Access to Mental Health Services Among Pacific Young Adults in Auckland, New Zealand: Relational Navigation of Mental Health and Help-Seeking

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Abstract

This study explores how young Pacific adults in Auckland navigate the tensions between cultural beliefs, social expectations, and access to mental health services. Despite evidence of disproportionately high levels of psychological distress among Pacific people in Aotearoa New Zealand, engagement with formal mental health services remains low. Existing research has predominantly focused on structural disparities and population-level patterns, with limited attention to the lived experiences of young Pacific adults and the relational processes that shape help-seeking.

Using a qualitative approach grounded in Pacific epistemologies, this research draws on the Ūloa methodology and the Talanoa method to support culturally appropriate, relational, and participant-led inquiry. Data were collected through individual Talanoa sessions with seven young Pacific adults aged 18 to 25 residing in Auckland. Thematic analysis was employed to identify key patterns and meanings across participants' narratives.

The findings indicate that mental health is understood in holistic and relational terms, shaped by interconnected domains such as family, culture, spirituality, and identity. Participants described navigating culturally embedded expectations of strength, silence, and collective responsibility, which often constrained emotional expression and delayed help-seeking. However, they also demonstrated agency in negotiating these expectations, actively balancing cultural belonging with personal wellbeing. Help-seeking emerged as a non-linear, relational process influenced by peer support, cultural alignment, and strategic decision-making.

This study contributes to Pacific mental health scholarship by revealing that young Pacific adults actively negotiate, rather than passively absorb, cultural and structural influences on their mental health. The findings underscore the importance of strengthened education and dialogue to bridge intergenerational gaps in mental health understandings, thereby fostering shared perspectives between older and younger Pacific generations. Such efforts would enable open conversations that challenge silence, stigma, and shame, reducing tensions between cultural and social expectations, and supporting the wellbeing of young Pacific adults.

Ethics Approval

Ethics approval was granted on 16 June 2025 by the Auckland University of Technology Ethics Committee (AUTEC). Ethics application number 25/180. Please refer to appendix A.

Dedication

"Whatever you do, do it with all your heart, as working for the Lord and not for human Masters"

Colossians 3:23

This study was entrusted into God's hands - guided and covered by His grace and mercy. It is work that extends beyond me, offered back to God as a reflection of His purpose in my life.

This thesis is lovingly dedicated to my parents, Ofa and Pasepa Topeni, whose sacrifices laid the foundation for my education and shaped the values that guide me.

This thesis is also dedicated to my siblings - Paula, Raewyn, Tui Emma, Junior, Angelina, and Asinate- thank you for your constant encouragement, support, and love.

This accomplishment is as much yours as it is mine.

Kuo Tau Ikuna

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To God be the glory, always.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

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List of Tables & Figures

Glossary of Terms & Abbreviations

‘Aiga / Kāinga	Family
Au	Coconut Leaf Net
Angalelei	Kindness
Fa’aaloalo / Faka’apa’apa	Respect
Fala	Mat
Fale	House
Loto	Heart
Mateuteu	Prepare
MVPFAFF+	Mahu, Vakasalewalewa, Palopa, Fa’afafine, Akava’ine, Fakafifine, Fakaleiti/leiti,
‘Ofa	Love
‘Ofa fe’unga	Appropriate compassion and empathy
Pākehā	European
Poto he anga	Wisdom in action
Tapu	Sacredness
Tauhi Vā / Teu Le Vā	Nurture/ protect the relational space
Tofu	Peace and harmony
Toutai	lead Fisherman
Tufa	To distribute
Tufunga	Construction
Tuki	Holding sack
Ūloa	Communal or village fishing method
Vā fealoa’I	Relationality
Whānau	Family

Chapter 1: Introduction

1.1 Overview

Mental health has become an increasingly urgent public health concern in Aotearoa New Zealand, with recent evidence indicating rising levels of psychological distress across the population, particularly among young people (Fleming et al., 2020). However, these challenges are not experienced evenly. Pacific people continue to report disproportionately high levels of psychological distress alongside persistently low engagement with formal mental health services, a pattern consistently reflected in national surveys and service-use data (Ataera-Minster et al., 2025; Foliaki et al., 2006; Tiatia-Seath, 2014). These inequities point to more than simply unmet needs; they reveal the complex interplay of cultural beliefs, structural barriers, and relational dynamics that shape how mental health is understood, experienced, and responded to within Pacific communities (Fa'alili-Fidow et al., 2016; Patterson et al., 2018). Pacific communities represent one of the youngest and fastest-growing populations in Aotearoa, with Auckland home to the largest Pacific population in the world (Auckland Council, 2023; Raymond & Leo-Anderson, 2021; Stats NZ, 2025). This demographic context emphasises the importance of examining Pacific youths' experiences, especially as they navigate worlds that differ significantly from those experienced by their parents and grandparents.

Despite this, mental health systems in Aotearoa remain largely grounded in Western biomedical models that prioritise individualised and clinical approaches to care. These frameworks often sit in tension with Pacific worldviews, in which wellbeing is understood as relational, holistic, and embedded within family, culture, spirituality, and community (Kapeli, 2026, Pulotu-Endemann & Tu'itahi, 2009; Suaalii-Sauni et al., 2009). As a result, many young Pacific people perceive mainstream services as culturally misaligned or insufficiently responsive to their relational needs (Patterson et al., 2018).

For Pacific people, mental health is rarely understood as an individual concern but is experienced through the lens of relationships, obligations, and collective life. Cultural values such as *fa'aaloalo* (respect), reciprocity, family responsibility, and maintaining relational harmony shape how distress is expressed, interpreted, and supported (Agnew et al., 2004; Samu & Suaalii-Sauni, 2009). Within these contexts, stigma, shame, and expectations of strength can limit open conversation about mental health, contributing to delays in help-seeking and reinforcing disparities in access to care (Statistics NZ & Ministry of Pacific Island Affairs, 2011; Subica et al., 2019). These challenges may intersect with spiritual interpretations of distress, such as tapu (sacredness and restriction) violations, curses, or ancestral concerns, which continue to influence how mental illness is understood within many Pacific households (Foliaki, 1997; Vaka et al., 2009).

Young Pacific adults often find themselves navigating these complex influences while also engaging with broader societal expectations. Many are New Zealand-born and negotiate multiple cultural worlds, balancing Pacific cultural obligations with the norms of contemporary urban life. This can generate tensions around identity, belonging, emotional expression, and understandings of wellbeing (Mila-Schaaf & Hudson, 2009; Uelese, 2025). While existing research has identified these challenges, less is known about how young Pacific adults themselves make sense of these dynamics in their everyday lives, how they interpret, negotiate, and respond to competing cultural, relational, and structural forces.

This gap is particularly evident in urban contexts such as Auckland, where Pacific identities are continually shaped by migration histories, community networks, shifting social norms, and diverse cultural influences. There remains a need for research that centres Pacific youth voices, captures the complexity of their lived experiences, and deepens understanding of how they navigate mental health within these evolving landscapes.

1.2 Research Gaps

Despite clear evidence of mental health inequities among Pacific people, a significant gap remains in understanding how young Pacific adults navigate access to mental health services. Much of the existing literature focuses on population-level disparities or structural barriers, with limited attention to lived experiences and the relational processes that shape help-seeking. In particular, there is a notable lack of research exploring the intersections of cultural expectations, family dynamics, spirituality, and identity in shaping help-seeking decisions. This lack of insight restricts the development of culturally responsive mental health services that reflect the lived realities of young Pacific people.

Existing research on Pacific mental health and wellbeing indicates that young Pacific adults often navigate intersecting structural, cultural, and socioeconomic pressures, including poverty, overcrowded housing, discrimination, and limited access to culturally safe services. These factors can heighten distress and influence how young people understand, express, and seek support for their mental health (Ataera-Minster et al., 2025; Fa'alili-Fidow et al., 2016; Foliaki et al., 2006). However, little is known about how these pressures are interpreted and managed in everyday life, or how they shape young people's decisions to engage with mental health services. Furthermore, emerging evidence suggests that Pacific youth experience disproportionately high levels of psychological distress, burnout, and identity strains shaped by cultural expectations of service, resilience, and collective responsibility (Fleming et al., 2020; Pilisi et al., 2025). These pressures often intersect with experiences of stigma, silence, and limited access to early intervention, creating environments in which distress may remain

unaddressed and seeking support is delayed (Statistics NZ & Ministry of Pacific Island Affairs, 2011; Suaalii-Sauni et al., 2009). Despite these well-documented inequities, little is known about how young Pacific adults themselves understand and navigate the cultural, relational, and structural influences that shape their mental health experiences.

This study therefore aims to explore how young Pacific adults in Auckland navigate the cultural, relational, and social tensions that arise when attempting to access mental health services, addressing a critical gap in the literature and contributing to a deeper understanding of Pacific youth mental health experiences. Developing this understanding is essential for fostering supportive environments, enhancing educational and social opportunities, challenging systemic and societal inequities, and strengthening access to culturally safe and Pacific-led mental health care. Such insights are vital for informing effective policies, programmes, and community initiatives that promote wellbeing, belonging, and holistic development; ultimately contributing to a more equitable and culturally responsive mental health environment in Auckland, New Zealand.

1.3 Research Aim and Question

This study aims to explore how young Pacific adults in Auckland navigate the tensions between cultural beliefs, social expectations, and access to mental health services.

The central research question guiding this study is:

> *How do young Pacific adults in Auckland navigate the tensions between their cultural beliefs and social expectations within Pacific communities while attempting to access mental health services?*

1.4 Research Objectives

To address this question, the study is guided by the following objectives:

- To explore how young Pacific adults understand and experience mental health within their cultural context
- To examine the influence of cultural and social expectations on help-seeking behaviours
- To investigate participants experiences with accessing mental health services in Auckland
- To identify the barriers and facilitators shaping engagement with mental health services

1.5 Significance of the Study

This study contributes to public health knowledge by focusing on the voices and lived experiences of young Pacific adults, a group that remains underrepresented in mental health research. By examining how individuals navigate cultural, relational, and structural influences, this research moves beyond problem-focused narratives and foregrounds the agency, resilience, and adaptability of Pacific youth.

