into mainstream psychology

grew out of the rift between Freud and Jung (Schermer, 2003). In the early days of psychoanalysis, Freud held that biological instincts, such as sex drive, were the touchstone of the psyche. Whereas Jung held that the root of the psyche emanated from the collective historical experience of the human race. This included gods and goddesses as well as other spiritual entities. Another view exists and it is that; "In my view, the fundamental spiritual element of psychology is not the archetypal realm as such, but life as it is lived, the actual individual journey from birth to death" (Schermer, 2003, p.83). Nonetheless, to ignore spiritual concerns of patients/consumers is a serious omission.

For many Maori, spirituality is fundamental and entwined in their day to day living experiences, although this is less so for those Maori not raised in a tikanga Maori environment. Maori apparently were unaware that they had a system of faith and religion until they had it pointed out to them by the Pakeha, it being so much an integral part of their daily lives; the need to "label it" in a similar fashion was not relevant. When they were made aware of it, it was to learn that it was flawed, evil and based on superstition (Andersen, 2003). Consequently, few Maori Institutions have survived colonial conversion unadulterated. Maori religion in particular remains to some extent a mystery to contemporary New Zealanders, including many of Maori descent. The reason for this is partly because of the secrecy that often surrounded it, but primarily because of its vilification and vigorous destruction by Christian missionaries (Andersen, 2003).

Assessment approaches

The emergence of cultural psychiatry in recent years has coincided with the growing recognition of the powerful influence of culture upon psychopathology (Tseng & Streltzer, 1997). However, the influence of culture in clinical environments is still insufficiently understood, despite the fact that it affects the day to day practice of mental health professionals.

In order to understand a 'patient' sufficiently enough to formulate a treatment approach, one must seriously consider the process of assessment. Mental health professionals regularly come across cases with an 'unusual' presentation that are unlike anything that text book or standard classification systems offer, invariably making assessment challenging. In order to make sense of 'cultural' influences on psychiatry and psychology clarification of the term 'culture' needs to be examined. Academics of behavioural science define culture in various ways. According to anthropologists (Kroeber & Kluckhohn 1952) culture comprises explicit and implicit patterns of behaviour acquired and communicated by symbols. Culture constitutes the characteristic achievements of human groups, including their embodiment in artefacts; the intrinsic essence of culture consists of traditional ideas and in particular, the values inherent in those cultural systems. Another anthropologist Keesing;

“...emphasised that culture exists at two levels. The first is the realm of observable phenomena-the patterns of life within a community; and the second is the realm of ideas-the organized system of knowledge and beliefs that allows a group to structure its experiences and choose among alternatives”
(Keesing, 1976 p.53).

More recent impressions of culture include the effects of “enculturation” on the mind-brain, as described by Castillo (1995). As a consequence of enculturation, every individual learns value systems that specify the operation of forces of nature in the world, such as a language, or a religion, as well as norms of behaviour and examples of experiencing the environment. These experiences are all programmed in the mid-brain by neural networks. These synaptic connections between individual neurons are strengthened by use (Thompson, Donegan & Lavond, 1988). By the habitual act of thinking in a specific language, or trusting in the forms of a certain religion, those forms of thought assume a kind of physical reality in the organisation of neural networks in the brain. These result in individuals accepting the social-cultural environment in a way that impacts in a physical structuring of the brain. This in turn will determine aspects of cognitive processing by individuals in the form of cognitive schemas

(Sperry, 1987). These cognitive schemas configure experience of the world, and thus influence the growth of psychopathology.

Race and ethnicity are terms commonly used to indicate culture. Use of the term race denotes a group of people with certain characteristics, such as similar physical features including skin colour, eye shape, hair and size. These characteristics distinguish them from other groups. Geographic race describes a human population that has inhabited a land mass or island chain, sufficiently long enough to have evolved its own unique genetic composition, when compared to other geographic populations (Hoebel, 1972). Thus race refers to a biological group that may or may not match a culture system shared by the group. The term ethnicity refers to social groups that differentiate themselves from other groups by a shared historical pathway, behaviour norms, and their own group identity.

As culture is such an abstract term, and fairly difficult to identify and distinguish, reference is routinely made to ethnicity or country. On the basis of this one might assume that Maori indigenous culture refers to the culture system that is shared by the Maori people of New Zealand. However, because of colonisation, the majority of Maori also identify with the Pakeha, mostly English, culture of the colonisers. Furthermore, prudence is necessary with such use, as the unit of culture does not necessarily equate with the unit of ethnicity or country (Tseng & Streltzer, 1997). Thus all Maori people do not necessarily share Maori culture, due in large part to the dominance of the monoculture. Furthermore, Pakeha culture has never really embraced Maori culture and has at times made attempts to extinguish both the culture and the language of the Maori people (Walker, 1987). Notwithstanding, Maori culture continues to delineate the lives of Maori and Pakeha to varying degrees, and in a variety of ways. Consequently, it is important to be aware of the different ways of grasping culture from an environmental, as well as a behavioural standpoint.

Another factor that needs consideration during the assessment process can be described using the terms *etic* (universal) and *emic* (specific). When applied to clinical assessment, an *etic* evaluation is one performed by a clinician who is external to the cultural system of the person being assessed. In this case the likelihood of misinterpretation or loss of meaningful interpretation of observed phenomena is possible (Draguns, 1989). However, one advantage might be that the *etic* assessor has a more objective view. Conversely, an *emic* assessment is one carried out by a clinician of the same cultural group as the client. The advantage of this approach is that valuable interpretation with cultural insight is more likely. On the other hand the chances are that it may be biased by subjectivity. Therefore, it is essential that the clinician be aware of his or her position regarding either an *etic* or *emic* appreciation when assessing and interpreting client's presentations and acknowledge the advantages and drawbacks of this.

Stigmatisation and ethnicity

Stigmatisation is an overwhelming cultural element in the social landscape generally, and also exists in health care. Stigmatisation of individuals, groups or certain conditions effectively halts any attempt at an objective assessment of such subjects. It leads to isolation and to the continual reinforcement of public neglect and social inflexibility toward the stigmatised (Penn & Martin 1998). Mental illness is one of the most stigmatised human conditions in modern life. Stigma can create a stereotyped approach to the assessment process, or worse contribute to prejudiced, uncritically accepted descriptions and explanations of behaviours. The stigma-stereotype dyad can have the effect of overestimating or underestimating a range of conditions. For ethnic minorities, stigma increases twofold by being connected to both mental illness and ethnic prejudices. Research findings that describe prejudice against people diagnosed with mental illnesses are markedly consistent over time and place. At the core of stereotypes of the mentally ill, is the perception of dangerousness and unpredictability (Green, 1987). This perception endures, despite evidence that the link between being a

psychiatric patient and being violent to others is grossly exaggerated (Mullen, 1997). While there is a basis for mental health professionals to hold the media responsible to a degree for perpetuating prejudice, the fundamental cause may be closer to home. It would appear that health professionals have more negative attitudes than those of the public when it comes to the 'mentally ill' and prefer not to work with the more severely psychotic.

In a survey of mental health users and their families there was an innate belief that they experience more stigma and discrimination from mental health professionals than from any other quarter of society (Walter, 1998). Efforts to reduce this prejudice and discrimination are often driven by ideology rather than relevant research. As a result of this conceptual flaw these efforts may be ineffective and even be perpetuating, if not worsening, the problem. The approach has been to 'educate' the public to accept the dominant biological paradigm (driven by drug companies) to improve the current perceptions of mental illness. Destigmatisation programmes have sought to align mental illness with medical conditions, in the hope of 'normalising' it. However, it would seem that after decades of trying to 'recondition' mind-sets, negative attitudes prevail, with no perceptual improvement being shown over time (Green, 1987, Huxley, 1993). Psychiatrists who are members of ethnic minorities are often the catalysts in efforts to address the issues of racism and stigmatisation (Bhugra & Bahl, 1999). In Britain black psychiatrists reached the following conclusions:

The evidence points to the conclusion that racism does lead to mental illness; firstly, by fermenting and maintaining social deprivation and so impairing chances of attaining mental health... Even if the medical model carries with it a kernel of truth, it cannot be generalised to all cases of mental illness most of which are entirely the result of the social environment that we live in. (Burke, 1986, p.177-8)

Therefore, greater credence must be given to understanding social and cultural dynamics, particularly, how they relate to power relationships

within society and how these give rise to psychological pathology. Psychiatry must take responsibility, and cast aside some of its outdated assumptions. Otherwise it will continue as a perpetrator of social abuse rather than an instrument of care and rehabilitation. Continued exclusion by the society in which they live, is too high a price to pay for those accessing mental health services. This issue needs to be appropriately addressed (Hutchinson, 1999).

Gender considerations in psychiatry

Because the concept of what constitutes madness in cultures continues to fluctuate, theorising how 'mental illness' impacts and oppresses other divisions of social society is now more widely discussed. The different experiences of women accessing health services is demanding these systems (including mental health systems) and the professionals in it, become more sensitive to the dynamics of discrimination and oppression, and better meet the needs of women living with mental distress. Over the past thirty years feminist writers from a diverse range of backgrounds in the vein of; Chesler, Ehrenreich, English, Miles, Orbach, Penfold, Walker, Russell, Showalter and Usher, (cited in Coppock & Hopton, 2000) have been among the instigators in opening up the milieu of "gender and madness" to wider discussion. One consistent theme with these writers is the over-representation of women as patients in the mental health system. It would seem that the simple act of departing from the expected roles of women in a patriarchal society suggests that madness is not an illness but a 'label' appended to women who step outside the parameters of feminine behaviour. Asylums and insanity at times function as mirror images of women's experiences; this was the punishment for being female, as well as for wanting to- or daring not to- be. (Chesler, 1972). To support this declaration Chesler cites the important study by Broverman, Broverman, Clarkson, Rosenkrantz & Vogel (1970) which explained clinicians' perceptions of mental health. The study documented the operation of gender-based stereotypes in perceptions in mental health and illness, as well as the assessment of what constitutes a mentally healthy adult (sex not specified) and how this correlates most directly with

the familiar masculine stereotype. Psychological ill health was more often associated with the feminine stereotype. This would suggest that the continuation of social constructs of women as essentially mad are considered to be one more manifestation of the way in which women are controlled within patriarchy. This perpetuates the labelling process that functions by maintaining women's position as outsiders, dismissing women's anger as illness; and relegating women's unhappiness as due to some internal flaw (Coppock, 2000).

Definitions of 'mental illness' may themselves be influenced by sex-role expectations, with women being seen as 'mad' if they either display too much traditional 'feminine' behaviour, or conversely deviate too far from traditional 'feminine' norms. (Johnstone, 2000, cited in Read, Mosher & Bentall, 2004).

Gender is the term used to refer to the psychological characteristic of living as a man or a woman. It is a substitute term for a composite of biological, behavioural, and psychological processes, which are determined by sex. Sex designates chromosomal phenomena correlated to having one or two X-chromosomes. Gender difference has featured poorly in clinical trials and all aspects of mental health research. A study of the National Institutes of Health (NIH) sponsored studies, revealed about one-fifth of these studies in medicine published through to 1998, did not include women. (Vidaver, 2000). This has highlighted the obvious but up to that time neglected fact that women are not just "little men". This is evidenced in the way medication dosages are developed, that is, using men as a yardstick and applying the same treatment dosages to women. Recent advances in drug metabolism have established significant differences in hepatic cyto-chrome P450 function between men and women Pollock, 1997. Differences in the representation of disease between males and females and all aspects of disease phenomenology in a population (including symptomatology, natural history, treatment responsivity, functional capacity, and vulnerability to disorder) are affected by gender. Consequently, psychiatry and research into it must reflect this (Pollock, 1997).

Women's madness

Matters related to culture are more and more being underscored within our popular press, as well as in academic literature. Within Aotearoa/New Zealand culture, ethnicity, race and nationality are discussed time and again. Nevertheless, communities and individuals struggle to understand the place held by people of differing cultures and how to comprehend and appreciate the differences between cultures. Because New Zealand society is unsure whether it is a bicultural or multicultural society, it also struggles with identifying a distinct New Zealand culture. These conundrums echo those questions posed regarding women's roles and the value that is placed on women's contribution to New Zealand society (Brookes, 1998). Knowledge of differences between women of different cultures, and their perceptions of mental health, their vulnerability to mental illness, and their experiences of mental health services is vital to understanding mental health needs, and the provision of appropriate and effective mental health services for women of all cultural backgrounds.

The dominance of medical discourse in women's lives as a whole has been echoed in the response to women's mental health. The correlation of women's madness with biology has legitimated 'treatments' from sterilisation, hysterectomy, through to lobotomy and clitoridectomy. Claims by Showalter, that some psychiatric texts in the 1970s recommended lobotomy as a way for women to cope with their marriages. Thus procuring the desired effect of reducing women to child-like dependency. (Showalter, 1987). Many factors that impact on women's mental health lie outside the health field, and are influenced greatly by women's inferior status in society. In particular the discrimination felt by women who are not of the main culture is even more pronounced. This is a global phenomenon that provides the medium out of which so much female mental disorder occurs (Ellis & Collings, 1997). In order to understand one woman's personal story of what it is to live with the pain and anguish that is 'madness' we need to look at what it means for women in general living in a patriarchal society. Madness is such an emotive term that serves to categorise, to delineate, and to

designate those that are different. Use of the term 'madness' recognises the meaning attached to the perception of dysfunction or pathology in the psychological arena. It is a description used as a means of regulating and positioning women within the social order. This is not to say that men are not mad, however, they are more likely to be positioned as 'bad'. Their discontent, anger and frustration manifests itself more visibly as criminal deviancy, thus regulating the positioning of women within the psychiatric discourse, and men within the criminal discourse (Ussher, 1992).

The correlation of women and irrationality has a long history in Western thinking. In the nineteenth century, European doctors believed the uterus and the brain to be connected through the nervous system, thus making women greatly susceptible to mental disturbance through shocks to the bodily system, (Brookes, 1998). This and similar beliefs created a culture within medicine that opposed the higher education of women, arguing that mental fatigue would damage women's reproductive systems. Dr Thomas Emmet, a leading American gynaecologist, went so far as to claim that "...the young girl commences life with an inheritance of a certain amount of nerve force which, if squandered in mental culture, will leave the physical growth defective at some point" Emmet, 1884 (cited in Romans, 1998, p.15). Such beliefs about women's limited nervous capacity and constitutional delicateness, was transported to New Zealand by the European doctors who arrived in the mid nineteenth century. There continues to be a tendency to attribute a woman's psychiatric status to her reproductive function, in ways that are not seen with male psychiatric disorders. Despite multiple studies, there has been no clear comprehensive neuro-hormonal explanation that reproductive function and female psychiatric disorders are linked. There is however, an abundance of 'theory' regarding biological considerations particularly, regarding depression in females. Rubinow, Angold, Worthman, Halbreich, Pearlstein, Arpels, (cited in Romans, 1998) maintain that most of this discourse has been focused on the hypothalamic-pituitary-ovarian systems because of its marked difference from male biology, and also because of the routinely changing hormone levels throughout the active

reproductive years No single biological explanation seems adequate to account for psychiatric gender differences, and that could well be because the aetiology has a number of instigating mechanisms.

Psychiatric disorders and pregnancy

Since Hippocratic times clinicians have noted an association between childbirth and mental disturbance. Observations are that there appears to be something etiologically unique about the postpartum period in the genesis of psychiatric disorders. Some theorists surmise that it is due to the added stress of pregnancy and childbirth, whilst others retain the notion that it is due to an underlying neuro-physiologic cause. The nature of this association nonetheless, remains unclear (Miller, 1999). What Brockington, (1996) is clear about is that childbirth is a complex event, brimming full with somatic and psychological milestones. It is a period of rapid biological, social and emotional transition. During pregnancy physical discomfort is apparent and there can be changes in social networks, along with financial pressures. Relationships can be strained and tedium can set in. After delivery there may be a period of excitement and elation, as well as exhaustion (Brockington, 1996). Dividing postpartum mood disorders into three broad categories- postpartum blues, postpartum depression and postpartum psychosis- is how most reviewers explain this presentation, often viewing the various presentations as a continuum of increasing severity. However, there is an increasing body of data that suggests that although in some cases there is an interrelated element, distinct postpartum states exist with different phenomenology's, aetiologies and predictive factors. Depression can appear at any time and to anyone. If the depression occurs in the first two years after the birth of a child and lasts longer than a month, it can generally be considered to be postnatal depression.

Overlooking the signs and symptoms of postnatal depression in mothers is something that occurs frequently. The dilemma is compounded by the fact that many new mothers who are depressed never seek help. In some cases this may be because they recover relatively quickly, whilst others

do not realise that they are ill, and another group may be apprehensive about seeking help because of the stigma attached to having a 'mental illness'. This group is often terrified of having their babies taken from them, or feared being labelled a 'failure' Richards, 1991, (cited in Brockington, 1996). Screening tools and questionnaires are a way of helping to combat the problem of oversight when trying to determine whether a mother is susceptible to, or suffering from depression.

A screening tool requires high sensitivity and specificity. Sensitivity is an index of the number correctly diagnosed as suffering from depression; and specificity is the number correctly identified as normal. Sensitivity is the more important, because a screening instrument must not miss cases; once a possible case has been identified, an interview can eliminate the false positives (Brockington, 1996, p.175).

The postpartum screening tool used most extensively world-wide, that has been validated against diagnostic methods, and can detect clinically significant depression in diverse populations, is one developed by Cox and his colleagues in 1987. It is the Edinburgh Postnatal Depression scale (EPDS).

The predominant feature of this tool is the expulsion of items that might reflect physical discomfort and confuse depression with the somatic effects of childbirth. This scale consists of a simple 10 item questionnaire with a score range between 0 and 40 (Refer Appendix II). Registering a score of 10-12 is indicative of minor depressive symptoms; a score over 12 implies more severe depressive symptoms. Five of the statements are concerned with dysphoric mood, two with anxiety, and one each with feelings of guilt, suicidality, and not coping. There are some interesting features of the scale- item 7 mixes insomnia with unhappiness; items 1 and 2 compare with previous states; seven of the items are reversed scored, and the answer key differs imperceptibly with every question (Cox, 1987).

The Beck Depression Inventory (BDI), another scale used in the diagnosis of depression and postnatal depression, does not appear to be as rigorous as the EPDS. Whiffen (cited in Brockington, 1996) reported that the BDI lacked specificity, because certain items including irritability, feeling unattractive, difficulty working, sleeplessness and fatigue were often reported by postpartum women who were not depressed. Another study revealed that the BDI appeared to be insensitive to minor postpartum depression.

Recently a new tool is being trialled for validation by Dr Gill White, in New Zealand, the Postnatal Depression Screening Scale, developed by an American nurse, Professor Cheryl Beck. The results demonstrate general comparability with the EPDS. It does have a greater sensitivity and will be useful for clinician's and research. To date though it has not been tested with a Maori population (Gill White, personal correspondence, June 8th, 2006).

Consequently, it is essential that diagnosis and treatment approaches be relevant and appropriate (Miller, 1999). The 'blues' for instance could be more than likely a highly spontaneous state, rather than a type of minor depression, and may be associated with normal postpartum neuro-physiologic changes. Postpartum depression, like depression experienced at other times, may be caused by an assortment of determinants. Including genetic endowment, psychosocial stresses, cultural precursors and physiological changes, all of which can influence vulnerability to some degree (Miller, 1999). Postpartum psychosis or puerperal psychosis as it is also known can appear abruptly, shortly after childbirth. Diagnosing this disorder can, however, be complicated one hallmark is confusion. This confusion can present itself as a 'disturbance of consciousness' marked by an apparent bewilderment and perplexity. This changeable delirium has been classified over time under different names, including amentia and cycloid psychosis Pauleikhoff, 1964 (cited in Brockington, 1996).