The findings carry important implications for the development of culturally grounded, relational, and youth-centred mental health services. By deepening understanding of how young Pacific adults experience, interpret, and engage with mental health systems, this study supports the ongoing efforts to reduce inequities and strengthen access to culturally responsive care in Aotearoa New Zealand. These insights are crucial for informing practice, policy, and service design that genuinely reflects the realities, values, and strengths of Pacific communities.

1.6 Structure of the Thesis

This thesis is organised into five chapters. Chapter Two provides a critical review of the literature on Pacific mental health, cultural expectations, and access to services. Chapter Three outlines the qualitative methodology underpinning this study, grounded in Pacific epistemologies and incorporating the use of *Ūloa* and T*alanoa*. Chapter Four presents the study's findings and the key themes that emerged from participants' narratives. Chapter Five discusses these findings in relation to existing literature and broader conceptual frameworks, and finally, Chapter Six will concludes the thesis by outlining its key contributions, implications, limitations, and recommendations for future research.

Chapter 2: Literature Review

This study examines access to mental health services among young Pacific adults in Auckland. Accordingly, this chapter critically reviews relevant literature to contextualise how young Pacific adults navigate the tensions between cultural and societal expectations within their Pacific communities and the process of accessing mental health services. By synthesising existing research, this chapter establishes the conceptual, cultural, and structural contexts that shape mental health service access for young Pacific adults.

The literature reviewed includes demographic and mental health data on Pacific people in New Zealand and Auckland, as well as qualitative research on Pacific understandings of mental health, cultural and societal expectations, stigma and shame, family dynamics, spirituality, and experiences with mental health services.

2.1 Pacific People in Aotearoa New Zealand and Auckland: Demographic and Mental Health Context

Pacific People in Aotearoa, New Zealand

Pacific people represent an integral and rapidly growing component of the social and cultural landscape of Aotearoa New Zealand. Their presence is particularly prominent in Auckland, which is home to the largest Pacific population globally (Raymond & Leo-Anderson, 2021). Developing a clear understanding of the demographic and socioeconomic characteristics of Pacific communities is therefore essential for contextualising the lived experiences of young Pacific adults in Auckland, particularly in relation to health, wellbeing, and access to mental health services.

Pacific people account for 8.9% of New Zealand's total population, reflecting a 16% increase since the 2018 Census (Stats NZ, 2025). The Pacific population is characterised by a notably youthful age profile, with a median age of 24.9 years compared with the national median age of 38.1 years (Ministry of Health, 2025). The 2023 Census also indicates that 69.3% of the Pacific population is aged 15 years and over, highlighting the relevance of education, employment, and income as key contextual factors shaping mental health and wellbeing. Within this population, 26.9% hold a tertiary qualification, 51.1% hold a secondary qualification, and 22% report no formal qualifications (Stats NZ, 2025). In terms of income, the median income for Pacific people is $35,200, representing a 44.8% increase since the 2018 Census, although it remains lower than the national median income (Stats NZ, 2025).

Employment patterns further illustrate the socioeconomic positioning of Pacific communities. While many Pacific people are employed in full-time roles (82.4%), a substantial proportion remains in part-time employment (17.6%), often within industries such as manufacturing and construction. In contrast, only a small proportion of Pacific people (9.5%) are employed in health care and social assistance roles (Stats NZ, 2025). Religion also remains a central feature of Pacific life, with 65.1% of Pacific people identifying as religious, predominantly within Christian traditions (Ministry of Health, 2025). In terms of ethnic composition, Samoan people constitute the largest group (48.1%), followed by Tongan (22.1%), Cook Islands Māori (21.3%), Niuean (7.9%), Fijian (5.7%), Tokelauan (2.2%), and Tuvaluan (1.5%) populations, noting that individuals may identify with more than one Pacific ethnicity (Stats NZ, 2025). Collectively, these demographic and socioeconomic characteristics underscore the diversity and complexity of Pacific communities in Auckland and provide essential context for understanding patterns of mental health service access among young Pacific adults.

Pacific People in Auckland

Auckland functions as the primary demographic and cultural centre for Pacific communities in Aotearoa New Zealand. The city is home to approximately 275,079 Pacific people, comprising 16.6% of Auckland's total population, and reflecting a population increase of 12.8% since the 2018 Census (Auckland Council, 2023). This growth has contributed to Auckland's recognition as the largest Polynesian city in the world (Raymond & Leo-Anderson, 2021). Consistent with national patterns, Samoan people constitute the largest Pacific ethnic group in Auckland (49.3%), followed by Tongan (26.4%), Cook Islands Māori (19.1%), Niuean (9.3%), Fijian (4.7%), and Tuvaluan (1.6%) communities, noting that individuals may identify with multiple Pacific ethnicities.

Census data further indicate a strong geographic concentration of Pacific people within specific areas, particularly Māngere-Ōtāhuhu (60.4%), Ōtara-Papatoetoe (48.7%), and Manurewa (39.9%) (Auckland Council, 2023). Auckland's Pacific population is also notably youthful, with 29.5% under the age of 15, compared with 17.2% of the total Auckland population, representing a 3% increase since the 2018 Census. The median age of Pacific people in Auckland is 25.6 years, remaining the youngest among all major ethnic groups in the region (Auckland Council, 2023). Taken together, these demographic patterns, marked by concentrated Pacific communities and a significantly youthful population, indicate that young Pacific people currently make up a growing proportion of those engaging in schools, tertiary institutions, health services, and the workforce. As the youth population grows, the limitations

of mainstream, Western-based systems become more evident, reinforcing the need for youth services that are culturally responsive and grounded in Pacific worldviews. Embedding Pacific-centred approaches that honour vā-based (relational space) relationships, collective values, spirituality, and holistic models of wellbeing is essential not only for supporting this rapidly expanding demographic, but also for ensuring that the systems they navigate reflect and uphold Pacific ways of being.

Beyond demographic significance, Pacific communities play a substantial role in shaping Auckland's cultural, linguistic, and social environment. Pacific cultural practices, church networks, and youth-led cultural engagement are central to community life and social organisations within Auckland. These contexts are particularly relevant when examining mental health service access, as they influence how young Pacific adults understand wellbeing, seek support, and navigate relationships between family, community, and formal health systems.

2.2 Policy and Strategic Context for Pacific Mental Health

Pacific mental health strategies influence how mental wellbeing is understood, valued, and delivered, shaping the systems that young Pacific adults must navigate when seeking support. While these policies do not reflect people's personal lived experiences, they outline the ideas, priorities, and structures that guide how mental health services operate and how wellbeing is framed. As a result, these strategies provide a useful lens for examining whether policy narratives centred on holistic, culturally grounded, and relational approaches to mental health align with the everyday experiences of young Pacific adults.

An example of this is the ʻAla Moʻui: Pathways to Pacific Health and Wellbeing 2014–2018 (Ministry of Health, 2014), a four-year outcomes framework that was designed to guide the delivery of high-quality, accessible, and sustainable health services for Pacific people. Building on earlier policies, the ʻAla Moʻui framework aligned with the Government's long-term health goals to ensure that all New Zealanders, including Pacific people, live healthier and more independent lives, have timely access to quality health services, and benefit from a sustainable health and disability system. The action plan reported that mental health service access rates for Pacific people were broadly comparable to those of the wider population, particularly in Auckland, where designated Pacific mental health and addiction services across the Auckland, Waitematā, and Counties Manukau District Health Boards contributed to improved service utilisation (Ministry of Health, 2018).

The Ola Manuia: Pacific Health and Wellbeing Framework (Ministry of Health, 2020) directly builds on the foundations established by ʻAla Moʻui. Translating to "living well" or "wellness"

across multiple Pacific languages, Ola Manuia articulates a holistic vision for equitable health outcomes grounded in Pacific worldviews, values, and collective wellbeing. Central to the framework is the promotion of independence and resilience, recognising that empowering Pacific people with culturally relevant knowledge and skills supports self-determination, prevention, and effective engagement with the health and disability system. Social cohesion, relational wellbeing, and community connectedness are positioned as foundational to health, particularly for children and young people, reinforcing the view that mental wellbeing is inseparable from family and community wellbeing.

Furthermore, Ola Manuia recognises that mental health is shaped by wider structural and systemic factors and highlights the need to address racism, inequitable access to resources, limited cultural safety, and the lack of holistic, culturally responsive approaches within mainstream services. Pacific people stressed that improving health outcomes requires a whole-of-system approach that acknowledges how institutional arrangements and service delivery models can perpetuate inequities. The framework also situates mental health and wellbeing within the social and economic determinants of health, advocating for cross-government leadership, intersectoral collaboration, and meaningful Pacific community involvement in the design of services and programmes. By centring Pacific voices and lived experience, Ola Manuia challenges deficit-based models of mental health and reframes wellbeing as relational, culturally embedded, and socially determined (Ministry of Health, 2020).

Strong Pacific leadership is identified as a critical enabler of system change, with the ongoing under-representation of Pacific people in senior health decision-making roles recognised as a significant barrier to culturally responsive mental health care. Ola Manuia also underscores the importance of Pacific-led data, evidence, and insights to inform decision-making, strengthen accountability, and ensure that mental health outcomes for Pacific people are visible, measurable, and acted upon. Collectively, these elements shape the mental health system encountered by young Pacific adults, one that increasingly recognises mental wellbeing as collective, culturally grounded, and inseparable from broader social, structural, and community contexts.

There is now a drafted Mental Health and Wellbeing Strategy 2026–2036 (Ministry of Health, 2026), which builds on earlier progress and commits to strengthening a system that is better connected, more responsive, and designed around the needs of people and communities. The strategy reaffirms that every New Zealander is entitled to timely access to quality mental health and addiction support and outlines actions to promote mental wellbeing and deliver responsive, needs-based services. Together, these policy frameworks illustrate a growing

commitment to culturally grounded and holistic approaches to Pacific mental health and wellbeing. However, while they shape the structural and ideological context of service delivery, less is known about how these policy intentions are experienced in practice by young Pacific adults. This highlights the need for research that centres their voices and lived experiences to better understand how mental health strategies are enacted and navigated on the ground.