Psychosis has diagnostic criteria requiring one or more of the following psychotic symptoms:

...delusions, hallucinations or disorganised speech and thought. These criteria define the psychological concept of psychosis in DSM-IV-TR, but imply nothing about the etiology of neither the disorder nor its consequences. The remaining criteria for each diagnosis differentiate the disorders according to the phenomenology of the psychotic symptoms and their duration, etiology, and associated symptoms. (Fauman, 2002, p.146)

Cycloid psychosis is described as an acute psychosis, often with a hereditary antecedent but without stress being a precipitant. The symptoms can range from confusion to affective features such as ecstasy or fear with transient delusions, auditory hallucinations, catatonic signs and thought disorder. The clinical picture of this disorder can change rapidly. There is usually a full recovery but with a tendency to recurrences. O'hara, (cited in Kendall-Tackett, & Kaaufman-Kantor, 1987) suggests that as a matter of practicality clinicians should focus on the severity of symptoms, thus ensuring that early intervention and treatment are the focus in order to alleviate exacerbation of symptoms.

Postpartum psychosis has its closest recognisable link to the psychotic sub-type known as manic depressive disorder or bipolar disorder. This is because symptoms of postpartum episodes often include mania. New mothers can present with feverish activity to the point of exhaustion or uncontrolled violence that may require considerable restraints to be used to hold them. A constant monologue of nonsensical chatter that is indecipherable can occur. Sexual disinhibition is also a feature. In a study by Dean & Kendall (1981) manic episodes were found to be 13% more frequent in mothers admitted to psychiatric hospitals within three months of childbirth, compared with 3% of other females. Commonly severe depression will follow a manic phase. Additionally some cases show a dramatic switch from excitement and garrulousness to morose reticence. Mixed manic episodes, some diurnal in nature, can also occur. Hattingen, (cited in Brockington, 1996, p.217) "...described a patient who changed

from nocturnal raving to daytime sopor from which she could hardly be woken”

Nosological systems such as the ICD and DSM have had a huge influence on puerperal psychosis. But most of that has been antagonistic. Although the ICD-8 and the DSM-III gave brief acknowledgement to the existence of puerperal psychosis, subsequent editions have narrowed its diagnostic range to such a degree that it has subjugated epidemiological research. The lack of sanctioning by the World Health Organisation and the American Psychiatric Association has impacted crudely on the provision of adequate and appropriate postnatal services. This inadequacy compelled Dr Hamilton to write the following statement to the task force on nomenclature and statistics of the American Psychiatric Association.

During most of the 19th century, almost every physician in the Western World knew that there was such a thing as puerperal psychosis, and that it had to be handled with special care. By contrast, for the past half-century, since the category of puerperal psychosis was abolished, identification and treatment of these cases has been casual, if not negligent. (Brockington, 1996, p.209).

Consequently, division exists with regard to postpartum depression and postpartum psychosis. Some researchers and clinicians view postpartum depression as no different from depression and psychotic illnesses, despite there being evidence that there are psychiatric disorders specific to this period. Others like Paffenberger, Pitt, Kendell, Brandon, Tongue, (cited in Buist, 1996) suggest lack of societal support and the lowered status of motherhood during pregnancy and the postpartum period as the originators of ‘depressive illnesses’ and abhor the over-medicalisation of it. Nonetheless it is generally recognised in clinical practice, and in most recent research publications, that the first 12 months postpartum are considered to be a period in which psychological and psychosocial problems are most likely to occur Pitt, Cox, Kumar & Robson, (cited in Buist, 1996). A number of etiological theories of postpartum psychosis

have been presumed. There remains however no consensus as to the cause, and it would appear that they are multitudinous. An interesting observation is that women can present with an unconscious connection to other worldly states, with an emphasis on religious or spiritual matters. Religion and spirituality are gaining legitimate importance as cultural variables operating in all the stages of the diagnostic and treatment processes. It is therefore, imperative that they be acknowledged, and examined in the history-taking and cultural formulation processes. Spirituality becomes a significant component of "...self-identity, self-care, insight, self-reliance, and resiliency in the treatment arena" (Lukoff & Turner, 1995, p.262).

Positives and negatives of diagnosis labelling

Viewing postpartum disorders as a medical disorder has its advantage in that timely evaluation and management of appropriate interventions are more likely to take place. Conversely, inadequate understanding of the causes of postpartum disorders impedes the treatment of affected women. Despite the fact that postpartum disorders are not clinically recognised by nosology, it remains an issue that, if ignored, can result in dire consequences. Attitudes to motherhood differ widely between Western and other cultures. Some researchers suggest that postpartum depression in Western cultures is a result of a lack of systemised support and assistance, and lack of recognition of the status of motherhood. Stern & Kruckman, 1983, (cited in Buist, 1996). Often mothers from some Western cultures receive little or no preparation for the postpartum period, the labour and delivery being the focus. Ordinarily pregnant women are not informed of the possibility of postpartum depression for fear of 'worrying them'. If information is given, it is often not detailed enough to be of much use. However, once depression is diagnosed implementation of interventions is usually prompt.

According to Mezzich, et al; 1992, (cited in Miller, 1999) designing cross-cultural research to validate Western notions of an unbiased scientific, diagnostic system has its pitfalls, given that 80% of the worlds population

is non-Western. The experiences and beliefs of illness of this 80% must be included in order to develop a truly comprehensive nosology of mental disorders. Rogler 1993, (cited in Miller, 1999) describes culture as affecting the expression of symptoms and the nature of help-seeking behaviour.

Studies of the various rites of passage to parenthood must therefore include the following:

1. An accurate description of the symptoms that mothers experience;
 2. take into account the cultural medium in which the behaviour is expressed and
 3. pay adequate attention to various pregnancy, birth and postpartum customs and rituals through the "translation" of observations by individuals who are immersed in the culture.
- Berry et al., 1986 (cited in Miller, 1999, p.87).

Pre-partum depression

Pre-partum depression has aroused less interest than the more commonly known post-partum depression. However, Paffenberger, (cited in, Brockington, 1996) noted pre-partum melancholia as tending to be recurrent in subsequent pregnancies. Studies have shown unsurprisingly, an association with social problems, adverse events or difficulties including marital conflict and lack of support Kumar & Robson 1984, (cited in Brockington, 1996). Parallels exist with pre-partum depression when compared to postpartum depression, including general vulnerability, emotional instability and psychiatric illness, as well as stress and lack of social support. In a study done by Dr Kristina Hofberg (2000), 24 women were examined over a two-year period. Of these women four developed toko-phobia (an unreasoning dread of childbirth) as a symptom of depression in the pre-natal period. They believed that they would be unable to deliver their babies – expecting to die in the process. Two of these women tried to end their pregnancies but recovered after receiving

psychological treatment. One woman responded well to antidepressants and delivered her baby by caesarean. Contrastingly the fourth woman, who declined an antidepressant and was refused a caesarean had a traumatic vaginal delivery, suffered from postnatal depression and did not form a bond with her baby. Walsh (cited in Hofberg, 2000) commented that this is due in large part to modern obstetrics' obsession with all that can go wrong during childbirth. He notes that it is little wonder that there has been an increase in the rate of caesarean deliveries or "vaginal bypass" that promise complete pain relief and protection of the pelvic floor. These are powerful disincentives to experiencing normal labour and birth. However Hofberg's study revealed that women with primary tokophobia were determined to deliver by caesarean. Four achieved this, and bonded well with their babies, as well as maintaining good psychological health. Three of the women endured vaginal deliveries against their will; the result being that they all suffered postnatal depression, with two of them suffering from post traumatic stress disorder (PTSD) and two had delayed problems bonding with their babies.

Consequently the need for empathic, professional, relevant and supportive maternity cares throughout the pregnancy, delivery and postnatally is imperative. This together with family support will assist women in achieving physical and mental wellbeing.

Postnatal depression in New Zealand

A 1994 study by (Webster, 1994) recorded the prevalence of postnatal depression (PND) in an Auckland community cohort of 153 European and 36 Maori women, screened for PND 4 weeks after the birth of their babies. The study determined the frequency of major depressive disorder amongst this group at 7.8%, with 13.6% of women communicating more minor depressive symptoms. The characteristics that emerged indicated that those more inclined to suffer from this 'disorder' were;

- I. single women;
- II. women under the age of 20 years at the birth of their first child;
- III. women in uncomfortable relationships with their partner;
- IV. women with a past history of psychiatric disorder which required hospitalisation and;
- V. women who were Maori.

Maori women were also 4 years younger, had fewer partners, but more children. Another 1995 study in Christchurch found 13% of its cohort was severely depressed, and another 7% on the brink of depression. Probable causes included depressive symptoms before and during pregnancy, poor partner relationships, and low levels of education and income. The principal instrument used in the Webster et al study was the EPDS, (Cox, Holden & Sagovsky, 1987).

The issues of translation of measures from one culture to another are huge. Cox (1996) one of the inventors of the EPDS, who has tested the scale with culturally different populations, has argued the need for a qualitative trans-cultural analysis of the issues surrounding the postnatal experience. Kumar (1994) underlines the fallacy that is often made when coming from Western diagnostic frameworks "...to assume that a particular "Western" diagnostic category and the method for evaluating it represent some sort of 'culture-free' gold standard that can be easily transported with impunity to other cultures" (Kumar, 1994, p.251).

A 1995 student project from Auckland University (Evans, Goessi, Overdyck, Prebble, Reed, & Shisram, 1995) reported that Maori did not see PND as a useful framework for looking at "spiritually distressed women" (p.1.) According to the "evolutionary" hypothesis of Hagen (1996) postnatal depression is an imprinted reaction by mothers to ensure social support when they are under stress, and that cultures have evolved specific internally consistent rituals and beliefs as ways of coping with the life crises connected with birth and early child rearing. Included are specific practical support structures for mother and baby, in the context of spiritual practices and beliefs which bind the community to the baby, not just the mother to the baby. Social displacement has isolated the mothers from traditional family and community support structures replacing these in Western society with institutional supports including hospitals and professional post-natal support systems. These structures are technology driven and therefore have limited resources in terms of providing spiritual support needs. Issues of translation of measures from one culture to another are immense. For instance, a study by Upadhyaya, Creed & Upadhyaya, (1989) noted that indigenous British women were more likely to identify mental un-wellness as being linked to their emotional states (anxiety, sadness, low mood). However Asian cohorts of the same study would exclusively report somatic symptoms (headaches, rashes, physical ailments) as determinants of mental ill health.

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) seems to have led a somewhat ignored life as a legitimate diagnostic category. There has been no mention of any type of trauma related disorder in either DSM -1 (1952) or DSM-II (1968). It wasn't until DSM-III (1980.) that official recognition was given to it. PTSD in fact was the only "neurotic" disorder that had no antecedent in the previous DSM's. By the time the DSM-III-R was published the description of PTSD had undergone a few refinements (Peterson, Prout & Schwarz, 1991).

Trimble (1981) has reported changes in the description of PTSD, the term "compensation neurosis" so called by Rigler in 1879, after an increase of invalidism reported after railway accidents, and the introduction of compensation laws in Prussia. The burgeoning number of claims against railway companies was so great that the syndrome became known as "railway spine". Trimble 1985, (cited in Figley, 1995). The term "shell shock" was coined by Mott in 1919, after the trauma suffered by returning soldiers of the First World War. By 1941, Kardiner was referring to these types of trauma as "traumatic neurosis" (Peterson, et al., 1991).

Accounts of symptoms and syndromes with PTSD like characteristics have existed in writings throughout the centuries. Trimble (1981) unearthed the first theoretical discussion of a post-traumatic syndrome in the medical community to the work of Erichsen, entitled *On the Concussion of the Spine: Nervous Shock and Other Obscure Injuries of the Nervous System in their Clinical and Medico-Legal Aspects*. The hypothesis of the work was that even mild trauma could cause serious impairment in functioning. The aetiology was presumed to be neurological. Debate ensued as to whether it was neurological or psychological, with some theorists arguing that the condition was a clear case of malingering (Peterson, et al., 1991). Nonetheless, the psychological formulation gained dominance. By the turn of the 20th century, hysteria became the primary explanatory principle for traumatic responses. With "psychological trauma" being the perceived precursor, as opposed to a psychological reaction to a physical trauma. Fenichel, (1946) describes psychological neurosis as - over excitement of the drives of the person that was traumatic. This over stimulation led to a disturbance of the psychic equilibrium. Between the 50's and 70s there was little or nothing written about post traumatic neurosis. Concurrently, psychology in general was undergoing numerous changes. In particular, the rising influence of cognitive and behavioural theories in the field was impacting hugely on treatment approaches. By the 70's and 80s there was a proliferation of research and writing on trauma-related disorders during which time systemic and ecological principles of pathology and

health were also gaining importance. The psychological casualties of the Vietnam War are largely responsible for the renewed interest in post traumatic neurosis, and were the main subjects of most of the early papers written about post traumatic events. The stressors themselves were seen to be the pre-determinants of psychological trauma. In time strong empirical support was gathered for the primacy of the traumatic nature of the stressor as the underlying agent of Post Traumatic Stress Disorder. Even this new name for the disorder seemed to reflect the increasing importance of the stressor itself.

As with other disorders born of the Diagnostic and Statistical Manual of Mental Disorders, the definition of PTSD is in essence phenomenological, based on the co-occurrence of specific symptoms in an individual for a certain length of time. DSM-IV diagnostic criteria differ from those formerly included in DSM-III definition of a traumatic event and do not necessitate the existence of an explicit stressor that would evoke essential symptoms of distress in almost anyone (Nutt, Davidson & Zohar, 2000). In studies using DSM-IV criteria (Appendix III) the probability of being subjected to a traumatic event during one's life is exceedingly high, reaching 97% of male adults in the United States (Nutt, et al., 2000). Secondly, the witnessing of traumatic events to others can result in PTSD. The element of being under direct threat is no longer a pre-requisite. Thirdly, the definition of the 'event' now includes an intense reaction, involving extreme fear, helplessness or terror. The international Classification of Diseases (ICD) ICD-10, has a more conservative approach and describes the event or situation (either of short or long duration) of an exceptionally threatening or catastrophic nature, that is likely to cause all-encompassing distress in almost anyone (Nutt, et al., 2000).

Post traumatic stress disorder due to childbirth

Childbirth is an emotional and immeasurably complex experience. Nothing can really prepare a woman for the incredible journey of pregnancy and eventual arrival of a new being. The range of emotions

that giving birth encompasses is vast. Leading up to delivery, a woman can anticipate what will happen in the physical sense, by way of literature or narratives told by friends, relations or even strangers. However, the emotional experience is unique. It is true to say that as extraordinary as this everyday miracle is, a woman's experience of it can run the gamut from spiritual to shattering. The process of giving birth and how a woman reacts to the newborn hinges on a number of variables. Does she want this baby? Will she be a good mother? There are a thousand and one "what ifs", and no crystal ball to know how it will all turn out. A woman's own genetic makeup, her own development inside the womb, her own delivery her social and biological experiences up to the point of giving birth, will all have helped mould the person she is at this time, and will shape how she will respond to giving birth and raising her own child.

In a study done by Breen (1975), fifty women having first babies were tested to see if the biological and psychological event of becoming a mother initiates processes that can be "adaptive" or "maladaptive". She used questionnaires, interviews and collected data throughout the study from obstetricians, as well as psychological testing. Although the results were complex, she maintains that the women who are most adjusted to childbearing are the ones who feel less enslaved by the experience, and have more diverse, more open judgements of themselves and others. These women do not aspire to be the perfect mother. Nor do they see themselves as self-sacrificing, passive or the archetypal example of femininity.

Nonetheless, for some women pregnancy is a time of considerable anxiety-fear of delivery often being expressed. In a study of 200 postpartum women done by Heymans and Winter (cited in, Brockington, 1996) 34% cited the pain of delivery as their main anxiety, and 15% feared complication of parturition (birthing) including maternal death. The importance of a supportive, preferably familiar person to attend through this process was cited as the most useful way to alleviate this fear.

In 1858 the renowned Parisian doctor Marcé formed the opinion that previously emotionally stable women could be susceptible to episodes of instability associated with the birth of their child. He noted also that women had a disconcerting fear of delivering a baby with hideous deformities. This was validated in Heyman and Winter's aforementioned study where the commonest fear for women indicated 52% had a dread of delivering babies with congenital abnormalities, and another 28% feared having a mentally handicapped baby.

Despite nosology's non-specificity of childbirth as an example of an extreme traumatic stressor, childbirth, can without doubt qualify as a traumatic event (Beck, 2004). The reported occurrence of diagnosed PTSD after childbirth ranges from 1.5% (Ayers & Pickering, 2001) to 6% (Menage, 1993). Possible features of PTSD after childbirth, as reported from the most recent review of the literature by (Bailham & Joseph, 2003) included avoiding sex, fear of giving birth, and mother-infant attachment problems, as well as problems with parenting. They are careful, however, not to sanction that these features, and consider they are at present provisional, and call for further research to explore the clinical presentation of PTSD in mothers as a result of traumatic births.

Among the few published qualitative studies completed, relating to the incidence of diagnosed PTSD attributable to childbirth and the PTSD symptoms of women after giving birth, two have been carried out- a phenomenologic study on birth trauma by (Beck, 2004), and another grounded theory study on the process and impact of traumatic childbirth by (Allen, 1998). Beck's phenomenologic study investigated women's experiences of birth trauma. The study was carried out via the Internet and included 40 women from various countries including; 23 from New Zealand, 8 in the United States, 6 in Australia, and 3 from the United Kingdom. The recruitment was carried out mainly through the Trauma and Birth Stress (TABS) organisation, a charitable trust located in New Zealand. The main characteristics of a traumatic birth that emerged from the study were the mothers' perceived lack of communication and caring

by labour and delivery staff, the provision of unsafe care, and an overshadowing of the trauma by the delivery end result (Beck, 2004). Beck's perception of the phenomenon experienced concluded that the trauma of birth lies very much in the eye of the beholder. The mothers also had a perception that their traumatic births were looked on by clinicians as routine.

Allen's grounded theory study investigated the processes that arose during traumatic childbirth, including the mediating variables in the development of PTSD symptoms, and the impact of postpartum adaptation (Allen, 1998). Her study included 20 mothers who were interviewed 10 months after delivery. The Revised Impact of Event Scale - A measure of subjective stress (Horowitz et al., 1979) was used to measure symptoms of PTSD. Six of the mothers reported scoring above the cut off point that point to clinically significant levels of PTSD symptoms after childbirth. Among the features of distress described by the mothers, panic and tearfulness caused by the prospect of the trauma were prevalent. Anger directed at clinicians, as well as their partners resulted in diminished closeness of their relationships with their partners. Emotional detachment from their babies also featured, as well as being less tolerant of their other children and fear at the prospect of becoming pregnant again.

In an ideal world if women were to receive adequate support throughout the antenatal, delivery, postpartum period and beyond, then the incidence and prevalence of postpartum illness would probably be reduced. Many mothers report having overwhelming feelings of isolation and abandonment, once they had their babies, and struggled with the responsibility of the 24-hour care a newborn requires. Some of the contributing factors to this isolation have been due to the migration from rural to city life which has eroded much of the social and family support that existed in communities in previous times. Current economic pressures too are a precipitant, and may require that both parents work at full-time employment. Clinicians who are aware, and acknowledge socio-

cultural factors are better able to help new parents articulate their anxieties and activate the mobilisation of resources that do exist. The protective barrier of social support lessens the likelihood of the development of depressive symptoms. In due course with appropriate supports in place, and with appropriate treatment, the depersonalising influences of the urban environment can be overcome. Further research on the impact of migration from rural to urban environments and the importance of social supports will help to address issues of isolation that some women experience during pregnancy, the post-partum period and beyond.

Ethics

The question of ethics and ethical practice is an integral part of research, and more and more researchers are expected to be accountable for their research undertakings in a way that ensures that those being researched are left intact at every level. The most important precept of ethical research is that the researcher, "Do no harm" (O'Leary, 2004, p.53). Furthermore, researchers take responsibility to ensure that participants are treated with dignity, respect and that the participants give informed consent to their participation in the research. The lack of all of the above was never more apparent than the calamity that arose out of what was referred to as the 'unfortunate experiment' This 'research' transpired out of the proposal presented at a meeting of senior medical staff at National Women's Hospital in Auckland in 1966. The proposal presented by Dr Herbert Green (Associate Professor in the Department of Obstetrics and Gynaecology) proposed treatment of women with carcinoma *in situ* (CIS): "...a lesion which is found on the surface of the epithelium (the lining or skin of the uterus or any area of the genital tract), and which has not invaded or spread beneath that layer" (Cartwright, 1988, p.23). At the time, international experts believed CIS was a forerunner of invasive cervical cancer. Dr Green believed otherwise, and stated that the aim of the research was to try to prove that CIS is not a pre-malignant disease. Apart from the Hospital Medical Committee, there was at the time, no other mechanism in place for dealing thoroughly with the ethics of

research. This was despite the fact that the World Medical Association had in 1964 drawn up a code of ethics (The Declaration of Helsinki) governing human experimentation. Furthermore, it was not until 1972 that the Auckland Hospital Board implemented policy to ensure an ethical review of research proposals (Davidson & Tolich, 1999). Consequently, Dr Green's proposal was moved and seconded, and commended to the rest of the staff. Despite concerns from other doctors, in particular Doctors' McIndoe and McLean to Dr Green's proposal, he was, over the next 20 years able to act in accordance with the 1966 proposal. The concerns proved to be well founded when, over time, the number of patients who had indeed developed invasive cancer came to light. Eventually, the government set up a committee of enquiry headed by Judge Silvia Cartwright. After lengthy investigations she concluded that there had been a failure to treat satisfactorily a number of patients with cervical CIS at National Women's Hospital. Of real concern was the "...number of ethical principles that had been violated: the patients had not been consulted, they had been exposed to harm, and research had replaced the clinical treatment to which they were entitled" (Davidson & Tolich, 1999, p.70). The research, the exposure, and the Cartwright Report marked a crossroads in the development of the ethics of research in New Zealand. The result has been that never again would professionals have exclusive power to ignore ethical considerations; this was extended to include other institutions such as universities, as well as hospitals where research is carried out.

A Maori perspective of ethical research

Everyday of every year, some aspect of the Maori world is being researched, be it from the secondary school student project, through to the more pessimistic studies on Maori use of alcohol or nicotine consumption (Te Awekotuku, 1991). Connected to this are the wider issues of responsibility, moral accountability, and social relevance; more importantly is the political application of research findings, and their relevance regarding tangible effectiveness. The very essence of social science, as determined by fact, takes on political meaning. In other words

the world of widely communicated nonsense or any statement of fact is of political and moral significance. By their mere existence social scientists are caught up in the struggle between enlightenment and obscurantism (Te Awekotuku, 1991). In order to avoid the cultural imperialism of past researchers and their practices of reporting - such as research undertaken by Shortland, Kendall, White, Smith, & Best, (cited in Awekotuku, 1991) - heed must be paid to ensuring that the taonga of recorded knowledge be of benefit to those being researched, particularly when the researched are of another culture to those undertaking the research.

The participants in this study are all women of Maori descent. A well documented fact is that since first contact with Europeans, Maori have always been involved in research, most often as the researched rather than the researcher (Smith, 1994). Critics of Western methodologies, used in the investigation into the lives of Maori, are agreed that Maori continue to be among the most researched people in the world. It is also evident that too often non-Maori researchers have been greater beneficiaries of the research (including academic and career benefits) than the Maori being researched have. This has often only served to marginalise and deride Maori history and knowledge and reinforce negative stereotypes (Bishop, 1992). Frequently this research has been comparative or descriptive, offering few insights for Maori, or measuring where they stand in relation to others (Stokes, 1985). Durie describes this as a social consciousness style of investigation. (Durie, 1992) Bishop further describes this type of research as a clear case of 'winners' and 'losers', Maori rarely featuring in the former category. (Bishop, 1992)

Stokes and Bishop accept that Maori have not been well served by non-Maori researchers, but fall short of concurring with the theory that only Maori should research Maori. Instead they maintain that what should be a pre-requisite is that any researcher of Maori people, have a 'bicultural' understanding and close involvement with the issues facing Maori society today. They propose a collaborative and interactive approach whereby

power and control of the research process remain with the whanau, and regardless of whether the researcher is Maori or Pakeha, that they remain accountable to the group. (Stokes, 1985, Bishop, 1992) Certainly this is a commendable rationale, but it does not allow for the fact that Maori researchers are defined according to their whakapapa links, and are intrinsically tied to their iwi, hapu and whanau connections. This is not something that a non-Maori researcher is able to bring to the process. The unease felt by Maori is that academic protocols regarding research studies privileges the researcher/s as the authors, and subsequently the authorities of Maori knowledge and endows them with an erroneous status, nationally and internationally perceived, as the voice of Maori (Davidson & Tolich, 1999). Conversely, a Maori researcher's knowledge needs to extend to a thorough comprehension of tikanga Maori. Moreover, the researchers' own tribal affiliations, as well as their age and gender are important factors to be considered when undertaking research with Maori. Colonisation has had far-reaching implications for Maori, and unless Maori researchers possess not just the appropriate knowledge of tikanga, but the necessary scholarly ability to record Maori issues then it cannot be assumed that they are the most appropriate people to be researching Maori (Walker, 1993). Whether or not, research undertaken by Maori will offset the damaging effects of past research by non-Maori of Maori society, remains to be seen. However, Durie maintains that

...Research by Maori is more likely to be conducted with an in-depth understanding of Maori values, attitudes and mores necessary for a successful outcome, as is the probability of an understanding and willingness to abide by a Maori system of ethics and accountability. (Durie, 1992, p.4)

Ensuring adherence to a particular ethnicities system of ethics and accountability is imperative to leaving it intact. Significantly, research about Maori requires clear objectives and goals, and reliable information based on actual Maori experience. For Maori, undertaking research of Maori for the sake of "knowing" is a pointless exercise (Stokes, 1985).

Ethnic diversity has much to offer the world. This needs to be preserved and protected. Eliminating or superimposing foreign paradigms over existing values and beliefs of in particular, minority cultures does nothing to sustain diversity and difference which are the basis of life. Every view of the world that is extinguished, every culture that is diminished only leaves a lacklustre homogeneity that benefits no one (Marsella & Westermeyer, 1993).

Support for Maori women during and after pregnancy has evolved over time. The rituals and customary practices of birthing that existed in the Maori world have all but disappeared. This is undoubtedly due to the vigorous attempts by colonialists to foist assimilation on Maori. The following chapter is an explanation in part, of how this happened.

CHAPTER THREE: TE AO MAORI

Te Po

"I am aged in aeons, and I am night of many nights, Night of my darkness's – Night of great darkness, long darkness, utter darkness, birth and death darkness; of darkness unseen, darkness touchable and untouchable, and of every kind of darkness that can be. In my womb lay Papatunuku who was conceived in Darkness, born into Darkness – and who matured in Darkness, and in Darkness became mated with the sky." (Kahukiwa & Grace, 1984, p.16)

The arrival of the Pakeha to Aotearoa in the 17th Century, first by Abel Tasman and then Captain James Cook forever changed the landscape that was to become New Zealand. The colonial constructs that have been imposed on Maori society have effectively undermined the culture and identity of the indigenous peoples of Aotearoa. Nonetheless, Maori have survived as a people because they have largely refused to be assimilated. That is not to say however, that they have not been influenced by Western ideologies. In fact they have integrated Pakeha practices to a far greater degree than Pakeha have to Maoritanga. That practice though has been selective, and determined by Maori values and beliefs. Ostensibly, the rights of Maori as a consequence of being the first arrivals to Aotearoa stem from the treaty they signed with the representatives of the British Crown in 1840. (King, 1991).

Te Tiriti o Waitangi versus The Treaty of Waitangi

Papatuanuku

"There was a time when I was as one with Rangi, but now we live far apart. Between us, but not separating us, were our many children to whom we had given life and nourishment, and into whose hands had been given future life and growth. But this life and growth required light and space. So our children set us apart, causing Ranginui the father, and me, Papatuanuku the mother, great pain and anguish." (Kahukiwa & Grace, 1984, p.22)

The compromise for Maori was to engage in a partnership paradigm with the British Crown. Although, this partnership was settled to by way of a written agreement called Te Tiriti o Waitangi or The Treaty of Waitangi it has never been evenly weighted, and statistical evidence shows that

Maori have battled, and continue to battle for the right to employ a tikanga Maori approach to the way they live their lives. It is only relatively recently that some recognition of Maori rights has transpired. (Refer Appendix IV)

An example of this recognition in the health arena was when in 1985 the Standing Committee on Maori Health advocated that Te Tiriti O Waitangi/Treaty of Waitangi be endorsed as a foundation for good health. However, because there are two versions of the Treaty, Maori and English, interpretation has been a contentious issue. Currently government policies focus on the 'principles' of the Treaty – 'Partnership, Participation and Protection'. Although not entirely comfortable with this representation, Maori have been able to debate issues, and contemporary Treaty applications have been determined (Durie, 2001a).

In 1986 the Department of Health was one of the first departments of the fourth Labour Government to respond to cabinet's decisive stand on Treaty issues. The implication was that all future legislation should be examined to ascertain any implications for the Treaty of Waitangi, and that all departments should consult with Maori on matters of significance, including assessment of financial and resource implications arising from Treaty considerations.

Because issues of health are complex they cannot be fully understood without recourse to a broader context. Nor can they be separated from the wider agendas that impact on Maori wellbeing, or considered in isolation of national economic and social policies the management of physical resources, or New Zealand's changing demography (Durie, 2001a, p.255).

What has evolved, and with the consensus that the Treaty of Waitangi is the founding document of New Zealand commonality, is the concept of 'biculturalism'. Despite this however, and despite tribal opposition, successive Governments have vigorously pursued the assimilation of Maori into a Eurocentric construct. Predictably, Maori reaction has been hostile to European presumptions about Maori aspirations. Moreover during the 60's and 70's Maori issues were lumped in with those of Pacific

Islanders, both being seen as similarly impoverished minorities and victims of European colonialism. This was another example of disregard for Tino Rangatiratanga and the guarantees contained in the Treaty of Waitangi. Thompson (cited in Durie, 2001). Decades later the reality is that biculturalism remains a concept that is without distinctness or symmetry (Kelsey, 1990). Understanding Maori health is to realise that it is more complicated than illness and lifestyle. People belong to families, communities, and are representative of the values and policies therein. They are part of the fabric of society. The notion of collective accountability is a cornerstone of Maori well-being. There is a greater need to strive for standards of health, which exceed physical dimensions and encompass those aspects which have been relatively neglected, such as wairua, hinengaro and whanau. Durie explains that kaupapa Maori services should be based on the following:

The components of culturally appropriate services include an assessment process that takes into account cultural values, whanau (extended family) participation, use of Maori language and custom, outcome measures that are relevant to Maori understandings of health, and a Maori workforce with both professional and cultural competence. Mental health commission, 1997 (cited in Durie, 2001, p.136).

Standards of mental health are a prime example of the gaps that exist between Maori and non-Maori. This is particularly noticeable when comparing mental health statistics. By using rates of first psychiatric admissions as indices of detectable psychiatric morbidity, the Maori population shows an increase in morbidity rates since the 1950s. These increases gained momentum in the 60s through to the 80s. Generally, the average Maori does less well than the non-Maori in his or her risk of psychiatric hospitalisation (Sachdev, 1989).

The differences between Maori and non-Maori are also evident in the ways in which Maori differ from each other (Durie, 2001a). Proof positive of this is that not all Maori subscribe to the same cultural values and beliefs, due in large part to the alienation from culture and whanau during preceding policies of institutionalisation, and through the medium of

imposed colonial laws. Nonetheless, specialist Maori mental health teams have the ability to reshape mental health services in ways that will strengthen cultural identity.

Be that as it may, Maori have a host of needs, which are not being met by public mental health services; this is evidenced in the disproportionate numbers of Maori admitted to acute inpatient and forensic services. Maori also have considerably higher rates of re-admission than non-Maori (Mental Health Commission, 1998). The Mental Health Commission recommends that performance measures used by mental health services need to be inclusive of a Maori world-view. The pursuit of recovery and good health needs to be the goal, not just the removal of symptoms. Maori need to have mental health services that offer choice, whether that is mainstream, kaupapa Maori, or both.

Maori concepts of illness

Hine-ahu-one

"I sneezed and therefore I lived. Tane the procreator set the parents apart so that there could be light and growth; so that people could be generated on earth." (Kahukiwa & Grace, 1984, p.28)

In order to give an appropriate diagnosis of a 'mental illness' for Maori, one must first discern what the term mental illness means for Maori. Western psychiatry does not acknowledge that ill health, both mental and physical, and accompanying afflictions can be influenced by spiritual causes. Maori culture does acknowledge this, however. The term for this is Mate Maori.

"Mate Maori, for example, leads to an affliction said to be related to spiritual causes, and requires the intervention of a traditional healer, a tohunga." (Durie, 2001a, p.24)

Consequently, in these cases, a traditional healer (tohunga) could be a more appropriate practitioner than a psychiatrist. There is reluctance however, on the part of many Maori to discuss Mate Maori in a clinical environment, because of the fear of ridicule or pressure to choose the psychiatric/Western treatment approach. Durie explains that Mate Maori

does not necessarily mean that there cannot be a co-existing mental disorder and that the term is an explanation of perceived causes of abnormality rather than the emerging symptoms or behaviour. This is high-lighted in the codes that exist within Maoridom.

Tapu and noa

Hine-titama

"My mother was formed from Papatuanuku by the hands of Tane. I was formed in the womb of my mother when Tane entered her, combining both male and female elements." (Kahukiwa & Grace, 1984, p.34)

For Maori a code of social and ecological responsibility exists that evolved out of the need for early Maori migrants (after their arrival in Aotearoa), to know what was safe (noa), and what was uncertain (tapu) in their new, and harsh environment. Where the risk was known to be perilous a rahui (total ban) would be placed until such time as the danger had passed. In due course what began as a series of whanau procedures based on the law of survival, evolved into a system that directed social conduct.

The link to survival remained, but the emphasis was focused more on the influence of tohunga and-or unforgiving gods. Thus the emphasis on survival assumed a spiritual manifestation and to some degree the original point was lost. Nevertheless, the spiritual explanation served to provide a rationale for prudent behaviour long after the threat to survival had passed (Durie, 1992). Contemporary interpretations of tapu and noa continue to emphasise a sacred quality and a connection to gods or deities. But there is also the functional view of the purpose of tapu, as discussed by Te Rangi Hiroa (cited in Durie, 1992). He describes a link between the use of tapu and the prevention of mishaps or calamities, implying that an unsafe activity or location ought to be declared tapu in order to prevent tragedy. Durie discusses tapu in the context of healthy practises, describing tapu as a regulatory process for public health, associated with the diminishment of risk and the promotion of good health (Durie, 1992).

How tapu and noa relate to issues of safety in psychiatry may not be obviously apparent in a Western assessment and treatment setting. It could be argued that the underpinning values of tapu and noa are so far removed from contemporary Maori experience that they have little weight and even less relevance. Nonetheless, there is evidence to suggest that even with the swathe that has cut through the cultural values of Maori, these values remain.

To understand the meaning of the tapu/noa paradigm in any purposeful sense, one must understand that the state of tapu exists until such time as risk is ruled out. This can be explained using the concepts of space, time and boundaries. Within these frameworks the clinician can make assessments using a continuum spanning high risk to low risk. For instance high risk may exist where the negotiation of space has been poorly managed or the observation of boundaries has been overlooked, or the allocation of time has not allowed for correct prioritisation. Allowing for space in which tangata whaiora/clients can be received, interviewed, and cared for in a manner that does not compromise their safe space, or the space of others, will serve to enhance interaction and rapport during the assessment process (Durie, 2000). As well, rushing through assessments in order to tend to workloads will not be conducive to the process, or the trust issues that tangata whaiora may have. There is evidence, both from mental health data, and other indices of social dysfunction, that Maori are limited in their ability to practice safe codes for living beyond the marae. Consequently, being mindful of these codes that make sense culturally are worthy of further examination and inclusion in the mental health assessment and treatment arena when engaging Maori (Durie, 2000).

Traditional healing practices

Taranga

"I am Taranga. I am both of this world and not of this world, inhabiting the earthly land by night - and by day the land of the manapau trees. Maui-potiki is my youngest child, the child of my old age. I gave birth to him on the beach secretly. He was stillborn. Without proper ritual or ceremony, I cut off my topknot of hair, wrapped him in it and put him on the sea to be cared for by the gulls and fishes. But I knew the power of my hair." (Kahukiwa & Grace, 1984, p.40)

Both ritual and spirituality feature in the healing process for Maori. Traditionally this was by way of a tohunga (Maori authoritarian). Tohunga as a matter of course share the same cultural beliefs as their whaiora (patients/clients), adopt a holistic approach, maintain a confidence-inspiring charisma and tend towards being directive (Durie, 2001a). Although the extent of traditional healing - as practised by a tohunga - is not known on a national scale, there have been surveys undertaken that suggest that tohunga have significant followings, with indications that there is an increase in the use of traditional healing methods. Despite traditional healing having no rigid definitions, in its wider context it should not be seen as the use of a single modality. Healing is governed by established (often oral) codes of practice that draw on ethical, cultural and philosophical principles. The rationale for its use then is not solely in the physical remedies that can be offered, but in the traditions, beliefs and culture of the clients and the practitioners. To use a crude analogy, tohunga can be described as herbalists, medicine men and shamans. Herbalists base their practice on the use of an assortment of botanical substances, often in combination for a range of disorders. Medicine men employ supernatural channels to re-establish good health, whilst shamans are able to enter into trances in order to call upon the spirits to give guidance. Most tohunga however use more than one method and will utilise plant products within a cultural context and often there is a corresponding appeal to nga tipuna/ancestors (Durie, 2001a).

There are a number of features that distinguish traditional healing from the medical model. Traditional healers are less concerned with proving

efficacy of their methods because of the faith they have in traditional medicines and therefore rarely question them. Conversely, biomedicine is empirical and positivist and based on a philosophy of scepticism. Although its origins could also be described as traditional, it is constantly reviewing and revising this knowledge (Durie, 2001a). Essentially the difference is between science and faith. Scientists have difficulty accepting faith or any knowledge base that has not been subjected to scientific investigation. This does not mean that faith has no validity or that it can be dismissed. The disparity between the two is not as clear cut as might be supposed, as many traditional healers build new elements into their range of healing techniques in order to improve and develop their practice, which could be seen as adopting a scientific aspect to their methodology. Equally, there are many biomedical healers who depend on faith as much as science when treating patients, and who prescribe treatment according to time-honoured practices rather than up-to-date developments in medical science. Western biomedical tradition and the Diagnostic and Statistical Manual (DSM-IV), which is very much an integral part of that tradition, are, in specific respects, products of culture (Durie, 2001a).

Kraus (1996) explains that Western biomedical knowledge is defined, communicated and modified through a nerve ending process of disease classification and reminds us that in an increasingly global world, 80% of the world population does not share in Western culture.

To understand the paradigm of traditional healing, three principles need to be considered –

- cultural integrity
- medical pluralism and
- self-determination

Traditional healing practices are inextricably linked with culture. The philosophical roots, delivery systems, treatments and ways in which healers are recognised are consistent with wider cultural belief systems and values. They are not necessarily confined to the past, nor do they

need to be exact replicas of past historical approaches, however their potency lies in how they reflect wider cultural dynamics. Their credibility lies in the cultural codes of the communities they serve, using language, concepts and healing methods that are aligned with the values and persuasion of their clients.

There are two underlying principles of cultural integrity:

- The first is that healing that is far removed from the cultural realities of its peoples cannot be justified as traditional, and
- Secondly, whilst similarities between traditional healing and Western healing can be identified, traditional healing can only ever be completely understood through the culture of its origin. Medical pluralism is a characteristic of modern society. A single disease will often have immensely different histories in different cultures, because socio-cultural attributes are themselves determinants of morbidity and mortality (Kunitz, 1994).