2.3 Mental Health Outcomes and Service-Use Among Pacific People

Pacific people in Aotearoa New Zealand face higher rates of psychological distress and common mental health disorders, notably depression and anxiety, influenced by intertwined socioeconomic and cultural factors (Foliaki et al., 2006). Research consistently indicates that while Pacific people experience very high levels of psychological distress, they are less likely to access or engage in formal mental health services (Ataera-Minster et al., 2025; Foliaki et al., 2006; Oakley et al., 2006). This pattern is longstanding and remains relatively stable over time (Ataera-Minster et al., 2025; Kapeli et al., 2020). Although this body of literature documents clear disparities in mental health outcomes and service utilisation, it often relies on population-level data that can obscure important differences within Pacific communities, particularly across age groups, ethnic subgroups, and migration histories. As a result, the specific experiences of young Pacific adults are not always clearly reflected within these broader patterns.

Socioeconomic disadvantages, including financial stress, overcrowded housing, and job insecurity contribute to poorer mental health outcomes among Pacific people (Patterson et al., 2018). However, framing these disparities primarily through socioeconomic indicators risks underrepresenting the relational and cultural dimensions of distress, including how family expectations, spirituality, and identity shape both experiences of mental health and decisions to seek support. Emerging research highlights that mental health challenges among Pacific people are not only structurally produced but are also culturally mediated. For example, Pilisi et al. (2025) identify extremely high levels of burnout among New Zealand-born Pacific populations, with nearly 90% of participants reporting burnout, many of whom experience it repeatedly. Burnout is commonly defined as a state of chronic physical, emotional, and mental exhaustion arising from prolonged stress and sustained role demands, accompanied by feelings of depletion, diminished efficacy, and detachment (Maslach, Schaufeli, & Leiter, 2001; World Health Organization, 2019). Burnout was most common among young adults aged 25–34, suggesting that this stage of life is a particularly vulnerable period when cultural, family, and work pressures come together. Importantly, the study shows

that burnout is influenced by Pacific cultural values such as collectivism, service, and self-sacrifice, with individuals often placing family and community responsibilities above their own wellbeing. Even when individuals recognise the importance of self-care, factors such as family expectations and financial pressures can limit their ability to act upon it, showing that wellbeing is shaped not only by personal choices but also by wider relational and structural factors (Pilisi et al., 2025). This highlights a broader limitation in existing research, where mental health outcomes are often viewed through individual or socioeconomic lenses, with limited attention to how culturally embedded expectations of service, obligation, and reciprocity shape experiences of distress.

These dynamics are further reflected in youth mental health patterns across Aotearoa New Zealand. Findings from the Youth19 Rangatahi Smart Survey indicate a concerning decline in youth mental health since 2012, with increasing levels of psychological distress, depressive symptoms, and suicide attempts, particularly among young women (Fleming et al., 2020). Approximately 23% of students report significant depressive symptoms, and 6% report having attempted suicide within a 12-month period, with these outcomes disproportionately affecting Māori and Pacific youth and those living in socioeconomically deprived communities (Fleming et al., 2020). While many young people report positive wellbeing overall, these findings highlight widening inequities shaped by structural determinants such as poverty, racism, family stress, and cultural disconnection. Barriers to accessing support remain significant, with many young people reporting difficulty seeking help, reinforcing patterns of unmet needs despite high levels of distress. At the same time, the study identifies important protective factors, including strong family and community relationships, cultural identity, and access to culturally responsive services, showing that wellbeing is shaped not only by risk but also by culturally grounded sources of support (Fleming et al., 2020). However, while such research identifies key risk and protective factors, it remains limited in examining how young Pacific adults actively interpret and navigate these influences within their everyday lives.

A substantial and growing body of research highlights persistent inequities in both mental health outcomes and service utilisation among Pacific people, particularly those living in Auckland (Ataera-Minster et al., 2025; Fa'alili-Fidow et al., 2016; Foliaki et al., 2006; Ministry of Health, 2025; Oakley et al., 2006; Patterson et al., 2018). Researchers caution against explanations that locate responsibility within Pacific individuals or cultures, rather than addressing broader structural and contextual factors. Instead, Pacific mental health outcomes must be understood within the context of wider structural forces, including historical marginalisation and ongoing systemic inequalities, rather than as the result of individual or cultural shortcomings. The He Ara Oranga report (Patterson et al., 2018) further highlights these concerns, documenting how Pacific communities frequently describe the

mental health system as culturally unsafe, coercive, and dominated by Western biomedical models that inadequately reflect Pacific worldviews. Experiences of institutional racism, inequity, and avoidable harm were reported to diminish trust and discourage service engagement. The report also identifies trauma, poverty, housing instability, unemployment, violence, discrimination, and social isolation as key structural drivers of mental distress among Pacific youth. These findings align with research by Ataera-Minster et al. (2025), which shows that mental health outcomes among Pacific people are shaped by broader social and demographic patterns, including higher rates of common mental disorders among Pacific women and distinct socioeconomic gradients compared with the general population.

Despite clear evidence of need, there is a lack of enabling engagement in service use among Pacific people. Pacific people remain underrepresented in mental health service utilisation compared to the general population (Tiatia-Seath, 2014). Research consistently shows that Pacific people are less likely to access primary or early-intervention mental health services and are more likely to engage with services at later stages of distress, often through acute or crisis-driven pathways (Changing Minds, 2024; Patterson et al., 2018). This pattern of delayed engagement contributes to poorer mental health outcomes and reinforces existing inequities. The disparity between high levels of need and low service use suggests that barriers to access extend beyond availability and instead reflect deeper cultural, social, and systemic factors.

Although Pacific people remain underrepresented in mental health service utilisation, a wide range of services are available to Pacific young adults in Aotearoa New Zealand. These include mainstream primary care and counselling services, school-based supports, youth-specific organisations, and Pacific-led providers that draw on culturally grounded models of care (Health New Zealand | Te Whatu Ora, 2026). Pacific-led services place Pacific principles and practices at the centre of care, providing culturally safe and inclusive settings that are family-centred, holistic, clinically and culturally integrated, community-based, and connected (Health New Zealand | Te Whatu Ora, 2026). However, the presence of these services does not necessarily translate into meaningful access for Pacific youth. Existing research shows that mainstream services are often experienced as culturally unsafe, overly clinical, or disconnected from Pacific relational and spiritual understandings of wellbeing (Kapeli, 2026). Pacific-led services, while highly valued, remain limited in availability and are frequently constrained by Western funding structures that restrict their ability to deliver holistic, culturally embedded care (Patterson et al., 2018). Consequently, many Pacific young adults rely on informal pathways; family, peers, church networks, or self-management, before approaching formal services, reinforcing patterns of delayed engagement despite high levels of need (Kapeli, 2026; Tiatia-Seath, 2014).

Table 1: Early-Intervention Mental Health Services in Auckland (Pacific-Led & Clinical)

Service	Type	Target age/group	Referral needed?	Core Supports	Cultural Responsiveness (Pacific)
South Seas Healthcare (Ōtara)	Pacific-led primary mental health	Pacific youth & young adults	No	Counselling, youth workers, social services, navigation, wellbeing programmes	Very high: Pacific clinicians, family-centred, community-embedded
The Fono (Central, West, South)	Pacific-led primary mental health	Pacific youth & young adults	No	Counselling, early-intervention support, youth wellbeing programmes	Very high: Pacific staff, holistic Pacific model
Vaka Tautua (Auckland)	Pacific mental health NGO	Pacific youth & adults	No	Psychosocial support, mental health support workers, navigation	High: Pacific workforce, family-inclusive
Harmony Pasifika (Auckland)	Pacific counselling & therapy	Pacific youth & families	No	Counselling, group therapy, Tongan-language programmes	High: Pacific-specific therapeutic approaches
Isa Lei – Waitematā Pacific Mental Health Service	DHB Pacific cultural-clinical team	Pacific youth & families	Yes (via CMHC or GP)	Cultural support, care coordination, clinical liaison	High: Pacific cultural advisors integrated with clinical teams
Village Collective (Manukau)	Pacific youth wellbeing	Pacific youth (incl. rainbow youth)	No	Talanoa-based support, youth programmes, sexual health & wellbeing	Very high: Pacific youth-led, identity-affirming
Kia Puāwai (Auckland)	Youth wellbeing service	Youth & rangatahi	No	Early-intervention support, therapy, whānau engagement	Moderate: culturally responsive, works with Pacific youth

Hāpai Ora – Early Intervention Service (Epsom)	Clinical early-intervention psychosis service	Youth & young adults (approx. 14–30)	Yes	Psychiatric care, therapy, home-based support, relapse prevention	Moderate–High: Māori & Pacific cultural advisors available
Community Mental Health Centres (CMHCs)	Clinical secondary mental health	Youth & adults	Yes	Psychiatric assessment, therapy, case management	Variable: depends on team; may involve Pacific clinicians
Access & Choice – Pacific Wellbeing Services (Auckland providers)	Pacific-led early-intervention wellbeing	Pacific youth & adults	No	Talking therapies, peer support, self-management tools	Very high: designed specifically for Pacific communities

Table 1 is a comparison of early-intervention mental health services in Auckland that illustrates how Pacific young adults navigate a complex and uneven service landscape shaped by longstanding inequities in access and cultural safety. Pacific-led providers, including South Seas Healthcare, The Fono, Vaka Tautua, Harmony Pasifika, Village Collective, and the Access & Choice Pacific Wellbeing Services - offer low-barrier, relational, and culturally grounded support that centres family, spirituality, identity, and community as core determinants of wellbeing (Health New Zealand | Te Whatu Ora, 2026). These services privilege Talanoa-based engagement, collective decision-making, and culturally safe environments led by Pacific clinicians and youth workers, aligning closely with Pacific young adults' preferences for holistic and relational care (Kapeli, 2026; Tiatia-Seath, 2014). In contrast, clinical early-intervention models such as Hāpai Ora, Community Mental Health Centres, and District Health Board (DHB)-based Pacific cultural-clinical teams (e.g., Isa Lei) operate within biomedical frameworks that emphasise diagnosis, risk management, and evidence-based psychiatric and psychological treatment, requiring formal referral pathways and often providing care only once distress has escalated (Patterson et al., 2018). Although cultural advisors are frequently embedded within these clinical teams, their role is typically additive rather than foundational, reflecting broader structural constraints that limit the integration of Pacific worldviews within mainstream services (Agnew et al., 2004; Samu & Suaalii-Sauni, 2009; Patterson et al., 2018).