It is not surprising then that people should seek assistance from a variety of helping agencies, often at the same time. Conventional medical treatment can be accessed along with alternative healing practices not normally considered scientific. Though there may not be a consistency in approach, the phenomenon is sufficiently widespread to suggest that healing is not the province of any single profession or group, nor is a single approach always likely to be regarded as comprehensive, at least not from the patient and families perspective. What medical pluralism provides is choice. As well as the option of – ‘the best of both worlds’. Including - cultural validation, and symptomatic cure (or relief). There is often a better sense of control and a greater understanding of the causes of the disease process and the benefit of two (or more) expert opinions (Kunitz, 1994).

However, problems with this approach can arise when one or other ‘expert’ is not prepared to tolerate a pluralistic approach to healing and insists on cessation of the interventions of the other. The important factor

here is that the client should not have to confront an "either/or" situation and the position of having to choose, or being made to do so takes away any sense of self-determination, which is the third principle of traditional healing. Self-determination is an aspiration of indigenous peoples the world over. This is based on the premise that if allowed to advance the development of cultural, social or economic terms a more positive outcome is likely to occur. Although not universally accepted by governments (because of its overtones of cession from the state), it is reasonable to consider that indigenous cultures are able to design, implement, and manage programmes in health, education and environmental issues, and make decisions about the formulation of policies and the allocation of resources. Thereby retaining cultural identities, then they are better placed to meet the needs of its people.

Maori women's health

Mahuika

"Where do you come from?" And he replied, "I come from the west." Then come and tell me what you want," I said, "because you are a relative of mine. You must be Maui-potiki, I have heard of your deeds on earth. I am Mahuika who keeps fires." "Fire has been lost to the world," Maui said, "so I have come to ask you for a flame." So I pulled out one of my flaring fingernails and gave it to him. He thanked me and went on his way." (Kahukiwa & Grace, 1984, p.46)

Between 1906 and 1911, accountability for Maori health care moved gradually from the Department of Native Affairs to the Department of Public Health. The history of maternity care for Maori women was recorded in the official documents under a separate title from the general report. A 1935, Appendix to the Journal of the House of Representatives (AJHR) report records a significantly higher maternal death rate for Maori (7.65 per 1,000 women in 1932) compared to the European population (3.02 per 1,000 women in 1932) (Smythe, 1998). The report further noted that there was extensive resistance by Maori to accepting "skilled" treatment. Whether this was due to the suspicions Maori had of Pakeha ways, or whether it was a preference to hold firmly to the practices that

were more familiar to them, or both, is cause for reflection and circumspection.

Maori birthing practices were different in a number of ways from those of Pakeha. According to the Committee of inquiry into Maternity Services in New Zealand in 1938, Maori women gave birth in the 'native fashion', assisted by their own folk (Coney, 1993). The native fashion involved squatting or kneeling to have the baby, and included support from the whanau, including men as well as women. The husband was almost always present at the birth, and in many regions had a pivotal support role in the birthing process. Childbirth practices also differed according to status and rank. For the average Maori woman, birth was something that was fairly commonplace, and might take place whilst on the march, or during routine tasks, a makeshift tent or hut being erected for the purpose of birthing. However, women of rank (wahine rangatira) could expect that childbirth would be a more organised event, and they would not be expected to do anything too strenuous once it was known they were 'with child' (Best, 1924). In these cases, the birth took place in a designated hut (whare kohanga) where the woman stayed shortly before the birth and a week or so after, until the pito (navel cord) dropped off and the Tua or Tohi rite had been performed on the newborn (Best, 1924). In later years a room in the main whare was made available for birthing. If difficulties arose during the birthing process, a Tohunga was called in to help facilitate the procedure, imparting chants, incantations and prayers to facilitate the procedure. The use of herbal (rongo) medicines was also used to help alleviate distress, with the cutting and tying of the umbilical cord, and for removing the placenta, which was later buried.

While the government Committee of Inquiry into Maternal Maternity Services of New Zealand considered Maori childbirth practices primitive, it also admitted that in the absence of complications, they were effective. However, the impact, and the enforcement of the Tohunga Suppression Act of 1907, began to make inroads. Increasingly during the twentieth century nurses and doctors, who had previously only provided

background support when complications occurred, slowly, but surely encroached on Maori birthing practices, thus ensuring the demise of Maori childbirth customs and rituals. By the late 1930s there was ever-increasing pressure to integrate Maori childbirth into the national system "Within the limitations of a centric culture the possibility of safety meant the eradication of difference" (Papps, 1997, p.104). Within three decades from the 1932, (AJHR) report 95% of Maori women were birthing in hospitals (Smythe, 1998).

Maori values associated with women and childbirth

Muriranga-whenua

"I have come to ask for your jawbone which will help me in what I want to achieve." So I replied, "That's right. I have been expecting you. You may as well have it now since parts of me are already dead from starvation." ... "It is my gift to you," I said, "and through you it is my gift to the people of the earthly land." (Kahukiwa & Grace, 1984, p.52)

Mana Whenua

The bones of buried tipuna (ancestors) and blood spilt in the defense of territory over generations consecrated the land as a gift from the ancestors to their descendants and future generations. Subsequent generations are bonded to the land at birth by the custom of planting the whenua (afterbirth) and the pito (umbilical cord). This is known as iho whenua (Walker, 1990). The iho is the core, the nucleus of the cord which links the child to the whenua, symbolising the connection to the land.

The Maori loved his land and identified with it. His close spiritual relationship with the land stemmed from his traditional concept of the basic origin of mankind deriving from the loving union of the earth mother, Papa-tu-a-nuku, with the sky-father, Rangi-nui-tu-nei" Sinclair (cited in Durie, 2001, p.35)

Large scale alienation of Maori land in the nineteenth century had far reaching implications for health and disease. Historically population decline was associated with losses in war, confiscation of land, and with it the loss of mana, epidemics, and the vilification of core features in Maori culture. Health and well-being are linked with tribal land ownership - mana whenua. The separation of Maori from their land had social as well as

economic repercussions. Land was part of the internalised identity that provided individuals and groups with a tactile past, a *turangawaewae*, a place to stand where they were able to feel secure, self-assured and supported. Customary land was owned collectively so that individuals were united by common shares in large expanses of land, as well as by the blood ties (Durie, 2001a). A direct result of land losses has been the dissolution of Maori social unity. The need to remain together to provide mutual support has diminished. An important foundation for health, the *whanau*, has weakened at a time when it is most needed. The continuation of the *whanau*, *hapu*, and *iwi* are the joint responsibility of *mana tane* and *mana wahine*.

Mana Tane

Tane is the name for man - Tane was *tapu* and represents the 'mauri' or life principle. The male genitalia were a prized object for show, particularly when performing the *haka*. Tipene-Leach 1977 (cited in Rimene, 1998) explains that the *haka* is an unashamedly male phallic ritual, when the male extends his tongue full length; it becomes the symbol of his manhood. Male virility is highlighted throughout traditional stories. As men develop from boyhood to manhood the genitalia become especially important because they not only symbolise his manhood, but they also represent his future descendants, and the continuation of *whakapapa* into the next. Women and the land are the reason that men went to war.

"He wahine, he whenua, ka ngaro te tangata"
 "For women, for land, man dies"
 (Rimene, 1998, p.36).

Therefore *mana tane* is embodied in man's responsibility to protect the things most precious, women and land.

Mana Wahine and Te Whare Tapu Tangata

Whakatauik/Proverb:

“E tama kei roto i te kura waka,
i te huaki pouri,
nau mai, haere mai”

“My child, who lies within the womb
on the edge of darkness,
come forth into the world”
(Rimene, 1998, p.42).

Szaszy explains “Women have mana that is unique and exclusive, because a woman is Te Whare Tapu Tangata - the sacred house of mankind. She carries and gives birth to the next generation” (cited in Ihimaera, 1993, p.287). Ukaipo refers to the place of nurturing, specifically the place where a person is suckled. Papatuanuku, the Earth Mother, with her partner Ranginui, the Sky Father, are the primeval parents of humankind. They gave life to many children, including Tane Mahuta, God of the Forests. He in turn created the first human person, Hine-Ahu-One, created from out of the earth itself and brought to life by the breath of life - ‘Tihei mauri ora’. Because the first human was a woman, their mana is recognised as unique. During menstruation, pregnancy and childbirth a woman is considered tapu. Tapu is a very complex concept with no direct meaning in English. Its meaning depends on the context in which the term is used. Missionaries gave it connotations of ‘holy’ or ‘sacred’ but there is more to it than that. It can be used as a noun, meaning a ceremonial restriction. For Maori the importance of tapu lies in the power and influence of the gods. After the birth of a child, the practice of burying the placenta or afterbirth in the ground is believed to strengthen the child’s ties to the land. The placenta is considered to be part of the person and for many Maori both rural and urban, it is not appropriate to simply discard it. If possible the placenta is returned to the home marae (turnagawaewae), however, if that is not possible then burial under a tree is acceptable (Parsons, 1984).

Relevant treatment approaches for Maori

Hine-nui-te-Po

It was because of shame that I left the world of light for the dark world, and promised to await my children and their descendants to welcome them here in Rarohenga. Now the time is near. (Kahukiwa & Grace, 1984, p.58)

To date there has not been a study of Maori women diagnosed with a mental illness and the impact pregnancy and childbirth has on them. In order to understand the culture of any ethnicity, a collective mass of cognitive schema needs to be employed. This can be accomplished by studying the culture of a person (as this study aims to do), the general behaviour that is appropriate for that particular grouping, their beliefs and worldview. By analysing the order of things for Maori, what their reality is, who they are and where they come from, a clearer picture of their mental health needs may emerge. Attention to ensuring that each person is treated as unique is important, as their individual perspective of their own culture may well contain variables (Castillo, 2003).

Incorporating cultural assessments as part of a mental health status exam, in order to gain a better appreciation of cultural identity and its relevance to mental health, will provide an opportunity to formally assess participation in, and access to, Te Ao Maori. When cultural assessment is used collaboratively with conventional clinical and social assessments, the opportunity to facilitate a more comprehensive and relevant treatment plan is likely to emerge (Durie, 1997).

Tensions between cultural perspectives can partially be resolved by consonance between paradigms, which should not be seen as opposing but as complementary. Positive implementation of cultural collaboration is essential to the provision of appropriate mental health services for Maori. An example of this exists in the Ministry of Health's Mental Health 'Blueprint', in which recommendations specify what the essential service components should be (Refer Appendix V).

According to Richie, 1964 (cited in Sachdev, 1989) the statistics available on mental illness in Maori are notably limited. The majority of published data is hospital based. No complete population surveys have been conducted from an ethnic viewpoint, with the exception of studies of alcohol abuse, and women's health, which were restricted in their aims. Richie completed a (limited in scope) study of Maori families, particularly women, in the Wellington region to determine the impact of urbanisation. She concluded that, on the whole, adjustment of women was good and they did not require much participation in Maori activities to maintain good psychological adjustment in the urban environment Richie 1964, (cited in Sachdev, 1989). However, a health survey study that included information on life style, attitudes toward health care and delivery, and the importance of Maoritanga to one's reality, conducted by the Maori Women's Welfare League in the Bay of Plenty, South Auckland, and Waikato, identified common problems of depression, asthma and bronchitis. The study with a response rate of 95% showed a strong correlation between socio-economic status and social problems; women with economic difficulties registered poorly on a number of indices. Smoking and obesity emerged as primary problems. The urban group was also identified as being at risk of losing its "Maori identity" through non-adherence to Maori cultural practices. Murchie, 1984 (cited in Sachdev, 1989).

There is, furthermore, a study currently underway by the Department of Maori Studies at Massey University, which is undertaking an extensive survey of 500 Maori households in four particular regions of New Zealand: Auckland, Tairāwhiti, Manawatu-Wanganui, and Wellington. This longitudinal study is tracking the progress, problems, aspirations and circumstances of Maori people from a diverse range of lifestyles. The study known as Te Hoe Nuku Roa, will be conducted over a ten or fifteen year time span. It will investigate the realities of Maori lives and explore social, economic and cultural indicators, which can then be analysed and synthesised to gain an integrated account. An important element of the study is cultural identity. In the study cultural identity is conceived as the fusion of personal perceptions, cultural knowledge and participation in

Maori society (Durie, Black, Christensen, Durie, Fitzgerald, Taiapa, et al., 1996).

Clearly, the diagnosis and treatment of mental illness should not be isolated from its cultural paradigm. Without a doubt, the manifestation of illness and subsequent treatment need to be inclusive of relative worldviews in order to ensure optimal outcomes. To base the management of care by using a diagnostic interview schedule and treatment approach that universally assumes only one interpretation of a particular human experience across all cultures, can only be considered folly.

CHAPTER FOUR: METHODOLOGY

The research methodology selected for this study was Phenomenology. The aims were to explore how pregnancy and childbirth affected women diagnosed with a mental illness, and whether current mental health and obstetric services were appropriate to their recovery, and if not, what interventions would have been more appropriate to meet their needs.

The choice of a qualitative methodology stems from the partiality of the researcher, to find out what the participants' lived experiences of a mental illness diagnosis meant to them and its impact during pregnancy, childbirth, and the immediate postnatal period. Qualitative research allows the researcher to investigate specific areas in a great deal of depth. It also allows for diversity and difference, with an emphasis on the 'texture' of the data being collected and is better able to grapple with complexities and pluralisms. Qualitative research data collection is generally more flexible than quantitative data collection. Qualitative research is inductive, and generates theory from (supposedly) atheoretical observations. One method of qualitative research data collection is the unstructured interview; the use of un-structured interviews enables the researcher to draw firmly on impressions, descriptions and quotes, while valuing personal involvement and subjectivity (Davidson & Tolich, 1999).

Phenomenology: A study of 'lived experience'

Qualitative research has been employed in this study because this methodology encompasses techniques which are not statistically based, and are best suited to the small participant numbers being studied. As well, it is suited to the small-scale analysis that occurs when attempting to know the social world being studied first-hand. In this current research participant interviewing in an in-depth and un-structured way are the chosen data collection methods (Finch, 1986). A qualitative approach also allows the researcher to discover hypotheses (not just test them) and to alter the direction in the course of the research. Rist, 1984 (cited in Finch, 1986, p.6) describes this as "...a different way of knowing – one

based on experience, empathy and involvement" A different way of knowing also resonates with the notion of examining meanings, as opposed to looking for the causes. Social qualitative research tries to uncover the meaning of social events, based on the lived experience of human society from the person's point of view (Finch, 1986).

Consequently, phenomenology, as a methodology would seem to be an appropriate vehicle to understanding an individual, group or society's lived experience of phenomena. Phenomenology began as a philosophical movement during the nineteenth century known as the era of 'Enlightenment' (Sarter, 1988). Edmund Husserl is credited with instituting the fundamental principle of phenomenology, although Brentano, (Husserl's mentor) can be credited as the immediate precursor of the phenomenological movement. Omery, 1983 (cited in Sarter, 1988) describes Husserl's expression "back to the things themselves" as the determining theme for phenomenological research. Other philosophers including Hume, Meinong, Brentano, Avenarius and James approached phenomenology along similar lines to Husserl (Mall, 1973). Husserl was a mathematician, but he was not blinded by the limitations of mathematical sciences. He never tired of repeating that his method consisted of 'showing', or 'pointing' to what is given. It is this given that is the point of phenomenological illumination. He was emphatic that the whole direction of phenomenological philosophy is directed towards the objective in the sense of being 'a given' as a correlate to the varied acts of intentions or as Mall describes it:

In order to guarantee the scientific character to any serious human inquiry, the point of departure must be the casting of a philosophical doubt upon the implicit presuppositions of all habitual thinking – scientific or otherwise. (Mall, 1973, p.10)

Husserl's phenomenology evolved from considerations in the field of mathematical logic to deliberations in the field of philosophy and history. This is not to say that phenomenology is anti-scientific, or that it ignores

empirical observations, analysis and acumen - rather that it wants to establish the definitive basis of all constitution and foundation. Phenomenologists want to work out the most original and ultimate ways and means, which can always be reactivated in order to trace the meaning of experience in its multiple contexts and its diverse layers. Philosophers have always struggled with the concepts of 'experience' and 'reason' in particular. The opposing views that they give rise to; the consequence of surrendering one, at the expense of the other, results in a divide between the two theories that is rarely bridged. "A phenomenological description deals with what is given in experience as such, with experiences just as they are in themselves" (Farber, 1966, p.44). Phenomenology can be interpreted as comprehending, clarifying and explaining the phenomena. The phenomenological philosophy is not a 'static' one, with metaphysical beliefs and attitudes. It is more or less a method of search for the 'noetic-noematic correlativity'. Husserl's phenomenology advocates a way forward in an attempt to untangle the problems that beleaguer the concepts, 'experience' and 'reason' (Mall, 1973).

Phenomenology in itself is a simple enough notion, and phenomenologists appreciate it as phenomena that present themselves directly to us as conscious human beings (Crotty, 1998). Phenomenologists recommend that, if we set aside, as much as we are able, the prevailing perceptions of those phenomena and revisit our immediate grasp of them, possibilities for new meaning surface for us. We are automatically programmed to draw on language and culture, so, it is about saying 'no!' to the meaning system bestowed to us. Though at times, this immediacy of – the 'things themselves' – may prove elusive to us, the intent is not to end up with a pre-suppositionless depiction of phenomena, but a reinterpretation – as new meaning, fuller meaning, or renewed meaning. This to the phenomenologist is the true essence of phenomenology (Crotty, 1998).

In the 1960s when phenomenologists such as Van Kaam, Giorgi and Colaizzi began expounding their step by step methodologies for phenomenological inquiry, humanistic psychology was already centre stage, and not about to cede its hold on the audience. They advocated that each of us must explore our own experience, not the experience of others, arguing that no one can take that step 'back to the things themselves' on our behalf (Crotty, 1998). The phenomenologist's important task then is to assist with the process of diversity and variability of human experience, as opposed to identification of essences to attempt to get inside someone else's experience as they express it (Spinelli, 1989).

It is a curious fact that numerous reputable scholars failed to comprehend phenomenology at any stage of its development. This was due in large part to their inability to depart from a rigorous scientific philosophy, and a perceived notion that phenomenology intended to substitute the methods of causal research with conjecture. (Farber, 1966). However, Husserl's aim was to establish a new science, a science of consciousness, which was not psychology. It was a phenomenology of consciousness, rather than a natural science of consciousness. He was forthright in his belief that phenomenology and psychology must stand in very close relationship since both are concerned with consciousness, albeit from a different delivery, and standpoint.

Psychology emphasises empirical consciousness, and tends to pathologise human experience. In particular, Husserl viewed experimental psychology as 'originary' psychology rather like social statistics is allied to 'originary' social science. Social statistics admittedly gather useful facts and detect valuable regularities in them; however, they are of a very indirect type. Furthermore, Husserl maintained that no experiment could contribute to the analysis of consciousness itself (Farber, 1966). Interestingly, phenomenology found a far more sympathetic arena immediately in its application to psychiatry. Professor Karl Jaspers was one of the precursors in this movement. Brentano,

Husserl and the later influence of Heidegger is apparent in the direction taken by the Swiss psychiatrist Dr. L. Binswanger, among others. The 'inner' approach of phenomenology is a complimentary mechanism for reconstructing and evaluating the meaning-world of the participant (Farber, 1966).

Natural science versus psychology

The natural scientist's journey is based on 'normal' and acceptable human inclination. He/she inserts a distance between his/her theoretical content and his/her everyday experience. For instance a philosopher may seethe about the ills of technology, all the while hammering out his theories on a computer. Colaizzi states that "It is not unusual for people to insert a distance between their theories and their experiences" (Colaizzi, 1978, p.59) On the other hand there is an expectation that with psychology, there be a closer tie-in between theory and experience in psychological inquiry. This difference was never more apparent when in 1879 Wilhelm Wundt gave birth to scientific psychology, which is underpinned by the 'experimental method'. Thus human experience was purged from psychological methodology. The experimental psychologist's penchant for operational definitions, and objectivity, results in there being as little as possible recourse for human experience. Furthermore, by designating phenomenon strictly in terms of measurable, observable, and readily duplicable operations it eliminates the validity of human experiences. Thus, to be objective from this perspective means using operational definitions as methodological principles that pre-determine and demarcate the content of psychological inquiry. In other words psychology traditionally insists that its method dictate what its content should be (Giorgio, 1970).