This comparison highlights a critical pattern in Pacific youth service use. Despite the availability of culturally grounded Pacific-led services, their reach remains limited due to

funding constraints, workforce shortages, and systemic reliance on Western accountability structures (Patterson et al., 2018). As a result, many Pacific young adults continue to rely on informal pathways such as family, peers, church networks, or self-management before engaging with formal services, contributing to delayed help-seeking and crisis-driven patterns of service utilisation (Tiatia Seath, 2014). The coexistence of culturally resonant Pacific-led services and clinically intensive biomedical models therefore underscores the need for integrated pathways that honour both cultural and clinical expertise, ensuring that Pacific young adults can access early, culturally safe, and developmentally appropriate support within Auckland's mental health system.

Table 2: Digital-Only Early-Intervention Tools for Pacific Youth Mental Health

Tools/ platform	Developer	Target age/group	Referral needed?	Core Function	Cultural Responsiveness (Pacific)
Aunty Dee	Le Va	Pacific & Māori youth (14–25)	No	Structured problem-solving (CBT-based), coping skills, safety prompts	Very high: co-designed with Pacific youth; uses Pacific relational metaphors
Headstrong	Le Va	Pacific youth	No	Wellbeing content, videos, identity-based strengths, mental health literacy	Very high: Pacific youth-focused, culturally grounded
Mental Wealth	Le Va	Pacific families & youth	No	Mental health literacy, stress/anxiety guidance, wellbeing information	High: Pacific inclusive content and framing
SPARX	University of Auckland	Youth (12–19)	No	CBT-based fantasy game teaching coping skills, mood management	Moderate–High: evaluated with Māori & Pacific youth; culturally safe
Small Steps	Te Whatu Ora	Youth & adults	No	Short digital exercises for anxiety, low mood, sleep, stress	Moderate: culturally inclusive, accessible to Pacific youth
Just a Thought	Wise Group	Youth & adults	No	Free online CBT courses (anxiety, depression, stress)	Moderate: not Pacific-specific but widely used by Pacific young adults
Village Collective Online Resources	Village Collective	Pacific youth (incl. rainbow youth)	No	Sexual health, identity, wellbeing content, Talanoa-based guidance	High: Pacific youth-led, culturally affirming

Le Va FLO Online Resources	Le Va	Pacific communities	No	Suicide prevention information, culturally grounded guidance	High: Pacific-specific suicide prevention content

Table 2 outlines the digital early intervention tools available to Pacific youth in Auckland, showing how online supports have become an essential response to persistent inequities in access, cultural safety, and early help seeking. Pacific-designed platforms such as Aunty Dee, Headstrong, Mental Wealth, and Le Va's FLO resources provide culturally grounded, strengths-based, and identity-affirming support that aligns closely with Pacific relational worldviews and collective approaches to coping. These tools offer low-barrier, anonymous pathways into mental health support, enabling Pacific young people to engage with structured problem-solving, wellbeing content, and suicide prevention guidance without navigating the cultural discomfort, stigma, or mistrust often associated with mainstream services (Kapeli, 2026; Tiatia-Seath, 2014). Their design reflects Pacific youth preferences for relational metaphors, cultural narratives, and holistic understandings of distress, addressing gaps in cultural responsiveness that continue to shape service-use inequities across the wider mental health system.

Alongside these Pacific-specific platforms, New Zealand's broader digital mental health tools, including SPARX, Small Steps, and Just a Thought, provide evidence-based cognitive behavioural therapy (CBT) strategies through free online CBT courses and interactive modules designed to support anxiety, low mood, stress, and sleep difficulties. Although not designed specifically for Pacific communities, these tools have been evaluated with Māori and Pacific youth and offer accessible, youth-friendly formats that complement Pacific wellbeing approaches (Fleming et al., 2020). Village Collective's online resources further extend this network by providing Talanoa based guidance, sexual health information, and identity-affirming content for Pacific youth, including rainbow communities, reinforcing the importance of culturally safe digital spaces.

2.4 Pacific Worldviews of Mental Health, Wellbeing, and Spirituality

Pacific worldviews of mental health and wellbeing are grounded in holistic, relational, and culturally embedded understandings of the individual (Suaalii-Sauni et al., 2009). While these frameworks are widely recognised within Pacific mental health research, they are often presented as coherent and unified models, with less attention given to diversity across Pacific ethnic groups, generational differences, and diasporic experiences in urban contexts such as Auckland. Scholars have also noted that mental health for Pacific people cannot be understood

in isolation from family, spirituality, culture, and social relationships. Rather than being conceptualised as an individual or purely psychological phenomenon, mental health and wellbeing are understood as an interconnected state shaped by spiritual balance, relational harmony, and collective identity (Tiatia-Seath, 2014). These worldviews provide essential context for understanding how Pacific people, particularly young Pacific adults, interpret mental distress and engage with mental health services.

This relational and holistic understanding of wellbeing contrasts with dominant Western models of mental health, which tend to emphasise individual disorders, diagnosis, and clinical intervention. Kapeli (2026) highlights the limitations of these individualised frameworks in addressing the needs of Pacific people, arguing that such approaches fail to accurately reflect the collective and relational nature of Pacific wellbeing. Instead, Pacific mental health is grounded in interconnected relationships between the individual, family, community, culture, and spirituality, with concepts such as vā (sacred relational space) reinforcing the importance of maintaining harmony and balance across these domains. While Pacific communities recognise the value of clinical expertise, healing is not viewed as an individual process but as one that occurs within relational networks, including family, church, and trusted community members. The dominance of Western models within Aotearoa New Zealand's mental health system has therefore contributed to disengagement, particularly where services are perceived as culturally unsafe or disconnected from Pacific ways of knowing and being. These insights reinforce the need for culturally grounded and relational approaches to mental health care that integrate clinical support with community and cultural systems (Kapeli, 2026).

Similarly, Manuela and Sibley (2013) argue that Pacific identity and wellbeing cannot be reduced to individual self-concept but must be understood as inherently relational and embedded within family and community contexts. Their development of the Pacific Identity and Wellbeing Scale (PIWBS) highlights key dimensions of Pacific wellbeing, including connectedness and belonging, religious centrality, and perceived familial wellbeing, all of which are deeply intertwined in shaping experiences of health. This framework emphasises that identity is not only about individual affiliation but about shared relationships, cultural participation, and collective belonging. In contrast to Western individualistic models, Pacific identity is sustained through relational ties, cultural practices, and spiritual engagement, which reflect a holistic understanding of the self. The authors further highlight the influence of the New Zealand social context, noting that Pacific people often navigate between cultural worlds, where maintaining cultural identity alongside engaging with dominant systems can shape both wellbeing and access to support (Manuela & Sibley, 2013). However, much of this literature remains largely descriptive, with limited observational studies of how these holistic

frameworks are actively interpreted and carried out by young Pacific adults navigating contemporary urban and institutional contexts.

The literature highlights that Pacific wellbeing is understood as a state of balance between these interconnected domains, rather than the absence of mental illness alone. Mental distress is therefore often interpreted as a disruption of balance, whether within the individual, the family, or the wider community. A prime illustration of this can be found in Pulotu-Endemann and Tu'itahi's (2009) Fonofale model of health, which uses the metaphor of a Samoan fale (house) to represent the interconnected domains that collectively shape Pacific wellbeing. The foundation of the fale represents the 'aiga or kāinga (family), signifying the central role of family in providing identity, belonging, support, and stability. The pou (posts) represent key dimensions of health, including spiritual wellbeing, physical wellbeing, mental wellbeing, and "other", acknowledging factors such as gender, sexuality, age, and socioeconomic status. The roof symbolises cultural values and beliefs that shelter family life, while the surrounding environment represents time and context, including historical, social, and political conditions that shape Pacific experiences of health and wellbeing. Collectively, the Fonofale model emphasises balance and interdependence across these domains, reflecting Pacific worldviews in which health is understood not merely as the absence of illness but as a state of harmony between the individual, family, culture, spirituality, and environment. While models such as Fonofale provide valuable culturally grounded frameworks, they are often applied in fixed or symbolic ways within policy and service contexts, with limited attention to how they are meaningfully implemented in practice.

The literature further recognises spirituality as a central component of Pacific mental health, challenging dominant Western biomedical explanations of mental distress (Suaalii-Sauni et al., 2009; Vaka et al., 2009). Suaalii-Sauni et al. (2009) emphasise the shared philosophical foundations that ground Pacific worldviews of mental health, particularly the importance of kin-based relationships and ancestral spirituality. Within these worldviews, spirituality is closely tied to how Pacific people understand themselves and is strongly connected to cultural values, social relationships, and collective identity. Concepts such as tapu shape understandings of the self and guide relational conduct. Pacific social relationships are described as socio-centric rather than individualistic, shaped not only by social and political relations but by spiritual connections between individuals, families, communities, the natural environment, and God(s). Core values such as reciprocity, love and compassion (e.g., 'Ofa in Tongan), respect and deference (e.g., fa'aaloalo in Samoan), and deep family interconnectedness (e.g., magafaoa in Niuean and kopu tangata in Cook Islands Māori) further reflect this relational worldview. The self is therefore understood as relational, with

rights and responsibilities situated within collective and spiritual relationships rather than individual autonomy, echoing the Fonofale model (Pulotu-Endemann & Tu'itahi, 2009).

2.5 Shame, Stigma, and Taboo

Shame and stigma operate as central mechanisms through which mental health becomes framed as taboo within many Pacific communities, shaping how distress is understood, disclosed, and acted upon (Suaalii-Sauni et al., 2009). While stigma and shame are consistently identified as key barriers, much of the literature tends to frame them as relatively stable cultural features, with limited attention to how young Pacific adults actively navigate, challenge, and reinterpret these norms in contemporary contexts. To strengthen this framing, stigma can be understood not as a static cultural trait but as a dynamic social process that shifts across contexts and generations. More broadly, stigma is not a fixed or uniform phenomenon but a dynamic social process. Corrigan and Watson (2002) conceptualise stigma as operating at both public and individual levels, where dominant stereotypes such as perceptions of dangerousness, incompetence, and personal weakness lead to discrimination and social exclusion. Unlike physical illness, mental illness is often perceived as being within individual control, resulting in a lack of sympathy and increased blame.

Clinically, mental illness refers to persistent disturbances in cognition, emotion regulation, or behaviour that lead to significant distress or impairment, as defined in major diagnostic systems such as the ICD-11 (International Classification of Diseases, 11th Revision) (World Health Organization, 2019). However, Pacific conceptualisations of mental illness differ significantly from biomedical definitions, shaped by holistic, relational, and spiritual worldviews, in which distress is understood not only as an individual psychological condition but as an expression of imbalance within social, cultural, or spiritual domains. Pacific peoples may interpret mental illness through spiritual or socio-moral explanations, including ancestral wrongdoing, relational disharmony, or breaches of cultural norms, and may view experiences such as depression or anxiety as arising from disruptions in family, community, or cultural obligations (Subica et al., 2019). These culturally grounded interpretations demonstrate that mental illness is not a universal category but one mediated by social, spiritual, and relational contexts, highlighting the importance of culturally responsive approaches to understanding Pacific experiences of distress.

These public attitudes can be internalised, producing self-stigma that can diminish self-esteem and self-efficacy. Yet Corrigan and Watson (2002) identify a central contradiction, in that while some individuals internalise stigma and feel diminished by it, others resist or reject these narratives, responding with indifference or anger depending on their identities and social

positions. This variability underscores that stigma is shaped by social context, identity, and power rather than being a fixed cultural barrier. Such insights highlight the need for more nuanced research with Pacific youth, whose experiences of stigma are shaped by rapidly changing cultural, social, and digital environments.

For Pacific young people, stigma is shaped by age, class, gender, migration history, and cultural context. Research illustrates that fears of judgment, embarrassment, and bringing shame upon oneself or one's family discourage open discussion of emotional distress and delay engagement with professional support (Beautrais et al., 2006; Statistics New Zealand & Ministry of Pacific Island Affairs, 2011; Uelese, 2025). Within Pacific communities, stigma is often reinforced through culturally embedded beliefs about the causes and meanings of mental illness. Subica et al. (2019) demonstrate that mental illness may be framed through socio-moral interpretations, including notions of poor character or upbringing, rather than biological causes. These conditions are sometimes perceived as less serious, more likely to resolve independently, and less responsive to treatment, all of which are associated with reduced help-seeking. Additionally, individuals experiencing mental illness may be perceived as dangerous, reinforcing social distancing and exclusion. These findings demonstrate how stigma is not only interpersonal but structurally embedded within cultural belief systems. However, attributing stigma solely to cultural beliefs risks reinforcing deficit narratives if not considered alongside broader structural and historical influences, including colonialism and systemic inequity. Equally important is recognising youth agency, as emphasising silence without acknowledging resilience, peer support, or digital spaces for disclosure may obscure the strengths Pacific youth draw upon.

Stigma is further intensified when young Pacific people navigate intersecting identities, particularly for those who identify as Rainbow or MVPFAFF+ (Māhū, Vakasalewalewa, Palopa, Fa'afafine, Akava'ine, Fakaleitī, Fakafifine), where cultural, social, and institutional marginalisation overlap and compound their experiences of distress (Thomsen & Brown-Acton, 2021). The 2023 census data in Aotearoa New Zealand show that sexual minority populations experience higher levels of poor mental wellbeing, discrimination, and difficulty expressing identity compared to heterosexual individuals (Stats NZ, 2023), with sexual minority youth also demonstrating significantly higher rates of depressive symptoms (Lucassen et al., 2017). Yet intersectional identities are not solely sites of vulnerability. Chiang et al. (2017) found that "double minority" youth may draw on culturally grounded protective factors such as family support, community belonging, and shared values, highlighting the protective role of cultural identity. However, broader evidence demonstrates that Rainbow and MVPFAFF+ communities continue to face significant structural barriers to care, including discrimination, pathologisation, and culturally unsafe services (Clark et al., 2014; Royal

Australian and New Zealand College of Psychiatrists, 2021; Veale et al., 2019). Moyle (2025) further highlights how stigma operates at an institutional level, demonstrating that historical assimilation practices have enacted identity erasure and contributed to ongoing mistrust and disengagement. Together, these findings illustrate that stigma for Pacific youth is intersectional and structural, shaped by overlapping identities and systemic inequities.

Acculturation further shapes the experiences of stigma. Kapeli, Manuela, and Sibley (2020) highlight the intersecting roles of acculturation, stigma, and mental health service engagement in shaping experiences of mental distress among Pacific people. Their review shows that mental distress varies across Pacific subgroups, with higher levels observed among New Zealand-born Pacific people compared to those who migrated as adults. This pattern is linked to prolonged exposure to Western social norms and the ongoing negotiation of competing cultural expectations. Acculturation— which refers to sustained contact with a new culture resulting in changes to values, behaviours, and ways of life (Berry, 2010)— may increase vulnerability to shame and stigma, especially when Western biomedical models of mental illness conflict with Pacific cultural values emphasising strength, collective reputation, and family honour (Foliaki, 1997; Vaka, 2009). For Pacific youth positioned at the intersection of these value systems, this tension may produce identity strain and internalised stigma. Similar patterns are reflected in Rudra's (2025) study of international students, which demonstrated that acculturation stress was associated with poorer psychological wellbeing and heightened self-stigma. These findings suggest that acculturative pressures not only heighten psychological vulnerability but may also suppress disclosure by framing distress as personal weakness or cultural failure.

These influential factors are deeply embedded within Pacific family and community structures, where cultural understandings of distress are most evident. Parents, extended kin, and church networks are often the first source of support when individuals experience mental distress. However, these same spaces can also be where stigma operates most strongly, acting as a barrier to disclosure and reducing compassion toward those experiencing mental illness, thereby reinforcing silence and avoidance (Ataera-Minster & Trowland, 2018; Deverick et al., 2017). Pacific worldviews conceptualise health holistically, as a balance across spiritual, cultural, relational, and physical domains. Within this framework, mental illness is often interpreted as resulting from violations of tapu, spiritual disturbances, disrupted relational harmony, or ancestral wrongdoing (Fa'alogo-Lilo & Cartwright, 2021; Foliaki, 1997; Parsons, 1984; Samu & Suaalii-Sauni, 2009; Vaka et al., 2009). Such interpretations carry profound moral and relational implications, linking mental distress to family reputation and spiritual accountability. For young Pacific people, this may increase fears of disappointing parents or exposing private, sacred matters to outsiders. Research further indicates that distress may be

attributed to ghosts, offending spirits, or intergenerational curses (Tucker-Masters & Tiatia-Seath, 2017; Vaka et al., 2009). While these interpretations can sometimes reduce individual blame by attributing illness to external forces (Leckie & Hughes, 2017), they may simultaneously reinforce stigma by embedding distress within moral and cultural narratives that demand silence and emotional restraint.

Intergenerational differences further complicate these dynamics. The younger generations may be more exposed to open mental health discourses through schools, social media, and non-Pacific peer networks, yet remain constrained by familial and cultural expectations that prioritise privacy, resilience, and respect (Suaalii-Sauni et al., 2009). Qualitative studies demonstrate that concerns about confidentiality, cultural caregiving obligations, and family honour often lead young Pacific adults, particularly young women, to conceal distress and rely on informal or spiritual supports rather than formal mental health services (Auva'a-Alatimu et al., 2024; Faleafa, 2010; Uelese, 2025). Foliaki (1997) similarly highlights how migration reshapes traditional beliefs and family dynamics, creating generational shifts that may simultaneously weaken traditional protective mechanisms and sustain concerns about reputation and shame. This results in complex, non-linear patterns of care that move between family, church, traditional healers, and biomedical services rather than straightforward engagement with mainstream mental health systems.

At the structural level, stigma and shame contribute to low utilisation of primary mental health care, with fear of reputational harm discouraging young adults from approaching general practitioners or disclosing distress within clinical settings (Statistics New Zealand & Ministry of Pacific Island Affairs, 2011). Consequently, many Pacific youths seek professional help only when distress becomes severe or crisis-driven, reinforcing inequities in access and outcomes (Auva'a-Alatimu et al., 2024). Families themselves may experience shame or guilt when external intervention is required, perceiving professional help as a failure of cultural caregiving responsibilities (Faleafa, 2010; Foliaki, 1997).

Viewed together, these findings illustrate that stigma and shame are not merely individual attitudes but relational and culturally embedded processes that shape how Pacific youth understand and respond to mental distress. These processes are sustained through family structures, spiritual worldviews, migration histories, intergenerational dynamics, and intersecting identities that regulate what can be spoken, who can speak, and when support can be sought. Despite extensive documentation of stigma as a barrier, limited research examines how young Pacific adults actively resist, reinterpret, or navigate stigma in their everyday lives. Addressing Pacific mental health inequities therefore requires more than improving service availability, it demands critical engagement with the cultural and

relational contexts that structure expectations of strength, resilience, respect, and collective responsibility. This provides the foundation for examining the cultural and social expectations shaping the lives of young Pacific adults, as explored in the following section.

2.6 Cultural and Societal Expectations Within Pacific Communities

Cultural and societal expectations within Pacific communities profoundly shape how mental health is understood, experienced, and managed. Pacific worldviews emphasise relational identity, collective responsibility, respect (fa'aaloalo), compassion (ofa), reciprocity, and sacred connections between people, ancestors, nature, and spirituality (Agnew et al., 2004). Within these frameworks, the self is understood as relational rather than individualised, and wellbeing is closely tied to family, church, and community. While these values provide belonging, resilience, and cultural strength, they also establish expectations that influence how young Pacific adults interpret distress and whether they feel able to seek external professional support. Through their interplay, these cultural foundations create both protective structures and subtle pressures that shape how mental health is navigated.