The phenomenological researcher's important task is to interpret accurately the lived experience of those participating. Moreover, "...the very worth of a phenomenological portrayal of reality must be judged in terms of how validly the researcher represents the experiences of those

who live the reality" Swanson-Kaufman & Schonwald, (cited in Sarter, 1988, p.98).

Because of the nature of phenomenological inquiry, there is no clear beginning or conclusion. A concerted attempt must be made to negotiate the empirical and the experimental. Colaizzi, 1978; Giorgi, 1970; Marton & Svenson, 1979; (cited in Sarter, 1988), describe four fundamental strategies inherent in each method. These are:

1. bracketing
2. analysing
3. intuiting and
4. describing

These are useful processes for getting back to the core issues.

Bracketing is a mechanism used to meet the ethical dictum of portraying precisely the reality of the phenomenon as it is lived and described by the researcher's informants. It is an essential component to avoid the following pitfalls.

1. The researcher's assumptions, prior to and during the gathering of data.
2. The researcher's inability to elicit and hear the reality of the informants experience.
4. Influencing the informants' interpretations of their experience (Sarter, 1988).

Researchers bring an assortment of intellectual 'baggage' to the tasks they embark on. Bracketing – a term coined by Husserl forces the researcher to avoid imposing their own beliefs, prior knowledge and judgements on the data, if they are to be true to the method (Beck, 1992). Other authors Bowman 1991; Breault and Polifroni 1992; Dobbie 1991; Hauck 1991; Montbriand and Laing 1991; Newman and Moch 1991; Wolf 1991; and Zwerwekh 1999; (cited in Crotty, 1998) suggest alternative terms; such as 'suspending' (of one's beliefs and assumptions). Lethbridge emphasises that bracketing requires that investigators' reflect

on their past and recent experiences so as to keep the meaning of those personal experiences disconnected from those revealed by participants (Lethbridge, 1991). By employing bracketing the researcher is able to focus on the respondents' experiences (Dobbie, 1991). Despite the complexity of trying to cast aside one's presuppositions, bracketing constitutes the starting point for research. It is intended as a sincere attempt not to accede to one's beliefs and assumptions to shape the data. Instead, the information must be allowed to 'emerge' in its own form and 'speak for itself' (Crotty, 1998). By preparing themselves for the task of data-collection and data analysis methods using bracketing, phenomenologists endeavour to hold their own preconceptions and presuppositions in check. They devise a data-collection process that attempts to rule out any impediment of interpretations from without and permits the themes to emerge from the data as spontaneously as possible.

Phenomenological analysis involves identifying the essence of the phenomena being investigated, based on the information obtained. Colaizzi describes the analysis of data thus:

1. Reading the descriptions
 2. Extracting 'significant statements'
 3. Formulating meanings
 4. Organising formulated meanings into clusters of themes
 5. Exhaustively describing the investigated phenomenon
 6. Validating the exhaustive description by each respondent
- Beck 1991, 1992; Rose 1992; Wolf 1991 (cited in Crotty, 1998, p.22).

The researcher listens to descriptions of quality of life and sits with the data. Common themes or essential qualities begin to emerge. In order to get an accurate and unadulterated description of the informant's experience it is sometimes necessary for researchers to immerse themselves in the data for as long as it takes. This may necessitate the reading and re-reading of the verbatim transcriptions in order to identify

how themes connect in order for the final analysis to be comprehensive and exhaustive (Streubert & Rinaldi-Carpenter, 1995). As well, the researcher should check the authenticity of the data with the participants to ensure the description reflects their true experiences.

Intuiting is a description of the personal link to the other's reality (Sarter, 1988). The outcome of phenomenological inquiry dictates that the researcher has the ability to engage with the informants' realities. This does not mean that the researcher has to have lived the studied phenomenon, but rather that each informant's story is approached with an emphatic recognition. Noddings 1984 (cited in Sarter, 1988, p.101), describes this experience of intuiting as one who cares and endeavours to understand "...as if the other's reality were her/his own".

Describing the process for the conduct of inquiry is complex, and often difficult to write about. Deriving a model for phenomenological inquiry should be universal enough to apply to each informant; the key elements should be simple and straightforward. Approaching the subject matter and the participants with a sense of wonderment, empathy and appreciation is vital to the process. Adeptness and a willingness to take chances are often the only means the researcher has for entering, sharing and reporting on the reality of others (Sarter, 1988).

Phenomenology resonates remarkably well with a Maori world view. This is because tikanga Maori is an oral culture based on narratives. It is in the story telling and the re-telling of stories that has brought many Maori to understand who they are and where they come from. Whakapapa (genealogy) is the oral ritual of identification for Maori. It includes a rich textural history of not just tipuna (ancestors) past, but also how they connected to their environment, including the land, mountains and water. That New Zealand's North Island was fished up by Maui (Te Ika a Maui – The fish of Maui) is a myth Maori find quite acceptable. Maori history is suffused with stories of links between the natural and the supernatural and between gods and man.

Even though the geographical origins of Maori are unclear - somewhere called Hawaiki - Maori identify with these stories because they have always been there, handed down by word of mouth, generation to generation (Salmond, 1991). It is their reality, and a perfect example of returning 'back to the things themselves'. The significance of phenomenology to the participants of this study is also apparent, as they are the ones best able to express and convey their own experiences.

In the next chapter the research method used is described in detail.

CHAPTER FIVE: RESEARCH DESIGN

Participants and Recruitment

Women of Maori descent, who experienced mental illness during any stage of their pregnancy including the immediate postnatal period, were invited to participate in the study. The mental illness diagnosis (as defined by the DSM-IV) can have been an existing one, or one that developed during or after the pregnancy.

Gaining ethics approval

Endorsement for this study was first sought from the various managers within the District Health Board (DHB) involved. Their collective approval allowed me access to the next layer, which involved finding supporters within the various women's health care services to assist me in the recruitment of possible participants. Once initial support and approval had been given from this quarter, I was able to submit my research proposal to the Massey University Ethics Committee. From here I embarked on the journey that is the Ethics Committee attached to all government funded health services. Because I had requested Maori women who had accessed mental and health services through the DHB to engage in my study, I also had to seek approval from the Maori Research Committee. Approval was subsequently given by all of these committees. This whole process took about 3 months.

Procedure for data collection

Approval ultimately meant that there were clear boundaries in place, and also served as a safety net for the participants, and the researcher. Recruitment for participants was carried out by staff of the District Health Board Maternal Mental Health Service. The participants had all at some stage engaged with this service. This process was by random selection. Staff first contacted them by telephone and if interested the women were sent a participant information letter. In the letter they were asked to contact the researcher directly if they wanted to participate. This process was to separate the researcher from direct recruitment and potential

coercion. All of the participants were offered the opportunity to have a support person/s with them during the data collection process. They were also offered the option of being interviewed in Te Reo Maori or English. Subsequently, all participants opted to be interviewed in English and by themselves. The data was collected by way of face to face, audio taped interviews with the researcher.

The four criteria for inclusion in the study were that the women:

- I. identify as being Maori,
- II. had experienced pregnancy, and childbirth,
- III. had a diagnosis of mental illness and were considered stable enough to take part in the proposed study, as assessed by the Maternal Mental Health staff involved; and
- IV. there was no documented neurological illness, brain damage, or mental retardation.

The final sample consisted of seven women.

The researcher met with each potential participant individually. At the initial meeting the study was verbally explained and an informed consent form signed prior to being interviewed.

The women were asked the following question:

“What does the experience of pregnancy and childbirth mean to Maori women with a diagnosis of mental illness?”

I engaged twelve prompts to help guide the interview. These prompts were used as a guide only if the information was not immediately apparent in the stories. Where participants wanted to elaborate more specifically in any particular area then the opportunity for them to do so was available.

1. What does it mean for you to be Maori
2. Tell me how you felt when you found out you were pregnant....
3. What is your understanding of mental illness in relation to the diagnosis you were given
4. Tell me more about the services and treatments you received.
5. How did your pregnancy affect you in terms of feelings, thoughts, motivation etc
6. What whanau support did you have regarding your mental illness, and throughout your pregnancy
7. Did you experience any symptoms of your illness during pregnancy and childbirth
8. If so what symptoms did you have
9. Did you have a birth plan
10. How much involvement did you have in making this plan
11. Do you think the services and treatment you received were relevant to your physical, mental (and if applicable spiritual) well being
12. What changes would you make, if any, to the treatment you received

The data collection took place over a 6 month period. The interviews were all audio-taped and subsequently transcribed verbatim by a professional transcriber (who signed a confidentiality agreement). Later the participants were given a copy of their transcripts and asked to add or delete any information from it. Anonymity was provided by way of pseudonyms, or an interview number. I later decided not to use either of these systems, as I didn't feel they would be effective in maintaining anonymity. The reason for this decision will be discussed in the following section that describes Colaizzi's 7-step method for extracting and analysing data.

Data Analysis

Analysis of the seven narratives that allowed exploration of the women's experiences of being Maori and having a mental illness before, during or after pregnancy and childbirth was by way of Colaizzi's descriptive phenomenology. This is an inductive approach that describes a phenomenon as it is experienced by an individual, and discards operationally defined behaviour. "Objectivity is fidelity to phenomena" (Colaizzi, 1978) Objectivity from the view of the phenomenological perspective is a refusal to tell the phenomenon what it is, and listens respectfully to what the phenomenon speaks of itself. Thus, objectivity requires that one not only acknowledge and affirm one's own experiences, but the experiences of others.

The women's transcripts were read and re-read, as well as listening to the audio tapes. The tapes provided a more comprehensive understanding of the stories, as metaphors, tone inflections, emphasis and emotions came through as a more candid and explicit source of their experiences. The middle steps of Colaizzi's thematic analysis involved extracting 'significant statements' relevant to the women's overall experience of pregnancy and childbirth, in particular their perceptions of the obstetric and mental health treatments and services provided them. The formulated meanings were then sorted into theme clusters, and an exhaustive investigation began in trying to describe the investigated phenomenon. The final part of the analysis involved validation of the participants' descriptions. Colaizzi (1978) describes participants in a phenomenological study as co-researchers; this consideration allows the researcher to invite the co-researchers to validate the exhaustive descriptions.

An outline of Colaizzi's - seven step method – for extracting, and analysing data of this research.

1. Working out how to sort the data:

"Acquiring a perception of each transcript" (Colaizzi, 1978)

First of all I listened to each of the tapes after the interviews. I did this either the same day or very soon after, as I wanted to be able to recall the interviews as clearly as possible from the perspective of just listening, and not having to worry about the interview process, and whether the tape was going, or any of the other environmental influences that take place during an interview. At this stage I took particular notice of the language, and inflections of the participants, making notes in particular, of any 'emphasis' the participants' conveyed. I then sent the tapes to the transcriber 1 or 2 at a time.

Once the transcripts were returned to me, I read through the descriptions making notes in the left hand column (relating to questions I had about responses). In the right hand column I made more specific notes about what the participant's response to the prompts were. Initially I was unsure about how I would sort out these preliminary findings, and decided on a code system that I would be comfortable using and understanding. I finally decided that I would use a table to sort out the data. Initially I made five, and then seven rows to represent the major themes I thought had arisen out of the transcripts. Then I made seven columns to represent each of the participants.

From here I reviewed the possible themes and then listened to the tapes again. I made more notes reflecting on the draft themes made, and tried to distinguish whether there were any sub-themes within the themes already made. Eventually three major themes emerged from the data; and subsequently nine sub-themes from these three major themes.

2. Method for extracting excerpts from interviews

"Extracting significant statements" (Colaizzi, 1978)

Initially, each excerpt was going to be identifiable by the interview number, page number and paragraph number; as follows:

Interview #

Page #

Paragraph

Example (6,15,4)

In the main, the excerpts were extracted verbatim. However, I endeavoured to keep participants identities as anonymous as possible, and so some of the excerpts from the interviews will read (for example) like this:

My friend (name omitted)... was with me,
and my husband (name omitted)...
or My Mum (name omitted)...

This system was also used when words were inaudible, or there was a pause in conversation.

However, once I had completed extracting 'significant statements' I decided against using any sort of identifying system. This is due to the fact that the study is a very small one - only seven participants. I didn't want participants to be identifiable to anyone but themselves. When I sent copies of the data analysis and findings to participants I included this system, but have since deleted it from the actual thesis. I am extremely grateful for the participants' involvement in this study. I know for some it was very difficult and emotionally draining to relive their experiences. It was a privilege to have the opportunity to listen to their stories, and hear their voices. Some were very hesitant to participate, and I stressed to them prior to interviewing them that I would protect their identities. To have proceeded with any sort of 'anonymous' identifying system would have, in my opinion, breached confidentiality.

Consequently, the only demographic data available on participants is that they fit the initial criteria for the participating in the study:

Of the seven participants:

2 had a diagnosis of Bipolar Disorder

4 had a diagnosis of Major Depressive Disorder

1 had a diagnosis of Depressive Disorder with dysthymia

3. Deciphering meanings from extracts, and acknowledge pre-suppositions “Formulation of meanings” (Colaizzi, 1978)

This stage required me to acknowledge my own experiences, and assumptions based on what I had observed when working in the area of maternal and mental health, and to comprehend what the participants were trying to say. This is known as phenomenological reduction or ‘bracketing’ (Saunders, 2003).

It was important that I not try to make the data fit the theory, that is, to ensure that I did not formulate meanings which had no connection with the data. Doing this would have resulted in imposing conceptual theories upon the data, and consequently not allowing the data to speak for itself. To guard against this and ensure rigour I had my supervisor critique my work regularly, during each section of the analysis. I also sought the opinions of experienced researchers through Massey University.

Whilst sifting through the transcripts, commonalities and differences between the participants’ experiences began to emerge, which means that during these procedural steps there is often overlap when trying to extract specific themes. Colaizzi’s methodology allows for this, and maintains that “...procedures and their sequences should be viewed flexibly and freely by each researcher, so that, depending upon his approach and his phenomenon, he can modify them in whatever ways seem appropriate” (Colaizzi, 1978). Given that the interviews were semi-structured questions this was unsurprising. The following table provides some examples of how significant statements were translated into more general formulated meanings to describe mental illness.

Table one

Generating formulated meanings from significant statements –
Participant descriptions of experiencing mental illness

Significant statements	Formulated meanings
Just for myself personally, how bad my life had become. It is not until you are sitting there, really having to explain it to someone that you really realise.	Speaking to someone and describing how bad things had become, made this participant realise the enormity of what was happening.
It didn't worry me none the least, cause all that mattered to me was flip man I need some help, man. I don't care what it is that I've got.	Being diagnosed/labelled was irrelevant in the face of what was happening.
Postnatal depression so... I think I was happy to actually find what the problem was at the end of the day	Being diagnosed provided answers to what was happening.
I don't know what was wrong with me. I went to the Doctor and asked if there was anything that they could do to help me. I was so desperate.	Feeling desperate enough to seek help.
I just felt like I was in the dark, in a big hole, and I couldn't get out at all, I thought I was going to be there forever.	The metaphor of a big dark hole describes feelings of utter hopelessness with no end in sight.
I could see the whole world below me. I was so high I could see the whole world below me, I was in the universe; I was in the universe, high as a kite.	Vivid description of being as high as a kite describes the experience of a hypo-mania.
Well it was a bit of a relief. There was an excuse for why things have been so crazy.	Relief at finally having answers to the craziness that had been going on

4. Themes "Organising amassed formulated meanings into clusters of themes" (Colaizzi, 1978)

Like the preceding step, validation needs to occur to ensure the original protocols are adhered to. In other words, ensuring that there is not anything in the themes or clusters of themes, that was not in the original

transcripts and ensuring that there isn't anything implied or proposed that wasn't there originally.

Once significant statements had been extracted, themes began to emerge. Three major themes were dominant in all of the interviews, which then gave rise to sixteen sub-themes.

5. Exhaustive descriptions of the phenomenon (Colaizzi, 1978)

Colaizzi's fifth stage of analysis requires that the results of data analysis so far collected are collated, and integrated into an exhaustive description of the topic. The discussion chapter will reflect this. Extensive quotations are, therefore, used from the participants in order to provide maximum opportunity for their voices to be heard.

6. Fundamental structure of the phenomenon (Colaizzi, 1978)

The information gathered from the participants allows hidden meanings of the familiar to emerge. It is not so much a creation of a new meaning, but a new way of seeing. This allows for a re-evaluation of one's perceptions of the phenomenon and a fresh aspect can be embraced.

7. Final validating step – returning to the participants

A final validating step was planned by returning the data analysis to each participant. In the end I sent letters to four of the participants (three had moved address, with no forwarding contact details) explaining how the three major themes were extracted, asking them whether they thought the summary a true account of what they meant to say, and whether they felt the extracted excerpts fit with the themes they were located in. Subsequently, the four participants who received the data analysis had no objections to the way their accounts were written up.

(Refer Appendix VI)

CHAPTER SIX: FINDINGS

This chapter looks at the findings of the interviews that address the research question:

What does the experience of pregnancy and childbirth mean to Maori women diagnosed with a mental illness?

A thematic analysis was used to identify the themes and subsequently the emergence of sub-themes, and formulated meanings from the narratives. Three themes emerged. Each theme will be described and excerpts from the narratives given. The formulated meaning for each theme has been summarized as a question.

Themes and sub-themes

Theme 1: Identity

Formulated meaning: Who am I?

Sub-themes

1. Maori Identity
2. Factoring in mental illness
3. Motherhood and mental illness
4. Partner relationships

Theme 1 Identity: Who am I?

Maori identity

Growing up in an environment where there was access to 'those things Maori' helped some participants more openly identify as Maori.

"I don't see myself as... I don't know what the typical Maori is, where I come from all of us went back to the Marae, so I was really lucky in the sense that... as a child at our Marae... deep within protocols and cultural Maori formalities. I guess, you know, you didn't think of it ... a Marae for us was... that's where you go for holidays, everybody sleeps together, eats together, all your cousins were there together... so yeah that's what it (being Maori) meant to me."

"My mother was a radical Maori; she got herself in heaps of trouble. She was never anti-Pakeha, she was very pro Maori but on the same account, I kind of went through a phase where I actually tuned her completely out. I didn't want to hear about it. It wasn't until I went through university that I started to think, actually mum told me this stuff, she did, and now I am reading about it. I thought about it in the lecture theatre."

For some identifying as Maori was less clear (not necessarily to them, but to others). This was due in large part to their physical appearance. The less like a Maori one looks the more likely it would seem, an explanation is required.

"I had always associated myself with being Maori, from school I did anything associated with being Maori... cultural groups, I tried to involve myself in anything... Yes people said, what nationality are you? You say you are Maori... and? And what? I was like I'm Maori. It gets really annoying."

A common occurrence for some of the participants, was when they had limited knowledge of Tikanga Maori, and looked even less like a Maori. This excerpt describes how this situation can present itself.

"...Some of the papers that they get you to sign, "What is your ethnicity?" I will sometimes put Maori and Pakeha, tick both of them, and other times I will just tick Pakeha. It depends on how I am feeling I think."

Being perceived as 'different' was the case for some participants, and interestingly more keenly felt in New Zealand than when abroad.

"Being Maori became more of an issue when I was identified by other people as being Maori. That is when I started to realise that I was in fact different, because before that I wasn't different and that kind of stayed until I went overseas."

In every case where there was knowledge of tikanga and te reo Maori, identity as a Maori, was more positively perceived by participants.

"Being Maori gives me pride; it gives me a feeling of belonging. Where I come from I speak the language and I try to practice tikanga Maori in my home environment as much as possible."

For many of the participants trying to determine where they fit in contemporary society is an ongoing dilemma. According to the Commission on Human Rights, 2004; (Durie, 1997) strengthening cultural identity has been recognised as essential for optimal mental health growth. In addition the longitudinal study Te Hoe Nuku Roa about Maori whanau, suggests that those who have a positive, confident cultural identity are more likely to have some defence against ill health. Moreover it gives Maori the impetus to empower and improve their educational and employment prospects (Durie, 1996).

Because identity represents the imprint of a person's heritage, values and personality, it has the ability to impact hugely on a person's day to day relationships, particularly those relationships outside of one's immediate family. Society has set 'social norms' that by and large most people accept. However, if those perceived norms – put together by the dominant culture - are not adhered to, or if someone deviates too far from society's model then an underlying uneasiness can result. Difference is not necessarily something readily accepted or tolerated. Almost, always this disquiet can be directly attributed to ignorance and or prejudice. This palpable unease may not be overt, but can manifest itself via verbal and body language.

"I suppose because they are used to seeing so many down and out Maoris, when... like they came to our house... I keep a tidy house and we have nice things, and they kind of look at you like, you don't really need their help. Like they would make comments... oh, that's a nice TV, that's a nice car you are driving and they have all done it. They have all done it. It does it really annoys me. You don't fit the normal visual criteria of what a down and out Maori is supposed to look like."

"I didn't feel like she was a good midwife at all because of a couple of things that she had done and I still continued with care because I thought I was just being a bit sensitive, being pregnant... I fired her, if you can fire... firing her and um... afterwards I thought maybe she was a little bit funny about me being part Maori. I can't say whether she was or not but I just... you know how sometimes you get a gut feeling."

Identity as a Maori (or just being seen as a brown person) and the midwifery care received by participants, impacted hugely on their experiences of pregnancy and childbirth.

"Yeah, had him in hospital. I will tell you right now I will never have any baby at the hospital... never ever, ever again – no. I am going to teach my boy to bring his own children into the world. Don't let any stranger do it. Some people are PC, but not everyone. – The midwife was cold. I didn't notice I was in far too much pain, but my Mum noticed huge amounts."

During labour a friend came to support her at the hospital.

"She said to me later, that midwife changed when I came into the room didn't she? I said she sure did... She said is that why you had me in there? I said no, I had you in there because you are my friend. She says, but she changed because I was white eh? I said, absolutely. She became more professional. Do you know what I mean?"

Factoring in mental illness

Trying to find where you fit as a Maori women in New Zealand society is one thing. The added stress that pregnancy often brings is another. But having to also contend with all that 'mental illness' gives rise to, is quite another. The seven women in this study experienced all of these factors. The following excerpts describe what it was like for them being diagnosed with a mental illness, and their feelings and thoughts about the impact that mental illness had on them.

"Just for myself personally, how bad my life had become. It is not until you are sitting there, really having to explain it to someone that you really realise that - I have been living in this black hole for a long time, actually. A lot longer, than I had thought."

Finding out what was happening to them, that is, being given a 'diagnosis' had a huge impact on participants. Particularly in terms of the symptoms, that had manifested over time.

"Um... it didn't worry me. It didn't worry me none the least, cause all that mattered to me was flip man I need some help, man. I don't care what it is that I've got, I've obviously got something and even before it was"

happening, even before I'd been diagnosed I kind of had a feeling that I might go down that track with a lot of the other stuff that was going on."

"Post-natal depression so... I think I was happy to actually find what the problem was at the end of the day. It was like oh, there is a reason why. If you can be happy (laughs), and happy that the Doctor could suggest that medication was what would help me and... yeah. So that was fine."

"Well it was a bit of a relief. There is an excuse for why things have been so crazy, why I have been doing this and that. It was like, oh yeah, there is an excuse and all the reasons why things were like that. I was really blaming... it took me awhile to understand the bipolar. I was constantly asking questions. Why is this happening to me - has anyone figured out how to cure bipolar?"

Not knowing what was happening, had in one case caused such despair that seeking a drastic solution, or way out, was considered the only option.

"I don't know what was wrong with me. I went to the Doctor and asked if there was anything that they could do to help me. I was so desperate. He put me onto some Arapax because I found I was constantly... and sleeping pills because I wasn't sleeping well, and I think I was psychotic at the time. I was hearing voices. It was a low mood when I first went there. When he gave me medication the mood was... I just felt really low and I took the pills hoping to...(You tried to overdose?) Yes. Still not knowing what was wrong with me."

Feelings of isolation featured significantly for many of the participants.

"I don't know, I started to feel very isolated and then my moods just went very... really down, like to a real low point where I just felt like I was in the dark, and in a big hole, and I couldn't get out at all, and I thought I was going to be there forever, cause it just felt that bad at the time."

Misdiagnosis had occurred for one of the participants and subsequently she was prescribed inappropriate medication. This in turn had caused psychotic symptoms to occur.

"I was diagnosed... about a year ago. Really recently. - Halfway through all these incidents I found myself getting quite depressed. I felt the need... after the man's suicide, I found the need to go onto antidepressants, so I approached a GP... to start Arapax, and I think four to six weeks later... I was so

high I could see the whole world below me. I was in the universe; I was in the universe, high as a kite. I was given... a hyper-manic episode induced by Arapax."

Motherhood and mental illness

All of the participants' experienced some sort of inadequacy during the pregnancy and/or postpartum period. This is not an uncommon occurrence for any new Mother who has to adjust to a new identity. Where the participants' mental illness was impacting on their ability to care for their babies, or their perception of how they could or should be caring for their babies, this was something that was detrimental to their confidence, and general wellbeing.

"When I was pregnant I was very... as I said, I was really scared and anxious because I didn't know anything else apart from having postnatal... well, depression really. I was shit scared to go through it with another baby and that's why I didn't really... I didn't want to have another Birth if that was going to happen."

"Yeah. I just still wasn't good. I wasn't doing anything. I couldn't do anything. I couldn't look after baby and... that's right I really felt like I was around people who didn't understand what I was going through. I don't know... my Mum was kind of like, come on... get up and do this and that, and stuff. She just... I just felt like she so didn't know what I was going through of course because... you know... they haven't been there."

I tried to be this perfect mum. I found two years down the track that I was still not happy. "What Happened? I think I started drinking; actually it made it worse, because what happened, I fell pregnant two years later. There was no way... absolutely no way I was going to have that baby. I will say depression now, but then, I never knew what it was."

Becoming a parent means adjusting not only to a new role but also a new dimension in one's relationships and *identity*. The experience of parenting for participants ran the gamut from serene bliss to utter despair.

"The pregnancy was beautiful. It was the most beautiful experience I have ever had in my life, having... yeah... going back to that thing, the contributing stuff. Physically I was very healthy. I am sure that was definitely having

some effect on my mentality. It was just beautiful, yeah. But the stuff I had to that... When it was confirmed that I was pregnant... I was attached. I have never... I don't know... do you call being detached when you are really shitty and real angry towards them? I felt like I wished she (baby) just wasn't around. I really felt like that."

"That was one thing that we all admitted to in the group, you do, you put on this front, but underneath you are crumbling, totally. It's a big effort putting on those acts. Even now when I think about it, I can't even remember the first year of her life."

Partner relationships

As one's identity is closely tied to one's relationships the following excerpts give a brief description about the responses the participants partners' had, particularly, around the time of conception, during the pregnancy or post-natally.

The strain on relationships being a mother with a mental illness.

"There was a great strain on my relationship with my child's father because I didn't feel he was being very helpful or supportive, which made me feel quite depressed, but I was still doing okay with him and I pretty much... I was looking after my child... every."

Telling the father of the pregnancy.

"I was already twelve weeks along in my pregnancy... well, fourteen by then. It was kind of like, you make a decision now and you live with it. Well, I chose not to have an abortion and then was like... okay, now I have made my choice, I have got to tell the father and his reaction... and he never wanted children... I had kind of made up my mind that I wasn't having children, not that I didn't want them... it was just... it wasn't a good idea..."

"Yeah, he was just as shocked... but happy, very happy. He had always wanted another child, whereas I didn't want any more children. He assumed everything from my previous pregnancy, which was great. So it should be... Get on with it. Be happy. I really suffered a lot in silence throughout that pregnancy."

"My partner wasn't too sure, but I was going ahead anyway. There was support there, mainly my mum and the father of the baby."

Falling apart in the relationship

"...this man kind of turned up from out of no where, and I have to say this, I saw him and thought, he would make really nice babies. I took one look at him and thought yeah he would make really awesome babies... It was a brief fling and then things fell apart three or four months later... Then the pregnancy itself, that was... I was pretty stable for the first three to six months but then I started getting really unreasonable, really irritable."

Getting support from the partner

"I would get a little bit emotional or a bit teary, but I would talk to Mum or my husband or... not often to a friend, it was usually just mum and my husband. My husband is a really positive person and I think that has really helped. He is not the sort of person who goes, oh for goodness sake, you are at home all day long, like some people I know. He is just like; you are just doing really well. Lots of positive reinforcement."

Summary

The theme Identity and its formulated meaning of – who am I? discussed what it meant for participants to experience identity as a Maori, diagnosed with a mental illness, motherhood and the relationships they had with their partners at the time. Participants talked about what it meant for them to be Maori. For those who had some knowledge or experience of tikanga, particularly during their formative years, identity as a Maori was something they felt more comfortable with. Those participants who looked "less" like a Maori felt they always had to explain themselves. Being perceived by others as being "different" also impacted on participants' sense of belonging and where they fit in New Zealand society. On top of this the experience of living with a "mental illness" compounded for participants' feelings of isolation and not fitting in. Becoming a mother meant adjusting to a whole new world, and impacted in various ways on the lives of participants. For a few it was a wonderful experience, but for the majority it only served to complicate and isolate them even further. What made a difference was whether they felt supported by their partners.

Often relationships suffered under the pressure of being a mother with a mental illness. For some participants their partner relationships fell apart, but when there was support and understanding the difference was huge.

Theme 2: Treatment approach

Formulated Meaning : What's happening to me?

Sub themes

1. Who is there for me?
2. Is it too much to ask to care for me?

Theme 2 Treatment Approach: What's happening to me?

Some of the participants were at a loss as to what was happening to them during and after pregnancy. Trying to find answers was not easy and often led to despair. However, when they got the proper support, specific to their circumstances, they coped better. Not all of them however, got the answers they were looking for.

"I never went back to him because... I don't know. I didn't get the answer I wanted the first time. So... I wanted someone to give me answers on what was going on with me. My mother wanted me to go to a Maori doctor, a Tohunga. My dad he came over and knew something was wrong with me and he took me to his doctor and I was really glad because I just needed an answer, what was going on with me. The doctor said I was suicidal and they rang the CAT Team."

"I bled right through. It was a very, very stressful pregnancy. Extremely stressful pregnancy and hard. I was in a lot of pain throughout. My pelvis was just... Um that... that pain actually was just from my baby growing. It was real sore. That is why they associated it with something else. But um... I ended up with pelvic anthropathy. My hips literally came apart. I was on crutches. I could barely walk to the letterbox. I was in a whole lot of pain. And yeah... just being thrust into, you're pregnant, having a baby you have got all these other things to worry about."

This participant also found it difficult to find a supportive midwife.

"I went through about three midwives... fired about three midwives. The first one was a shocker. Just told me I was going to have a miscarriage and don't worry about it."

There was a real need to try and find answers as to what was happening.

"I don't know why I got postnatal depression. I really don't. It was just there. I never had the feeling that I did with the other children and the other pregnancies and after the pregnancies, that I had with her. I have talked to quite a few people and my sister-in-law seems to think that... and it is only a theory, but it could be a very real theory, that it has got something to do with having a female child. That the hormones... her hormones and your hormones mixed together, actually fire and trigger something, because she had a bit of postnatal depression when she had her daughter."

Who is there for me?

The midwifery care that participants received had a huge impact on them, and generally not in a positive way. The lack of co-ordination and integration between midwifery and maternal mental health care caused additional worry.

"I don't know what you can change. You can't go back in time and have babies on the ground and have all the women in the village around you supporting you, but you can have a modern version of that, just knowing what services are available... Like, I didn't even know that there was a Maori Midwifery Team and it was just that I had Bipolar and the Maori midwife had experience in mental health, that's how that happened and it ended up that that she was part of a ... because I was going to one midwifery service; the lady said that I am not trained to take on somebody with bipolar. If anything happened mentally I wouldn't know what to do, and I think she was a bit scared of what people are capable of when they're not in the right frame of mind. So I was like it's okay! And so she said I am going to refer you back to... Hospital and they will find you a midwife that has experience in mental health... In the beginning was the midwife and the mental health aspect but it's not. So that being made quite clear would be a good idea, or even the idea of having midwives with mental health experience as part of the team, would be a good thing I think."

"It was... (nurse from maternal mental health) that was the mainstay of my mental health...and my mother's mental health. She was just real functional, you know. Get real. What you have got to do is keep yourself safe. You are going to get X amount of... per day, at the same time every day, you have got to, that kind of thing. It is not just the

breast feeding that is the problem it is the fact that it will wear you down. That is the kind of message she gave."

This participant was eventually hospitalized yet felt she lacked the attention she needed

"I was put in for observation at... (Hospital), that went to crap. They were useless, cold dirty environment and you know what, I only got attention when I walked out. I signed myself out. Also they got all really interested in my mental health... honestly they couldn't give me the time of day. So I went home... Pregnancy services were swarming over my house and then I had... yeah, yeah, the crisis team-like every day, until I spoke to them at the end of five days... I think I probably had every service that you can get publicly. They are not crossing over at all. No. When I went into the ward at (hospital) they were not integrated at all."

Lack of Maori health professionals is a real issue

"...there needs to be more Maori in the service. I guess... yeah, trying to get our people educated to take up these roles. Just see our people out there can be a big help. You go to all these appointments and there would just be Europeans. You think, oh, where are all our people? The services are there, probably, but I still think they need to be... you have got to be told about them... if you don't know, you don't know. I think specifically for Maori, they should be... it should be a given for either the GP or the midwife, to have all the information, services that they can tap into, given to them and not always having to ask."

Postnatal support is essential to prevent high anxiety and distress

"I had absolutely no idea what to do with a baby and yeah... I don't know how to look after one or... you know... so I was very anxious and quite distressed about being around him by myself, so yeah, I needed some help and got some there." - (Maternity home)

"I really looked forward to people visiting because I had six weeks when I couldn't drive. It was good of (nurse from Maternal Mental Health Team; name omitted)... to actually come and see me... I think every second week. I think more so... I know they were monitoring me very closely, which was really reassuring"

"I don't think I had time to concentrate on what was going on with me and then it was probably about 4 - 6 weeks, 4 - 8 weeks, I started to... she was in a little bit of a routine... not much, and then I just didn't want to go out anymore..."

My Mother had a friend who had really bad postnatal depression a few years back and she was a nurse and my Mum talked to her and she said I would like you to talk to her because she had postnatal depression and I think you might benefit from talking to her. I did, I rang her and she was really helpful. She said, are you sure you are okay? I said, yeah, I think I am fine. Then she said to my Mum, I don't think she is fine."

Social support is often observed against a backdrop of social stress (life events, persistent stress and daily irritations). These factors have been shown consistently as antecedents of a range of psychological and physical disorders.

(Mothers' PND Support Group)... "They had a partners night. That was good. That was actually the best thing out of the whole thing, the partners evening. I think all of us actually found that to be the most important night out of everything. Most of... all bar two or three of the partners came. My partner went. That was actually really interesting. Because of the way... the guy, he was excellent at getting the men to talk and actually hearing their side of it. Yeah, just their honesty. They were all being honest, so they all just opened up. Just hearing what he had to say and... it kind of gave clarification to a few things too... But actually hearing him say it, admit it, and he admitted that he buried his head in the sand. He would just say, she'll get over it, she'll get over it, she'll come 'round, she is strong, she will do it. It was kind of like... yeah, well it didn't happen this time. It's a long hard road."

The participants in this study described stress as the main precipitator to becoming unwell. However, the support they received, or did not receive is what made the difference.

"I was referred there by my G.P. (Maternal Mental Health) I didn't know anything about it, but the doctor said they would be a good help to me. I got a phone call by... (nurse) and doctor for a visit. When they came to visit I was a bit reluctant for them to come and assess me... (nurse) I didn't mind, because she said she was Maori... I didn't want (Doctor) coming into my house. My mother talked me into letting them in... They wanted to make sure that I was taking my medication."

"Yeah so when I was there for the first month I really hated it and kept debating on whether... If I was going to leave or not and... but I knew I had no where else to go and um... and um... We had a social worker that worked on the premises at... and so... yeah, I could pretty much speak to her about how I felt and my problems and stuff like that and then... a couple of months later things started to feel not so bad, as in staying there and... but um... throughout my time there, things just gradually got better. I actually realised that I received a lot of help while I was there."

"The support of Maternal Mental Health, was monitoring my medication and seeing me consistently also helped. They were there with their appointments. I would go and see them, they made me feel comfortable. They monitored whether I needed to reduce or whatever."

"They (Maori community support services) took me to my postnatal depression course. They would come and pick me up. I just don't feel comfortable driving sometimes. That is something I have to overcome. Just ringing up, just talking... like next week we are going to meet up and just go for a coffee somewhere... yeah, it is just good to talk to someone different and um... Maori."

Medication is a given (in Western treatment approaches) for the treatment of chronic psychiatric illness. The following excerpts describe participants' experiences of being on medication.

Fear of taking the medication

"I know that I am manic-depressive and it was like.... Oh dear. One, what am I passing onto my child and can I do this, was my biggest fear... When I spoke to the GP a few years ago, he said – the most important thing for me would be to stay on contraceptives, whatever it is, so that I don't get pregnant while I am taking lithium."

Perceptions of the health professionals

"The same Doctor from Maternal Mental Health comes in and he is freaking out... couple of days later he is absolutely freaking out and he is like... we have to get you on this medication and all the complications and he was really... worried. Like, oh, this could tip you over the edge and... I really didn't like it. He didn't need to convince me that I needed to take medication. I had already agreed to that and he

was making me scared of things that may never happen."

Feeling the benefits of medication

"I cope with my high moods they are pretty cool, but the low moods, no. The low moods are horrid. If I wasn't on my medication I wouldn't be this relaxed. I couldn't be... yeah, I am resigned actually. I like being sociable. I like not having fights with people, I like not being irritable, I like having the level of inhibition that I have. Before I had none. I had very risky sexual behaviour with other people. I feel that my condition was me, part of it and part of it was genetic, but part of it is me. It is the way I was brought up when I was young... It (medication) gives you choice and option in treatment, but it is not the only choice. It is so big. What is science today is faith tomorrow."

"It was sort of about... it must have been about 8 weeks that I went to the doctor. He just said I probably needed to have some medication, after he talked to me. He said... fairly normal to be crying a lot, and... help you with some medication. I didn't really care; I just wanted to feel better and happier, because it wasn't normal. Yeah. I think the medication helped to eliminate the emotion. If you can be contradictory. I didn't like it, but it worked."

Is it too much to ask to care for me?

The type of care participants received impacted significantly on their sense of emotional and mental wellbeing. The following excerpt epitomises a lack of caring felt by this participant.

"Not knowing a bit better, I went back... meeting and she was quite surprised to see me. Are you still carrying this baby? I just knew then... I just found someone else. I ended up going through... Midwives. They were no better I ended up... Just the lack of caring. I wanted to know why I was bleeding and no one could tell me. I bled right to the day I delivered her. There was no compassion. That is what really annoyed me. They were kind of stumped. It was like, oh, still bleeding mmmm. I had five scans to make sure that everything was okay and I asked quite a few of them... I know my baby is okay. They were... No asking you, what you want. The impression they gave me... because I was classed as high risk, it was like, why really go through the whole thing with her when she probably may not have a baby anyway. This is honestly how they made me feel. I would go home and tell my sister and she was like... Oh, my God. She could just tell from the look on my face when I'd walk in. It was

like, what is it now? Do they know why you are bleeding?
– No.”