A recurring theme in the literature is the tension experienced by young Pacific adults, particularly young Pacific women, who describe being "torn between two cultures" when navigating Pacific cultural expectations alongside Western societal norms (Uelese, 2025). However, describing young Pacific adults as being "in-between" cultures similarly risks oversimplifying their lived experiences, as it positions Pacific and Western cultures as fixed and oppositional rather than acknowledging the fluid, negotiated nature of identity. Mila-Schaaf and Hudson (2009) challenge this binary by introducing the concept of a "negotiated space," where Pacific people actively engage with, adapt, and integrate multiple knowledge systems. Rather than being passively caught between cultures, young Pacific adults exercise agency in selecting what is meaningful from both Pacific and Western frameworks. Central to this process is Vā, the relational space that connects people, ideas, and systems, which must be maintained through balance, reciprocity, and respect. This perspective reframes cultural navigation as a dynamic and relational process, enabling dialogue, transformation, and the co-existence of multiple ways of knowing. This challenges dominant deficit-oriented narratives that position Pacific youth as passively caught between cultures, instead emphasising agency, adaptability, and the active construction of identity within complex and shifting social environments. In doing so, it counters deficit-oriented narratives and foregrounds Pacific youth agency, adaptability, and relational strength.

This adaptive negotiation is further reflected in broader Pacific experiences of social change. Macpherson and Macpherson (2013) demonstrate how Sāmoan society has historically engaged with globalisation through selective adaptation rather than cultural

loss, maintaining core relational structures such as ‘aiga (family) and village systems while incorporating external influences. Within these systems, values of respect, reciprocity, and relationality (vā fealoa‘i) continue to shape identity and social roles. The coexistence of Indigenous spiritual beliefs alongside Christianity, and traditional healing alongside Western biomedical models, illustrates how multiple systems of knowledge can operate in parallel. These insights suggest that young Pacific adults navigating mental health are not simply negotiating opposing systems but are often operating within integrated and overlapping frameworks shaped by both continuity and change. This highlights cultural change as an ongoing process of adaptation rather than erosion, requiring nuanced interpretation within Pacific mental health research.

Despite this capacity for negotiation, tensions remain evident and can produce identity strain, internal conflict, and feelings of disconnection from parents and elders. Respect hierarchies and expectations of deference can constrain open discussion of mental distress, leaving young people feeling unable to disclose struggles out of fear of judgement, shame, or disappointing their families. These generational and cultural tensions may weaken the parent–child relationships and complicate help-seeking, particularly for New Zealand-born Pacific youth negotiating hybrid identities (Fa’alili-Fidow et al., 2016; Mila-Schaaf, 2011). Gendered expectations further intensify these pressures. Pacific young women experience disproportionately high rates of depression, self-harm, and suicidal ideation compared to their male counterparts, reflecting intersecting cultural and social pressures (Statistics New Zealand & Ministry of Pacific Island Affairs, 2011). Cultural expectations surrounding obedience, achievement, caregiving, and emotional restraint contribute to heightened vulnerability, while social pressures from family, teachers, and peers compound feelings of not belonging or being overwhelmed (Roy et al., 2023). For young Pacific adults holding multiple marginalised identities, such as being Pacific and Rainbow or Pacific and disabled, these tensions are further intensified, creating layered barriers to safety and support in both community and clinical settings (Roy et al., 2023). Yet, despite these pressures, many young people actively draw on cultural strengths, relational networks, and identity-based resources to navigate these challenges, an area still underexplored in the literature.

By contrast, identity complexity does not solely produce vulnerability. In the social-psychological literature, “identity complexity” refers to an individual’s subjective understanding of how their multiple social group memberships relate to one another, including the degree of overlap, distinctiveness, and integration across identities (Roccas & Brewer, 2002). Higher identity complexity is associated with more flexible identity negotiation and, in some cases, more adaptive coping. Research on “double minority” youth suggests that intersectional identities can also foster resilience. Chiang et al. (2017) found that ethnic

minority youth may draw on culturally grounded resources such as family support, community belonging, and shared values to protect against discrimination and psychological distress. In some cases, young people with intersecting identities reported comparable or even better wellbeing outcomes than their peers, highlighting the protective role of culturally embedded support systems. These findings suggest that identity complexity can generate not only strain but also strength, enabling young people to draw on multiple identity-based resources when navigating challenging social contexts. This underscores a critical gap in literature, which has historically prioritised risk over resilience.

Identity complexity is particularly relevant for Pacific youth in Aotearoa New Zealand, who often navigate multiple, overlapping identities shaped by ethnicity, migration history, generational status, spirituality, language, and engagement with both Pacific and Western cultural systems (Ataera-Minster & Trowland, 2018; Veukiso-Ulugia et al., 2025). For many young Pacific adults, identity negotiation involves balancing expectations of cultural continuity with the realities of living in a Western context that prioritises individual autonomy, clinical disclosure, and self-expression (Vaka, Brannelly, & Huntington, 2016). This negotiation can be a source of resilience when young people draw on cultural values, kinship networks, and collective identity as protective resources (Veukiso-Ulugia et al., 2025), but it can also produce strain when expectations of cultural authenticity, language fluency, or adherence to traditional practices conflict with lived experiences (Samu & Suaalii-Sauni, 2009). These tensions illustrate how identity navigation is both culturally grounded and context-dependent, shaped by competing expectations across relational and institutional settings.

Family expectations remain central within Pacific communities and significantly influence mental health navigation. Extended family, church, and village networks often require financial and material contributions to social and religious events and failure to meet these obligations can result in embarrassment and emotional distress (Foliaki, 1997). While strong family and religious networks may mitigate certain stressors, they can also intensify pressure when cultural responsibilities are prioritised over individual wellbeing (Foliaki, 1997). Mental health decisions are frequently negotiated within families through shared “kinship stories,” where narratives of illness are constructed relationally rather than individually (Parsons, 1984). Consequently, accessing professional mental health services is not solely an individual decision but a relational and moral process that can generate feelings of shame or guilt associated with perceived shortcomings in cultural caregiving responsibilities (Faleafa, 2010). Stigma and expectations of resilience further shape help-seeking behaviours. Cultural attitudes that problems should be managed within the family rather than externally can delay engagement with formal mental health services (Fa’alogo-Lilo & Cartwright, 2021).

Research indicates that only a minority of Pacific individuals with serious mental disorders access mental health services, with many entering care through acute or forensic pathways rather than community-based supports (Foliaki et al., 2006). These patterns reflect both structural barriers and cultural expectations surrounding strength, honour, and collective responsibility. Among some young people, distress may be communicated indirectly through low optimism, sadness, or expressions of hopelessness, rather than explicit suicidal ideation, especially in contexts where discussing suicide is heavily stigmatised (Auva'a-Alatimu et al., 2024). Such indirect expressions highlight how cultural norms shape not only the visibility of distress but also the pathways through which support is sought.

Identity complexity also emerges as a key theme. Although cultural connectedness is generally protective, notable variation exists across Pacific subgroups, with multi-ethnic and New Zealand-born Pacific youth often reporting weaker cultural attachment and poorer mental health outcomes (Ataera-Minster & Trowland, 2018). Pride in cultural identity does not necessarily correspond with confidence in navigating cultural practices or fluency in language, creating tension between expectations of authenticity and lived experience. Samu et al. (2019) highlights the importance of heritage language as a core component of identity and wellbeing, with language loss posing significant threats to young people's sense of belonging and cultural continuity. While efforts to reclaim language are emerging, limited access to resources and fluent speakers makes this process challenging, contributing to ongoing identity tension. In this context, identity complexity becomes a central lens for understanding how Pacific youth negotiate multiple cultural expectations simultaneously, and how these negotiations shape both resilience and vulnerability in mental health navigation. Consequently, young Pacific adults often navigate expectations to uphold cultural integrity while engaging with Western institutions that prioritise individual autonomy and clinical disclosure (Vaka et al., 2022). This dual navigation underscores the relational and context-dependent nature of Pacific youth mental health experiences.

Through this body of evidence, these insights illustrate that cultural and societal expectations within Pacific communities operate as both protective and constraining forces. They provide identity, belonging, and relational support, yet may also generate pressure, silence, and delayed help-seeking when mental distress is experienced. For young Pacific adults in Auckland, navigating mental health services involves ongoing negotiation between cultural loyalty, family obligations, spiritual beliefs, social pressures, and institutional systems that are not always designed to accommodate their realities (Agnew et al., 2004; Faleafa, 2010). Taken collectively, this body of literature highlights the need to move beyond simplified notions of cultural conflict and instead recognise the complex, relational, and context-dependent processes through which young Pacific adults actively navigate mental health and

help-seeking. These findings reinforce the importance of culturally responsive, relational, and youth-centred approaches to mental health care, directly informing this study's focus on how young Pacific adults negotiate tensions between cultural expectations and access to mental health services.

2.7 Young Pacific Adults Navigating "In-Between" Cultural Worlds

With expectations comes tensions, and this chapter examines how young Pacific adults navigate the tensions "in-between" cultural worlds. Rather than reiterating cultural norms themselves, the literature shifts attention to the processes of negotiation that young Pacific adults undertake as they move between familial, cultural, and societal spaces. However, positioning these experiences solely as "in-between" risks oversimplifying the complexity of young Pacific adults lived experiences, as it may reinforce binary understandings of culture rather than recognising identity as fluid, overlapping, and relational. Within parent–child relationships, respect for elders and traditional communication practices remain deeply embedded; however, these same norms can constrain open conversations about mental health (Uelese, 2025). Young Pacific women describe the emotional labour involved in balancing openness with deference, often suppressing distress to avoid appearing disrespectful or ungrateful. When generational expectations clash with contemporary understandings of mental health, young people may feel unheard or dismissed, contributing to relational distance and identity strain (Uelese, 2025). This highlights a broader gap within the literature, which often documents these tensions without sufficiently examining how young Pacific adults actively navigate, resist, or reinterpret these dynamics in everyday contexts.