Summary

The theme - treatment approach with the formulated meaning of - What's happening to me? explains what participants thought of the “treatment” they received by the various health professionals and the services they accessed, either for their mental health needs or during their pregnancies and the postpartum period. In particular finding a supportive and caring midwife seemed to be the most contentious issue for participants, this was because there either wasn't enough information given about what was happening to them or they felt no sense of collaboration in terms of how they were treated. The participants also had issues with various mental health professionals. What most participants were at variance with was the lack of co-ordination between the various services they accessed. However whether they felt informed or supported largely depended on the health professional involved.

Theme 3: Tikanga Maori

Formulated Meaning: Where do I belong?

Sub themes

1. A lack of Maori midwives
2. Trying to integrate tikanga Maori
3. Cultural significance

Theme 3 Tikanga Maori: Where do I belong?

Of the seven participants, most had an understanding at some level of Tikanga Maori. This understanding ranged from minimal to extensive, including knowledge of whakapapa, protocols, language and pronunciation. Only one of the participants had conversational language skills in Te Reo Maori, and one other considered that she had some fluency in the language. Both however, had a sound knowledge of tikanga Maori.

“ Mum didn't know about Kohanga, but by the time I was seventeen, my friend said; I am going to go and do this course in Kohanga Reo, and I went along for the ride and

ended up going and doing the same thing, and she left but I carried on, because I couldn't speak Maori and I wanted to learn, so I carried on learning in a total immersion course called Te Aatarangi. I don't consider myself fluent, but you know... semi. Maori culture wasn't really available. Then after five, going to school, you learnt a couple of waiata and basically that was about it. Nothing in the home. Mum didn't know how to speak Maori. She was trying to learn some."

"I think the problem with being Maori is that everyone wants to pigeon hole everything. They want to do... what is Maori? Is it cultural, is it biological, is it to whakapapa? For me it has come down to, after all these years, down to... we have pre-colonial ancestors from this land, which you have never forgotten, and if you have forgotten, you have to understand why they were forgotten. You also Have to, as a consequence know all of your whakapapa Because that... to abstain from the rest of your tipuna is not of good Maori standing."

"I feel funny about some things. I know you are not supposed to sit on tables, so I won't let anyone sit on a table. I tell them to get off. But it is only little things. It is not a lot. I wish I did know a lot, but because I am so busy I haven't delved into it."

"It wasn't until I grew up that I realised, oh so that's what... I guess that's where you get into your life, those things about being Maori, the cultural formalities and traditions... it depends on where your going... You don't think about that, you just naturally do it. For example taking off your shoes... those are just things that are normal for us, but from outside of Maori, yeah it's different."

"I'm proud of my heritage. Strong beliefs... I would like to go back to my roots, which I am currently doing with our land. It is very interesting... we have just succeeded to my mother's land. So that has been interesting. So just learning about our... where we came from... grandparents, great grandparents... I don't like living in... I wanted to live here, but if I had a choice I would quite happily go up north... I have always loved it up there. Never really knew why. It wasn't until latter in life that I realised that is where our mum was born... yeah."

A lack of Maori Midwives

For some of the participants, the difference between having a Maori health professional or Maori treatment approach, or not, was significant to their perception of being supported. Comments from participants show that there are gaps for Maori women in a midwifery service that is predominantly non-Maori.

"I rang the 0800Mums2be, and I was looking for a Maori midwife, and they send you a list of names and there was one with a Maori last name and I rang her up and she couldn't take me on, and I found that she was married to a Maori, she was Pakeha. I felt out of 80 midwives and no Maori midwives on the North shore?"

"It probably would have been good... not so much for me, but more for my mum... for me I was comfortable with the service I was using and the people that were providing the service and how they were providing it to me and... a little bit better for my mother to see a Maori face as well and that person being Maori... maybe if it was just a Maori person to explain to my mother, what it was her daughter is going through, maybe Mum might have understood it more."

"Through the pregnancy, like... I don't know, I feel comfortable with Maori, I don't know what it is... Someone who can follow through, and just... who will look after you through the whole thing, pregnancy and after pregnancy. Make sure things are... I felt that's what I needed. Instead of being passed on to all different doctors and nurses."

Trying to integrate tikanga Maori

For the participants who were trying to integrate tikanga Maori into their day to day lives, this has been no easy task. Particularly, where tikanga Maori was not integral in their early years.

"Some people who do go looking back for their whakapapa, who've never experienced that Maori side of what it is to be connected to whanau, they go looking for

similar relationships they have in the Pakeha world, and in the Maori world, they are not the same."

However, all of the participants have alluded to the view that it is something they want in their lives, and in the lives of their children. The following excerpts describe their experiences of this.

"I never really got any background into it. There was a time when I went to a night class to start speaking the language I went to two classes of it and then something happened, I think I got pregnant again. It does really interest me. I just feel because I don't know enough about it that I can't express the heritage or whatever you want to call it, to other people because I don't know enough about it."

"So when did I decide I was Maori, when I came back to New Zealand and spent a few years at University. And it clarified where I was. After that ... I think being Maori for me is like being on a journey, not a name. I don't think I have ever worn a label. It has become more of a cerebral thing."

The following participant expressed what it was like not fitting into the dominant culture during therapy.

"The first thing I noticed was that I was the only Maori in the room. That kind of set me back right from the start ... I almost dropped out after the second time. Yeah I felt kind of the odd one out. I couldn't connect with them. Recognising symptoms, coping strategies behaviour therapy...CBT. I found that really hard to grasp... I actually found that really hard to grasp. Most days I went in there completely blank. We had to do exercises and I would go...can't do it. I would sit there and say, can't do it. They would all get into their role plays and I would just sit there, can't do it."

Cultural significance

Cultural significance in this context refers to any incidence of participants' experiences that were related to being Maori. The significance of spirituality and whakapapa strengthens the sense of belongingness and deepens the pride of being Maori.

"The only thing, like the Maori spirituality basically having the whenua (placenta) given back to me so that I can bury it. I know that spiritually I do have some shifts and that I know is enough and I have some knowledge of what that is, and I don't want to delve into it because of my mental health history but... you know... spirituality... I feel that it was something that I needed to do. It was my next lesson in life. It is just another lesson in your life, basically to learn to love and care for someone else."

"I have spent quite a bit of time learning my mum's whakapapa, which has meant twelve generations on. My father's side I have started on. For me, I have noticed a considerable influx of people wanting to know who they belong to, wanting to belong to someone and it is heartbreaking for them, having been locked out, sometimes more than their own generation and wanting in. That's their journey. Because our connections these days are skint. Over half our Maori population is under 20. 90% do not have access to their extended whanau, including their kaumatua... they don't get told. They don't even... the closest they will come to it is at a Tangi. That cultural aspect, that connectedness, the literal connectedness which is actually – I can group this person by their last name is lost. The majority don't have connections to their land."

These excerpts are a clear indication of what the participants were feeling and experiencing throughout their pregnancies and postnatally, being Maori women with a mental illness becoming mothers. They are also a very revealing description of what services they found appropriate and helpful and also what services were not. Their stories also make it evident where, when and by whom they felt supported as Maori women, and also when they did not. The three major themes Identity; Treatment approaches; and tikanga Maori were accompanied by their formulated meanings according to the Colaizzi method of analysis these meanings being: Who am I? What's happening to me? and Where do I belong? The discussion chapter which follows will elaborate more fully on these findings.

Summary

This final theme, Tikanga Maori, with the formulated meaning – where do I belong? identifies what the participants felt would have made a difference to them whilst accessing midwifery and mental health services. Despite the fact that not all participants had extensive knowledge of tikanga Maori, most suggested that having a Maori health professional practitioner would have gone a long way to helping them understand and access the services that they needed. Furthermore, their impression was that had this happened, they would have felt less ostracised and isolated. The most explicit disparity that participants identified under this theme was the lack of Maori midwives. Most said that this above all else would have made a difference to their experience of accessing services providing midwifery and mental health care. This was due in large part to their being able to identify with someone who was similar to them. Cultural significance by way of whakawhanaungatanga was acknowledged as something that helped to strengthen their sense of identity and belonging. Thus, making their experience of being Maori, and a mother with a diagnosis of mental illness a more positive one.

CHAPTER SEVEN: DISCUSSION

This phenomenological research arose from the question

“What does the experience of pregnancy and childbirth mean to Maori women with a diagnosis of mental illness?”

The three major themes described in the findings suggest that pregnancy and childbirth raise questions about identity, as a Maori, as a mother, and as a Maori mother with a mental illness. Making the transition to motherhood involves a serious re-evaluation of identity and the question “Who am I? is not uncommon. Having strong roots to tradition is helpful in becoming a mother as a woman has some foundation for her mothering skills. Factoring in mental illness being unsure of who you are can be a precursor and so these mothers are additionally burdened with pregnancy, childbirth, identity as mother and Maori and dealing with a mental illness. For Maori women becoming a mother often forces identification with their Maori roots and may place a greater stress on the transition to motherhood and on the relationships with their partners.

The treatment approach within both the maternity services (being pregnant and experiencing childbirth) and mental health services (being diagnosed with a mental illness) identified by the participants caused them to cry out “what is happening to me?” Lack of Maori midwives, lack of understanding by non-Maori midwives and non-Maori mental health workers caused the women to ask “who is there for me?” Stereotyping Maori, the stigma of mental illness, and the inconsistency of care raised the question “is it too much to care for me?”

Finally these women poignantly called forth the essence of the phenomenon of being a Maori women with a diagnosis of a mental illness and experiencing pregnancy and childbirth as “Where do I belong?” The lack of Maori midwives and health workers in the field of mental health

reduced their ability to reconcile their motherhood with being Maori and their integration of tikanga Maori into their daily lives. The dominant western model of maternity and mental health care provision did not address their need for validation as Maori women becoming mothers.

Further commentary on the services

With the exception of Maori community support services, the maternity and mental health services originate from western frameworks. This is true also of both the maternity and mental health diagnoses and treatment approaches offered. Only the Maori community support services offer a kaupapa Maori approach, and a Maori 'key worker'.

In the following sections of this chapter I will discuss service and support categories under the headings: maternal mental health, community mental health, obstetric and midwifery services, General Practitioners, Maori community support services and whanau/family support. I have done this principally because there were specific examples communicated by the participants² of particular services and or networks, related to their mental and physical health. The delivery of services shaped participants' views of whether or not the service was appropriate, assisted them to make the transition to motherhood and to heal from their diagnosis of a mental illness, and more to the point whether they would choose to access a particular service again.

Identity, treatment approach and tikanga Maori have been an integral part of this study and are therefore pivotal to understanding how participants viewed the treatments they received, along with the support, or lack thereof.

Maternal Mental Health Services

Maternal mental health services were seen by participants as offering a specialist service. However, that very much depended on how well the care was co-coordinated. This often depended on who the 'key worker' i.e. who the central person co-coordinating care was. Monitoring of

participants' mental status postpartum was generally fairly prompt. Where there was good rapport and a clear explanation and collaboration of what the treatment plan was - successful engagement occurred. Having a Maori 'key worker' was seen as a bonus.

Community Mental Health Services

By and large participants were satisfied with the care they received from community mental health services. Where the transition from maternal mental health services to community mental health services, and vice versa was relatively seamless, the participants tended to engage more readily. Again, this was often dependent on the mental health professionals involved, their knowledge and also their experience of working with Maori. Where a participant had a pre-existing mental illness diagnosis there was usually a birth plan in place and regular appointments with a psychiatrist and key worker.

Some of the participants had changed their geographical address during or after their pregnancies. This meant for some a change of the District Health Board delivering services. When this occurred stress levels increased proportionately to how their transfers of care were handled. Noticeably, where this transition was relatively straightforward the women coped better, and felt better supported through the process.

Obstetric and Midwifery Health Services

Of all of the services involved in the care of participants of this study, obstetric and midwifery services featured as the most inadequate. This finding was directly attributable to the attitudes of the midwives involved in providing 'care'. Many participants saw the service as fragmented and cited attitudes of midwives as the main failure of the service to provide appropriate, helpful and caring treatment. On the whole participants were generally dissatisfied with their midwives citing lack of caring, inappropriate comments, and feelings of being treated as inadequate or inferior as the cause of their dissatisfaction. Some participants describe 'firing' their midwives, and not unusually on more than one occasion

during the same pregnancy. Some participants felt there was not enough information provided when accessing obstetric services, and feelings of disempowerment were common. Lack of caring was also prevalent, as were feelings of discrimination because of being Maori. The support most valued by participants during the pregnancy and birthing process was time after time that provided by whanau or friends.

General Practitioners

For participants who had involvement with their general practitioner (GP) an element of trust was usually in place. This was due to the fact that the GP had been involved in other facets of the participants' general health and or previous pregnancies. There was also acknowledged history, and existing trust and rapport. General practitioners were often the first port of call for participants, not so much for their physical health, but when their mental health deteriorated to such a level that they felt they had reached 'rock bottom' and were not coping. For those participants who had not previously been involved with mental health services, they were invariably referred on to maternal mental health services.

Maori Community Support Services

For those participants who were referred to Maori community support services varying degrees of endorsement were reported. Maori support services generally fared well in terms of the care and services they provided invariably because a Maori worker was involved. Almost all of the participants who received care directly from a Maori worker reported feeling supported and understood. Rapport easily developed and subsequently engagement with the service lasted longer when compared with other services. Despite the fact that in general Maori community support services do not have a clinical component, the support received was seen as very valuable. Nevertheless, not all participants thought that the services they received from this quarter were appropriate. This usually hinged on the professionalism of the workers involved and their knowledge about mental illness both from a Maori perspective and also from that of western frameworks. Where these factors were apparent

engagement with the service and trust in the key worker was more likely to take place.

Whanau/Family Support

Undoubtedly support from whanau featured as the most desired and helpful support available. Mothers of participants almost always provided the most relevant, appropriate and caring support. Participants found this support the most valuable and constructive. This was due to the fact that they didn't need to explain themselves, their values or beliefs, and the support was unconditional.

Summary

The findings of this study clearly indicate that there is a lack of co-ordination between services, whether these services were by way of hospital based obstetric care, independent midwives, general practitioners, maternal mental health services, community mental health services or Maori community support services. Each of the services had strengths and weaknesses. Generally, the strengths observed by the participants were dependent on the attitudes of staff involved. Where rapport and trust were apparent engagement was obvious. When participants felt marginalised and even discriminated against, then disengagement by the participants swiftly followed.

Because identity was relevant to each of the participants - who were all of Maori and non-Maori descent but identified as Maori - how they were perceived by others influenced how they viewed the effectiveness and appropriateness of the service being delivered. A commonly held view of all of the participants was that there is a lack of understanding by service deliverers as to what it is that Maori women want and need in terms of the care and support they receive when diagnosed with a mental illness, during and after pregnancy. All of the participants had some experience of living in 'two worlds' that of Te Ao Maori and Te Ao Pakeha. The participants were all able to articulate what it is they thought needed to be improved and/or changed.

Where there was a pre-existing mental illness, participants generally, had some idea of what to expect from mental health services. Those participants who presented with symptoms of mental illness in the postpartum period, found it more difficult to navigate the 'system'. It was not unusual for a participant to blame themselves if things were disintegrating. Often battling on alone and not seeking help until someone else, usually a friend or family member pointed out that something was wrong. Being given a diagnosis was often seen as a positive, as this was seen as verification that something was wrong and that there was a reason for why they were feeling the way they were. Medication on the other hand was often seen as a 'last resort' and an inability to cope. Compliance depended on the education provided at the time of prescribing, monitoring of medication, and whether participants thought it was effective. Without a doubt participants felt that there needed to be more Maori involved in the service design and delivery of health care for Maori mothers. A 'one-stop-shop' was suggested as a way forward, where all care is delivered by one service, and at one location. This would certainly simplify things and make engagement more likely. Participants talked of having to go to up to five different services throughout their pregnancies and during the post natal period. This had the effect of being very stressful, and resulted in some participants attending appointments less frequently. This was particularly true where participants had other young children who had to be looked after before appointments could be attended. Because being Maori often means walking in two worlds, services need to adapt their delivery to accommodate this fact. As one participant suggested

"You can't go back and have babies on the ground and have all the women in the village around you supporting you, but you can have a modern version of that."

How this modern version of midwifery and mental health care for Maori women might look is very much dependent on how the two different world views are linked. Possible suggestions and ways forward will be discussed in the conclusion chapter.

CHAPTER EIGHT: CONCLUSION

In this chapter the strengths and limitations of the research will be outlined, links between the paradigms of the West and Te Ao Maori will be addressed and further research recommended.

Strengths and limitations of this research

The most obvious strength of this research is the fact that there has previously been no specific qualitative study completed about Maori women diagnosed with a mental illness, and their experiences of pregnancy and childbirth. The voices of the participants are clearly saying that the way services are delivered needs to be changed because currently, they are not meeting the needs of Maori women during pregnancy, childbirth and the postpartum period. The interventions provided also need to be appropriate, to meet the needs of Maori women, and at present this is not the case.

A limitation of this study is that there is not a prolonged discussion of the postpartum period. Subsequently, this study has its parameters set at the period from pregnancy (when first realised), up to the recent postpartum period. Also because the study involved only seven participants in one region of New Zealand it cannot be said to be conclusive of Maori women's views of the country's midwifery and mental health services. However, it can certainly claim to have provided an indication of how these services are affecting this particular group in terms of delivery and appropriateness.

Linking paradigms

Durie (2001a) declares the major difference between biomedicine (which is Western, empirical and positivist based) and traditional Maori healing is essentially the belief systems inherent in each. Furthermore healing, of any description, can only be completely understood through the culture of its origin. Nevertheless due to the impact of colonialism on Maori people, it is unsurprising that they will seek help from a variety of healing

agencies, often in tandem. When indigenous cultures are able to design, implement and manage their own health solutions effectively the chances of retaining their cultural identity are far greater. Consequently these services are better positioned to meet the needs of its people.

Diagnostic criteria (for example, DSM IV) have been classified on the basis of a dominant group (Caucasian and from the West). Specific cultural beliefs e.g. spiritual, naturalism, holism are not taken into account (officially) in the diagnosis of 'mental illness'. Failure to recognise a cultural dimension affects treatment approaches. The use of diagnostic classification of mental illness and subsequent treatment approaches coupled collaboratively with cultural integrity, medical pluralism and self determination are ways forward in resolving the disparities that currently exist for Maori women accessing maternal health and mental health services.

Work force development

Te Rau Matatini is a national Maori mental health workforce development programme that was established in 2001. Funded by the Ministry of Health it was developed to ensure that Maori mental health consumers, tangata whaiora and whanau have access to a cogent, qualified Maori mental health workforce. Te Rau Matini has completed reports that are built on the strengths of previous workforce reports. Their report – Te Rau Whakawhanui: Maori Primary Mental Health Care Workforce development project provided a forum for sector leadership and advocacy for addressing Maori mental health needs within the primary health sector and how these needs can be met (Tupara & Ihimaera, 2004). The following data was an outcome of this report. In 2003 there were 3528 midwives holding an active midwifery qualification. Based on Practising Certificate applications in 2003, 7.6% self reported as New Zealand Maori, 6.5% identified as other, and 9.4% chose not to report their ethnicity. It is evident that Maori are under-represented in the midwifery workforce, a statistic that has parallels with similar under-representation in other health arenas. These statistics mirror what participants thought

and that is, that there is a lack of Maori midwives. Anecdotal information suggests that in 2003 there were 120 Maori midwives in active practice. As previously stated one cannot assume that all women who identify as Maori will choose a Maori midwife. However, the option to receive care from a midwife who can comprehend a health perspective from a similar standpoint to their own, thus providing choice is something that needs to be available to all Maori women seeking care pre- and post- pregnancy. Currently this is not the case, as voiced by the majority of the participants, who experienced marginalisation in particular from midwives.

Where a Maori woman has also been diagnosed with a mental illness then even greater sensitivity to her cultural belief system is vital. Few midwives have a background in maternal mental health (and illness). The figures suggest it is even less likely for pregnant and childbearing Maori women with a mental illness to receive the appropriate care they require.