Navigation also occurs at the level of identity and belonging. Young Pacific adults frequently experience tension between Pacific cultural traditions and life in New Zealand, shaping how they interpret distress and whether they consider formal mental health care appropriate (Foliaki et al., 2006). For some, strong ethnic identification fosters resilience and belonging; for others, visible cultural identity may heighten exposure to discrimination and institutional racism, complicating their sense of safety within mainstream systems (Marie et al., 2008). These layered experiences mean that negotiating mental health support is not simply about reconciling two cultures, but about managing the intersection of identity, marginalisation, and belonging within broader social structures. This underscores the importance of situating help-seeking within broader histories of institutional mistrust and cultural marginalisation, which continue to shape how Pacific communities engage with formal mental health systems. Moyle (2025) further illustrates how institutional, medical, and faith-based systems in Aotearoa New Zealand have historically functioned as sites of identity regulation and exclusion for diverse communities, producing ongoing mistrust and cultural misalignment within the care systems. This suggests that engagement with mental health

services is shaped not only by cultural negotiation but also by structural dynamics, including power, recognition, and the extent to which systems affirm or marginalise Pacific identities. Such histories contribute to contemporary hesitancy towards formal mental health services, particularly where systems fail to recognise the interconnected nature of identity, culture, and wellbeing.

At the same time, identity is not only a site of tension but also a source of strength. Moyle (2025) emphasises that cultural, gender, and social identities are experienced holistically and can foster resilience when affirmed within supportive family and community environments. This aligns with broader Pacific understandings of relational identity, where belonging and collective care can act as protective factors in navigating distress. However, when these identities are misunderstood or unsupported within the institutional settings, they may instead become sources of vulnerability, further complicating engagement with mental health services.

Family remains central to this navigation process. Emotional wellbeing is shaped within family dynamics, which may function as sites of resilience when characterised by trust and affirmation, yet also become sites of tension where stigma or generational misunderstandings persist (Agnew et al., 2004; Uelese, 2025). Decisions about whether to disclose distress or involve family in care are therefore carefully weighed. Accessing services is understood not as an individual act, but as a relational and moral negotiation that must account for family expectations, cultural meanings, and perceptions of honour (Faleafa, 2010). However, literature often assumes these negotiations occur within stable family structures, with less attention given to how shifting family dynamics, migration histories, and changing social contexts reshape these processes over time. Spirituality introduces an additional layer of complexity; traditional cosmological beliefs and Christian practices frequently coexist, and young people may evaluate whether providers recognise these dimensions when deciding whom they can trust (Agnew et al., 2004).

Environmental pressures add to the complexity of these negotiations. Migration-related stress, economic demands, and racial stereotyping intensify vulnerability within some Pacific households (Tamasese et al., 2005; Vaka et al., 2022). Youth may align more readily with Western biopsychosocial interpretations of distress than older generations, producing further intergenerational tensions (Vaka et al., 2022). Practical constraints, including socioeconomic pressures and limitations within the health system, shape when and how support is sought (Ministry of Health, 2020). Importantly, policy acknowledges that the burden of navigation is not solely cultural but also structural, underscoring the need for systemic transformation toward culturally responsive and equitable services (Ministry of Health, 2020). Despite policy

recognition of these issues, there remains limited evidence of how such transformations are meaningfully implemented in practice, particularly from the perspectives of young Pacific service users.

The literature demonstrates that young Pacific adults navigate mental health challenges through the ongoing negotiation of identity, family relationships, spirituality, and institutional systems. Help-seeking is not simply an individual act but a culturally and socially mediated process, requiring young Pacific people to balance belonging with autonomy, respect with vulnerability, and collective responsibility with personal need. These layered tensions directly relate to this study's central question of how young Pacific adults in Auckland navigate the tensions between their cultural beliefs and social expectations while attempting to access mental health services. This highlights that navigating mental health is not simply about managing personal distress, but involves negotiating the intersections of culture, identity, and power within systems that often fail to recognise or support Pacific ways of being. Understanding help-seeking as relational and contextually embedded highlights that access is shaped not only by personal willingness but also by how health systems respond to these cultural realities. The following chapter therefore examines the structural dimensions of access, focusing on cultural safety, systemic barriers, and the lived experiences of young Pacific adults within mental health services in Aotearoa New Zealand.

2.8 Accessing Mental Health Services: Cultural Safety, Systemic Barriers, and Service Experiences

The literature highlights a substantial gap between mental health needs and service utilisation among Pacific people in Aotearoa New Zealand. Although Pacific people report high levels of psychological distress, they are diagnosed with mood and anxiety disorders at disproportionately low rates, suggesting systemic barriers to visibility and service accessibility (Ataera-Minster et al., 2025). Data from Mulder et al (2020) indicate that only 25% of Pacific individuals with serious mental disorders receive mental health treatment compared to 58% of the general population. Inequities are particularly concerning young Pacific people. Despite high prevalence of depression, anxiety, and suicide attempts, they experience greater difficulty accessing care and are significantly less likely to be hospitalised for mental health concerns, indicating systemic barriers across referral pathways and follow-up processes even when the needs are high (Ministry of Health, 2020; Statistics New Zealand & Ministry of Pacific Island Affairs, 2011; Tiatia-Seath, 2014). Although the prevalence of severe disorders aligns with that of the broader population, Pacific people remain underrepresented in community-based services and are more likely to enter care through acute or forensic pathways (Foliaki et al.,

2006). Collectively, these patterns highlight a persistent inequity between need and utilisation, raising concerns about cultural fit, systemic accessibility, and service responsiveness.

Cultural Safety and Cultural Competence

A widely observed pattern in the literature is that cultural safety and accessibility are fundamentally interconnected. The development of mental health services in Aotearoa has been dominated by Western biomedical approaches that fail to adequately incorporate culture as a core determinant of wellbeing (Agnew et al., 2004; Samu & Suaalii-Sauni, 2009). In contrast, Pacific models of care emphasise holistic, relational, spiritual, and family-centred approaches. Kapeli (2026) further highlights the limitations of individualised Western frameworks, arguing that they inadequately reflect Pacific understandings of wellbeing, which are grounded in interconnected relationships between the individual, family, community, culture, and spirituality. Concepts such as V*ā* emphasise the importance of relational balance, reinforcing that healing is not an individual process but one that occurs within collective networks. While Pacific communities recognise the value of clinical expertise, there is a strong preference for relational support systems including family, church, and trusted community members. When services prioritise individualised, symptom-focused interventions without integrating these relational and spiritual dimensions, they risk being perceived as culturally unsafe, contributing to disengagement (Kapeli, 2026; Suaalii-Sauni et al., 2009; Tiatia-Seath, 2014).

Cultural appropriateness is also repeatedly identified as one of the most important determinants of service accessibility (Samu & Suaalii-Sauni, 2009). Ataera-Minster et al. (2025) argues that achieving equity requires not only expanding service availability but strengthening the capabilities of non-Pacific clinicians to deliver culturally safe care, supporting co-designed services that incorporate Pacific concepts of mental wellbeing, and implementing policies that sustain a Pacific mental health workforce. Similarly, Statistics New Zealand and the Ministry of Pacific Island Affairs (2011) emphasise that culturally competent services informed by Pacific perspectives are essential to improving engagement and outcomes. Without alignment between service frameworks and Pacific concepts of wellbeing, young Pacific adults may perceive services as irrelevant, overly clinical, or misaligned with their values (Tiatia-Seath, 2014). This highlights a persistent disconnection between service design and the lived realities of Pacific communities, suggesting that improving access requires not only increasing availability but fundamentally rethinking how care is conceptualised and delivered.

Generational differences further complicate cultural safety. Pacific workforce competencies are often categorised into "clinical" and "cultural" paradigms, yet the cultural domains are frequently shaped by island-born, traditional, and Christian frameworks that may not reflect the experiences of New Zealand-born Pacific youth (Suaalii-Sauni et al., 2009; Vaka et al., 2022). This generational disconnection can make services feel unwelcoming or culturally distant, particularly for young Pacific adults navigating bicultural identities. In addition, documentation and funding systems frequently fail to capture the relational labour required in Pacific models of care, restricting the ability of culturally grounded services to be sustained over time (Ministry of Health, 2020; Suaalii-Sauni et al., 2009).

Structural and Systemic Barriers

Beyond cultural alignment, literature identifies the significant structural barriers that limit access. Pacific people report limited knowledge of available services, uncertainty about where to seek help, and poor awareness of national mental health resources (Ataera-Minster & Trowland, 2018; Fa'alogo-Lilo & Cartwright, 2021). Families and service users frequently describe not knowing how to access community support workers, short-term care, treatment pathways, or culturally relevant services, placing additional navigation burdens on those already experiencing distress (Agnew et al., 2004). Constraints related to service capacity and access thresholds further reinforce inequities. Despite rising levels of psychological distress, consultation rates with mental health professionals have shown minimal change, suggesting that service accessibility and capacity have not kept pace with demands (Ministry of Health, 2025). High thresholds of service availability based on acuity means that many young people are deemed "not unwell enough" to receive care until distress escalates to a crisis point (Patterson et al., 2018). This reinforces patterns of late presentation and acute service entry, particularly among Pacific people (Foliaki et al., 2006).

Cost also remains a barrier within primary care. A significant proportion of Pacific adults report not visiting a GP or collecting prescribed medication due to cost, limiting early intervention opportunities (Ministry of Health, 2025). These access barriers are compounded by persistent socioeconomic disadvantage among Pacific youth, including deprivation, overcrowded housing, and food insecurity, shaping both mental health risk and capacity to seek timely care (Fa'alili-Fidow et al., 2016). These patterns demonstrate that access is not solely a matter of service availability but is deeply shaped by broader socioeconomic conditions that constrain the ability of individuals and families to engage with care. National survey data further confirm substantial unmet needs, with Pacific people and younger

populations experiencing some of the lowest rates of service use despite significant mental health burdens (Oakley et al., 2006).

Structural barriers are also evident within income support systems designed to facilitate access to care. Neuwelt-Kearns et al. (2020) highlight significant challenges in accessing the disability allowance, including complex application processes, ongoing administrative burden, and requirements to pay costs upfront before reimbursement. These processes create financial and logistical barriers, particularly for families with limited resources. Confusion around eligibility and inconsistencies between support schemes further reduces uptake, while the need for repeated engagement with administrative systems places an additional strain on individuals already experiencing distress. The report also identifies systemic inequities, with Māori and Pacific people receiving lower average payments than Pākehā, likely reflecting barriers in accessing healthcare, navigating institutional structures, and experiences of discrimination. These barriers are compounded for those seeking mental health support, as accessing disability allowance funded counselling involves repeated applications, capped sessions, and additional out-of-pocket costs, rendering services unaffordable for many. Consequently, uptake of the disability allowance for counselling has declined despite rising levels of mental distress among young people. Overall, these findings demonstrate that support systems are often difficult to access, inequitable, and insufficient, reinforcing socioeconomic disparities and limiting access to essential mental health care (Neuwelt-Kearns et al., 2020). These findings illustrate how structural barriers are embedded within policy and funding systems, effectively shifting the burden of navigating care onto individuals and families who are already experiencing distress.