Iwi based services

Outcomes for midwifery and mental health services will be much improved when they are delivered in ways that meet the cultural needs of Maori. This view has been substantiated by international and national research studies. These studies report comparable results that advocate a match between health consumers and the professionals they work with. Cultural and clinical competence needs to be intrinsic and available. Achieving this goal requires that health services continue to develop a sound cultural and clinical pathway that evolves as and when change is required. (Tupara, & Ihimaera, 2004). In practical terms I would suggest that a service that could provide ante-natal, birthing and post-natal care at one location for Maori women diagnosed with a mental illness is not unrealistic. It should be based on a kaupapa Maori paradigm that combines Maori values and beliefs with modern medical interventions and technology, as and when required. Maori for Maori health services are a way to acknowledge, and provide treatment and support that is unquestionably needed. This could be achieved through Iwi based

services that have the potential to develop further the services some already offer, to accommodate Maori women pre and post pregnancy.

Defining mental health for Maori women during pregnancy and postnatally

The notion that health services are for all is a great concept. The idea of a homogeneous health system is not. Maori have specific needs related to their identity as Maori. These needs can be met in a number of ways. In a pilot study - Maori Primary Mental Health Midwifery and Whanau/Tamaki Ora-Well Child Pilot, it was proposed that the following key objectives be implemented:

- I. Increase the capacity of Maori midwives and whanau/tamariki ora-well child nurses/workers to identify and recognise mental illness present in Maori women in primary care settings
- II. Increase the capacity for timely and appropriate consultation or liaison, and or referral to specialist mental health services
- III. Establish a national training standard in relation to mental health as a baseline for future professional development of Maori midwives and whanau/tamariki ora-well child services
- IV. Identify and clarify key areas of need for future development of mental health expertise among Maori midwives and whanau tamariki ora-well child services and,
- V. Enable recommendations to be made for future mental health training and education in the primary sector. (Tupara & Ihimaera, 2004, p.9).

Recommendations for further research

In light of the fact that there is a lack of Maori midwives working either independently or within existing health organisations, the following suggestions would go far in improving service delivery for Maori women pre and post pregnancy.

- I. Evaluate the cultural component in the current midwifery education programmes
- II. Evaluate the education of student midwives about maternal mental health
- III. Explore ways of recruiting and educating more Maori midwives
- IV. Identify, develop and evaluate different ways of providing mental health care and appropriate treatment approaches to mental illness for Maori
- V. Explore what it means for Maori women to be well, both physically and mentally, particularly during pregnancy, childbirth and the postpartum period.

Summary

In a Ministry of Health study it was found that only one in three people in New Zealand receive appropriate mental health care- (Ministry of Health, 2004). International research has found that 50% of serious cases of mental illness in developed countries and 85% of similar cases in underdeveloped countries went untreated. This is despite the fact that research into mental health has found that mental illness has a profound impact on role functioning, more so than many severe chronic physical illnesses- (World Health Organisation World Mental Health Survey Consortium, 2004). Undoubtedly, workforce development needs to reflect the needs of Maori women. More Maori for Maori will help provide services where Maori women feel they have someone who is aligned with tikanga Maori, as well as being educated in the ways of western psychiatric treatment approaches.

All of the women who participated in this study have shown courage and strength in the way they managed their lives during periods that at times seemed very dark and very lonely. This research has identified a number of gaps in treatment approaches and service delivery. These include training of professionals, and further research into understanding what it means for Maori women to be well, both physically and mentally,

particularly during pregnancy, childbirth and the postpartum period. Support from whatever quarter made a positive difference to participants, and when they felt they were well informed about procedures then a sense of autonomy prevailed. A holistic approach that bases service delivery on the principles of Maori belief systems is a way forward.

APPENDIX I

WHARE TAPA WHA

The Maori philosophy towards health is based on a wellness or holistic health model. Maori see health as a four-sided concept representing four basic beliefs of life: Te Taha Hinengaro (psychological health), Te Taha Wairua (spiritual health), Te Taha Tinana (physical health) and Te Taha Whanau (family health).

This is known as Te Whare Tapa Wha.

The Whare Tapa Wha can be applied to any health issue affecting Maori from physical to psychological wellbeing.

The following dimensions of Te Whare Tapa Wha are described below:

Wairua/Spirituality - is acknowledged to be the most essential requirement for health. It is believed that without a spiritual awareness an individual can be considered to be lacking in wellbeing and more prone to ill health. Wairua may also explore relationships with the environment, between people, or with heritage. The breakdown of this relationship could be seen in terms of ill health or lack of personal identity. When confronted with a problem Maori do not seek to analyse its separate components or parts but ask in what larger context it resides, incorporating ancestors or future generations to discussions. This may mean the discussion goes off on a tangent but the flow will return to the question.

Hinengaro/Psychic - thoughts, feelings and behaviour are vital to health in Te Ao Maori (the Maori world). Maori may be more impressed with unspoken signals, eye movement, bland expressions, and in some cases regard words as superfluous, even demeaning. Maori thinking can be described as being holistic. Understanding occurs less by dividing things into smaller and smaller parts. Healthy thinking for a Maori person is about relationships. The individual whose first thought is about putting themselves, their personal ambitions and their needs first, without recognising the impact that it may have on others is considered unhealthy. Communication through emotions is important and more meaningful than the exchange of words and is valued just as much, for example, if Maori show what they feel, instead of talking about their feelings, this is regarded as healthy.

Tinana/Physical - is the most familiar component to all of us. For Maori the body and things associated with it are Tapu (sacred/special). There is a clear separation between sacred and common. For instance the head is regarded as tapu and Maori do not pat each other on the head, nor should food be anywhere near a person's head. When this happens it can be perceived as unhealthy. Hairbrushes should not be placed on tables nor should hats.

Food is kept away from the body and so are utensils. A common thing that is observed in Maori households is that tea-towels are not placed in a washing machine but always washed by hand. Kitchen sinks/tubs should not be used to wash personal items either. When a laundry is in close proximity to the kitchen this can pose problems as well.

There is also the question of personal space to take into account. Maori consider stepping over someone as rude and demeaning to that person's mana (personal authority/power). However there are different ways in which respect is shown to another person. For example Maori tend to have minimal eye contact and respect each other's space in formal situations. Body language is also an important feature to note.

Whanau/Family - is the prime support system providing care, not only physically but also culturally and emotionally. For Maori, whanau is about extended relationships rather than the western nuclear family concept. Maintaining family relationships is an important part of life and caring for young and old alike is paramount. Everyone has a place and a role to fulfil within their own whanau. Families contribute to a person's wellbeing and most importantly a person's identity. A Maori viewpoint of identity derives much from family characteristics. It is important to understand that a person carrying an ancestral name will often be seen as having the qualities of their namesake.

It is important to be aware for Maori, a person's identity is gleaned by asking "Where are you from" rather than "What is your name?" Maori identity is based upon an ancestral Waka (canoe) a physical landmark, which is usually a Maunga (mountain), a body of water Awa (river), Moana (sea) and a significant Tupuna (ancestor). Once this is known people can share a common bond.

APPENDIX II

EDINBURGH POSTNATAL DEPRESSION SCALE

The Edinburgh Postnatal Depression Scale has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression; a distressing disorder more prolonged than the "blues" (which occur in the first week after delivery) but less severe than puerperal psychosis. Previous studies have shown that postnatal depression affects at least 10% of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long-term effects on the family. The EPDS was developed at health centers in Livingston and Edinburgh. It consists of ten short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than 5 minutes. The validation study showed that mothers who scored above threshold 92.3% were likely to be suffering from a depressive illness of varying severity. Nevertheless the EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorder.

Instructions for users:

1. The mother is asked to underline the response which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6-8 weeks to screen postnatal women. The child health clinic, postnatal check-up or a home visit may provide suitable opportunities for its completion.

Name: _____

Address: _____

Baby's Age: _____

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

1. I have been able to laugh and see the funny side of things.

As much as I always could
 Not quite so much now
 Definitely not so much now
 Not at all

2. I have looked forward with enjoyment to things.

As much as I ever did
 Rather less than I used to
 Definitely less than I used to
 Hardly at all

3. * I have blamed myself unnecessarily when things went wrong.

Yes, most of the time
 Yes, some of the time
 Not very often
 No, never

4. I have been anxious or worried for no good reason.

No, not at all
 Hardly ever
 Yes, sometimes
 Yes, very often

5. * I have felt scared or panicky for not very good reason.

Yes, quite a lot
 Yes, sometimes
 No, not much
 No, not at all

6. * Things have been getting on top of me.

Yes, most of the time I haven't been able to cope at all
 Yes, sometimes I haven't been coping as well as usual
 No, most of the time I have coped quite well
 No, I have been coping as well as ever

7. * I have been so unhappy that I have had difficulty sleeping.

Yes, most of the time
 Yes, sometimes
 Not very often
 No, not at all

8. * I have felt sad or miserable.

Yes, most of the time

Yes, quite often
Not very often
No, not at all

9. * I have been so unhappy that I have been crying.

Yes, most of the time
Yes, quite often
Only occasionally
No, never

10. * The thought of harming myself has occurred to me.

Yes, quite often
Sometimes
Hardly ever
Never

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptoms. Items marked with an asterisk are reverse scored (i.e. 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

APPENDIX III

DIAGNOSTIC CRITERIA FOR POST TRAUMATIC STRESS DISORDER

<p>A. The person has been exposed to a traumatic event in which both of the following were present:</p> <p>the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.</p> <p>the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior</p>
<p>B. The traumatic event is persistently reexperienced in one (or more) of the following ways:</p> <p>recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.</p> <p>recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content</p> <p>acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.</p> <p>intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event</p> <p>physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event</p>
<p>C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:</p> <p>efforts to avoid thoughts, feelings, or conversations associated with the trauma</p> <p>efforts to avoid activities, places, or people that arouse recollections of the trauma</p> <p>inability to recall an important aspect of the trauma</p> <p>markedly diminished interest or participation in significant activities</p> <p>feeling of detachment or estrangement from others</p> <p>restricted range of affect (e.g., unable to have loving feelings)</p> <p>sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)</p>

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

difficulty falling or staying asleep

irritability or outbursts of anger

difficulty concentrating

Hypervigilance

exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if :

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

APPENDIX IV

THE TREATY OF WAITANGI

HER MAJESTY VICTORIA Queen of the United Kingdom of Great Britain and Ireland regarding with Her Royal Favour the Native Chiefs and Tribes of New Zealand and anxious to protect their just Rights and Property and to secure to them the enjoyment of Peace and Good Order has deemed it necessary in consequence of the great number of Her Majesty's Subjects who have already settled in New Zealand and the rapid extension of Emigration both from Europe and Australia which is still in progress to constitute and appoint a functionary properly authorised to treat with the Aborigines of New Zealand for the recognition of Her Majesty's Sovereign authority over the whole or any part of those islands - Her Majesty therefore being desirous to establish a settled form of Civil Government with a view to avert the evil consequences which must result from the absence of the necessary Laws and Institutions alike to the native population and to Her subjects has been graciously pleased to empower and to authorise me William Hobson a Captain in Her Majesty's Royal Navy Consul and Lieutenant-

KO WIKITORIA te Kuini o Ingarani i tana mahara atawai ki nga Rangatira me nga Hapu o Nu Tirani i tana hiahia hoki kia tohungia ki a ratou o ratou rangatiratanga me to ratou wenua, a kia mau tonu hoki te Rongo ki a ratou me te Atanoho hoki kua wakaaro ia he mea tika kia tukua mai tetahi Rangatira - hei kai wakarite ki nga Tangata maori o Nu Tirani - kia wakaaetia e nga Rangatira Maori te Kawanatanga o te Kuini ki nga wahikatoa o te wenua nei me nga motu - na te mea hoki he tokomaha ke nga tangata o tona Iwi Kua noho ki tenei wenua, a e haere mai nei.

Na ko te Kuini e hiahia ana kia wakaritea te Kawanatanga kia kaua ai nga kino e puta mai ki te tangata Maori ki te Pakeha e noho ture kore ana.

Na kua pai te Kuini kia tukua a hau a Wiremu Hopihona he Kapitana i te Roiara Nawi hei Kawana mo nga wahi katoa o Nu Tirani e tukua aiane amua atu ki te Kuini, e mea atu ana ia ki nga Rangatira o te wakaminenga o nga hapu o Nu Tirani me era Rangatira atu enei ture ka korerotia nei.

TE TIRITI O WAITANGI

The preamble of the English version states the British intentions were to:

- protect Māori interests from the encroaching British settlement
- provide for British settlement
- establish a government to maintain peace and order.

The Māori text suggests that the Queen's main promises to Māori were to:

- provide a government while securing tribal rangatiratanga and Māori land ownership for as long as they wished to retain it.

Governor of such parts of New Zealand as may be or hereafter shall be ceded to her Majesty to invite the confederated and independent Chiefs of New Zealand to concur in the following Articles and Conditions.

ARTICLE THE FIRST KO TE TUATAHI

The Chiefs of the Confederation of the United Tribes of New Zealand and the separate and independent Chiefs who have not become members of the Confederation cede to Her Majesty the Queen of England absolutely and without reservation all the rights and powers of Sovereignty which the said Confederation or Individual Chiefs respectively exercise or possess, or may be supposed to exercise or to possess over their respective Territories as the sole sovereigns thereof.

Ko nga Rangatira o te wakaminenga me nga Rangatira katoa hoki ki hai i uru ki taua wakaminenga ka tuku rawa atu ki te Kuini o Ingarani ake tonu atu - te Kawanatanga katoa o o ratou wenua.

In the English text of the Treaty, Māori leaders gave the Queen "all the rights and powers of sovereignty" over their land.

In the Māori text of the Treaty, Māori leaders gave the Queen "te kawanatanga katoa" – the complete government over their land.

ARTICLE THE SECOND KO TE TUARUA

Her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof the full exclusive and undisturbed possession of their Lands and Estates Forests Fisheries and other properties which they may collectively or individually possess so long as it is their wish and desire to retain the same in their possession; but the

Ko te Kuini o Ingarani ka wakarite ka wakaee ki nga Rangitira ki nga hapu - ki nga tangata katoa o Nu Tirani te tino rangatiratanga o o ratou wenua o ratou kainga me o ratou taonga katoa. Otiia ko nga Rangatira o te wakaminenga me nga Rangatira katoa atu ka tuku ki te Kuini te hokonga o era wahi wenua e pai ai te tangata nona te Wenua - ki te ritenga o te utu e wakaritea ai e ratou ko te kai hoko e meatia nei e te Kuini hei kai hoko

In the English text of the Treaty, Māori leaders and people, collectively and individually, were confirmed and guaranteed "exclusive and undisturbed possession of their lands and estates, forests, fisheries and other properties".

In the Māori text of the Treaty, Māori were guaranteed "te tino rangatiratanga" – the unqualified exercise of their chieftainship over

Chiefs of the United Tribes and the individual Chiefs yield to Her Majesty the exclusive right of Preemption over such lands as the proprietors thereof may be disposed to alienate at such prices as may be agreed upon between the respective Proprietors and persons appointed by Her Majesty to treat with them in that behalf.

mona.

their lands "wenua", villages "kainga", and all their property/treasures "taonga katoa".

In the English text of the Treaty, Māori yielded to the Crown an exclusive right to purchase their land.

Māori agreed to give the Crown the right to buy land from them should Māori wish to sell it.

THROUGH THE THIRD KO TE TUATORU

In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her royal protection and imparts to them all the Rights and Privileges of British Subjects.

Hei wakaritenga mai hoki tenei mo te wakaaetanga ki te Kawanatanga o te Kuini - Ka tiakina e te Kuini o Ingarani nga tangata maori katoa o Nu Tirani ka tukua ki a ratou nga tikanga katoa rite tahi ki ana mea ki nga tangata o Ingarani.

In the Māori text of the Treaty, the Crown gave an assurance that Māori would have the Queen's protection and all rights - "tikanga" - accorded to British subjects.

This is considered a fair translation of the English.

(signed)
William Hobson,
Lieutenant Governor.

(signed)
William Hobson,
Consul and Lieutenant-Governor.

Now therefore We the Chiefs of the Confederation of the United Tribes of New Zealand being assembled in Congress at Victoria in Waitangi and We the Separate and Independent Chiefs of New Zealand claiming authority over the Tribes and Territories which are specified after our respective names, having been made fully to understand the Provisions of the

Na ko matou ko nga Rangatira o te Wakaminenga o nga hapu o Nu Tirani ka huihui nei ki Waitangi ko matou hoki ko nga Rangatira o Nu Tirani ka kite nei i te ritenga o enei kupu, ka tangohia ka wakaaetia katoatia e matou, koia ka tohungia ai o matou ingoa o matou tohu.

Ka meatia tenei ki Waitangi i te ono o nga ra o Pepueri i te tau



foregoing Treaty, accept
and enter into the same
in the full spirit and
meaning thereof in
witness of which we
have attached our
signatures or marks at
the places and the dates
respectively
specified. Done at
Waitangi this Sixth day
of February in the year
of Our Lord one
thousand eight hundred
and forty.

kotahi mano, e waru rau
e wa te kau o to tatou
Ariki.

APPENDIX V

ESSENTIAL SERVICE COMPONENTS FOR MAORI

Component	Description	Purpose
Cultural assessment	Assessment of cultural status and cultural needs to enable Maori values and healing practices to be offered as an addition to treatment for tangata whaiora.	Ensures the most appropriate and effective services are available to Maori.
Whanau and tangata whaiora participation	Whanu and tangata whaiora participation in: <ul style="list-style-type: none"> - assessment and treatment plans - provision of treatment and support and education for recovery - early intervention programmes and training and education for whanau. 	Fosters whanaungatanga which is emphasised as the basis for healing.
Maori language	Tangata whaiora have the choice to converse in te reo Maori	Enable Maori language to be used in the expression of Maori beliefs and values, as an important part of the healing process.
Tikanga Maori	An environment in which Maori protocols and processes are acknowledged and which allows for both physical and spiritual healing to take place.	Provides an environment for Maori which acknowledges their values and beliefs as integral to the healing process for Maori.
Treatment process	Maori need the full range of choice of Maori healing methodologies, processes, and natural medicines, as well as clinical treatments including access to new medications, and recovery approaches.	Acknowledges the positive impact culturally based treatments have on the healing process for Maori.

Workforce	Maori participate in the workforce as health professional, clinicians, managers, and decision makers.	Creates an environment and service standards that are more suitable for dealing with tangata whaiora.
Performance measures relevant to Maori	The Te Whare Tapa Wha model is incorporated in performance measures.	Ensures performance measures go beyond the immediate clinical parameters and encompass the wider measures of good health for Maori.

APPENDIX VI

PARTICIPANT VALIDATION LETTER

Wendy Semmons
C/- St Lukes CMHC,
615 New North Road,
Morningside,
Auckland.

(09) 845-0940

21st April 2006

Tena koe

Further to our telephone conversation, this letter is to let you know that I have completed sorting out the data collected from the interviews held (seven in total). I am now requesting your input regarding the content of the data analysis.

The data analysis revealed three major themes, with subsequent sub-themes. To assist with anonymity I have given each participant a number that correlates with their particular excerpts extracted from the interviews. Your identifying number is ____ after each excerpt you will see some figures in brackets; for example (3, 17, 4) indicates the participant number, the page number and lastly the paragraph that the excerpt was taken from.

As you read through the summaries and recognise which excerpts are yours, I would ask you to think about whether they are a true account of what you meant to say, and also whether they fit the context they are written in. By that I mean do you think that excerpt fits with the 'theme' or 'sub-theme' that it is located in. I will contact you in a few days, and if you would like, I could meet with you in person to discuss the findings.

I will continue to keep you informed as the study winds down. Once again, I want to thank you for agreeing to participate in this study, and for the unique perspective you bring to it. I believe the findings of this study offers service providers an opportunity to ensure that treatment and services to Maori are relevant and appropriate.

Noho ora mai

Wendy Semmons
(Researcher)

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