Service Experience: Mistrust, Misunderstanding, and Disagreement

Access is not solely determined by availability; it is also shaped by lived experiences within services. Pacific people often describe mental health engagement as influenced by mistrust, fear of stigma, and perceptions that services are incompatible with Pacific values (Fa'alogo-Lilo & Cartwright, 2021). Shame and fear of judgment by family and community remain significant barriers of early help-seeking (Beautrais et al., 2006; Fa'alogo-Lilo & Cartwright, 2021). As a result, many Pacific individuals seek support from family, church, or traditional healers first, with formal mental health services accessed later or only when distress becomes severe (Faleafa, 2010; Foliaki, 1997). Participant narratives in Tiatia-Seath's (2014) study highlights a perceived dichotomy between Western clinical models and Pacific understandings of distress, shaping trust in services and perceptions of treatment relevance. Barriers to sustained engagement include limited personal connection with clinicians, inadequate

understanding of Pacific relational dynamics, and difficulties with Western therapeutic approaches that feel culturally misaligned (Fa'alogo-Lilo & Cartwright, 2021). Where services fail to acknowledge spirituality, family involvement, and relational accountability, young Pacific adults may disengage or avoid continued contact (Agnew et al., 2004; Suaalii-Sauni et al., 2009). This reinforces that engagement with mental health services is not determined solely by need, but by the extent to which services are perceived as culturally safe, relationally responsive, and aligned with Pacific values.

Conversely, the literature identifies several facilitators of engagement, including strong family support, trust-based relationships with providers, culturally responsive care, and the presence of Pacific practitioners within services (Agnew et al., 2004; Fa'alogo-Lilo & Cartwright, 2021). Policy recommendations emphasise coordinated, culturally governed service networks and community-based access points in trusted environments such as schools and churches (Ministry of Health, 2020; Patterson et al., 2018). These approaches recognise that engagement is relational and that culturally safe spaces are critical for sustaining trust and continuity of care.

This body of research consistently demonstrates that inequities in Pacific mental health service access are shaped by the interaction of cultural safety concerns, structural constraints, and lived experiences of mistrust and misalignments. Elevated psychological distress alongside persistent underutilisation reflects not merely individual reluctance, but systemic inequities embedded in service design, workforce composition, funding structures, and broader social determinants of health (Ataera-Minster et al., 2025; Ministry of Health, 2020; Mulder et al., 2020). For young Pacific adults in Auckland, accessing mental health services therefore requires navigating across cultural expectations, relational obligations, and institutional systems that are not always designed to accommodate their realities. Despite extensive documentation of these inequities, there remains limited research examining how young Pacific adults actively navigate and make sense of these systemic barriers in their help-seeking journeys. These dynamics underscore the necessity of culturally grounded, equitable, and developmentally responsive models of care.

2.9 The Impact of Family in Pacific Mental Health and Help-Seeking

A review of the literature reveals that family is positioned as a central organising structure for Pacific wellbeing, shaping how mental distress is recognised, interpreted, and addressed. Pacific perspectives on health are holistic and relational, with wellbeing grounded in strong family relationships (Statistics New Zealand & Ministry of Pacific Island Affairs, 2011). Within this worldview, family is not merely a source of support surrounding the individual but

a central site where identity, belonging, roles, honour, and care are sustained, and where health journeys are navigated across their life course (Pulotu-Endemann & Tu'itahi, 2009; Teganahau, 2023; Tiatia-Seath, 2014). Accordingly, working with Pacific service users often requires working with families, including immediate and extended members, as family involvement is widely understood as integral to healing and to what makes them well (Agnew et al., 2004; Suaalii-Sauni et al., 2009). While the centrality of family is well established, literature often assumes family involvement as uniformly beneficial, with less attention given to the complexities, tensions, and conditional nature of family support in practice. This relational orientation is further reinforced by Auva'a-Alatimu (2024), who emphasises that Pacific youth's wellbeing is grounded in cultural, spiritual, and relational values, where family and faith function as primary sources of support during times of distress.

Family connectedness has emerged across studies as a key protective factor, providing emotional security, guidance, and stability. Many Pacific youths report generally positive family relationships and high levels of parental care, with family connectedness serving as an important source of wellbeing and socialisation (Fa'alili-Fidow et al., 2016). Uelese's (2025) qualitative study indicates that warm, nurturing, and emotionally attuned parent-child relationships serve as key protective factors for young Pacific women, fostering a sense of safety, belonging, and support that helps lessen vulnerability and enhance resilience. Families also play active roles in recovery, including assisting with access to support workers, supporting medication adherence, transporting relatives to appointments, facilitating community and church supports, and "*keeping the spirit lifted*" (Agnew et al., 2004). These practices illustrate that family support is enacted through everyday relational care, practical assistance, and spiritual encouragement, rather than solely through formal engagement with treatment services. Similarly, Auva'a-Alatimu (2024) highlights that young people often turn to whānau and spiritual support first, reinforcing that help-seeking is relational and embedded within culturally familiar networks rather than individualised service pathways.

Literature also continually underscores the importance of family inclusion in prevention and suicide response. Even when family dynamics are complicated or characterised by past conflicts, young people may still regard family participation as culturally essential, particularly in the context of suicide prevention planning (Tiatia-Seath, 2014). More broadly, family and whānau are recognised as critical protective factors across the life course and are often the first to identify early signs of distress, playing a vital role in early intervention and preventing escalation when adequately resourced and supported (Patterson et al., 2018). Evidence of family-inclusive approaches, including collaborative models such as Open

Dialogue, further underscores the value of relational, network-based engagement in mental health recovery (Patterson et al., 2018).

While family support is strongly valued, the literature also demonstrates that family can function as a site of tension that shapes the timing and pathways of help-seeking. Family dynamics, especially parental relationships, play a pivotal role in shaping vulnerability and resilience among young Pacific women, with emotional experiences deeply influenced and sometimes limited by the family setting (Tucker-Masters & Tiatia-Seath, 2017; Uelese, 2025). Participants describe how some families maintain dismissive responses to emotional expression, including messages to "*just get over it*," which invalidate distress and undermine trust, contributing to silence and concealment of important issues (Uelese, 2025). Auva'a-Alatimu (2024) similarly notes that some young people avoid disclosing distress to family due to fears of burdening others or a limited shared understanding of mental health, highlighting how relational obligations can constrain open communication. Similar patterns have been observed in wider Pacific research, where stigma, shame, and fear of negative judgement within families discouraged open discussion of mental distress and delayed engagement with support services (Fa'alogo-Lilo & Cartwright, 2021; Roy et al., 2023). This underscores a key tension within the literature, where family is simultaneously positioned as both a protective resource and a potential barrier, yet there remains limited exploration of how young Pacific adults actively navigate this dual role in their help-seeking decisions. These dynamics highlight how family relationships, while central to Pacific wellbeing, may also create barriers to help-seeking when cultural expectations, generational differences, or stigma shape how emotional distress is interpreted and responded to (Suaalii-Sauni et al., 2009; Tiatia-Seath, 2014).

This complexity is also evident in broader Pacific research, which emphasises that family involvement is desirable but not universally appropriate, particularly for some youth who may not want family included in their care due to fear of judgement, stigma, or generational misunderstandings (Agnew et al., 2004; Suaalii-Sauni et al., 2009). Practical barriers and culturally mediated factors, including shame, can impede access to extended family support. Consequently, some families resort to state assistance only under conditions of severe need or when legally required (Suaalii-Sauni et al., 2009). These findings illustrate the importance of avoiding blanket assumptions about "family inclusion," instead recognising that young Pacific adults may need to carefully negotiate when family involvement is supportive and when it may intensify distress or risk disclosure.

Where family communication is constrained, peers can become critical sources of support. Uelese (2025) found that for young Pacific women, friends are often the preferred

first point of disclosure, perceived as more understanding, less judgmental, and able to relate through shared experiences. This peer reliance reflects both the strength of youth support networks and the barriers that young Pacific women experience within family contexts, particularly when disclosure risks invalidation or shame (Uelese, 2025). In youth-focused research more broadly, participants emphasise the value of support from culturally familiar mentors, role models, and trusted adults who share lived experiences, and they call for proactive outreach rather than placing responsibility solely on young people to initiate help-seeking (Roy et al., 2023). Viewed together, these findings demonstrate that while family remains central to wellbeing, trust and emotional safety determines whether family functions as the first line of support or whether young people seek initial validation elsewhere.

The literature further demonstrates that family support is closely interwoven with church and spiritual communities, which often function as key sites of social, emotional, and spiritual care within Pacific contexts. Pacific perspectives on wellbeing emphasise spirituality, social cohesion, and community participation as core components of health, with church communities frequently functioning as important spaces of belonging and support (Statistics New Zealand & Ministry of Pacific Island Affairs, 2011; Tiatia-Seath, 2014). Auva'a-Alatimu (2024) reinforces this, describing how culturally familiar environments such as church spaces can function as sites of healing, protection, and belonging, particularly when mental health support is framed through culturally meaningful narratives. The relationship between the church, Pasifika parishioners/family, and the health system is described as multifaceted, with church frequently experienced as a safe space that offers mental, social, and emotional support, fostering reflection, healing, and resilience (Teganahau, 2023). Within Pacific communities, help-seeking often occurs through interconnected pathways that include family, church, and other culturally embedded networks before engagement with formal mental health services (Foliaki, 1997; Roy et al., 2023). However, whether church-based support becomes accessible can depend on the familial context at a given time, with family dynamics either enabling or constraining open-hearted discussion required for support and advice (Teganahau, 2023). Relational health is therefore mediated through the Vā where the timing and history of communication can either strengthen or weaken the possibility of constructive dialogue (Teganahau, 2023).

A key implication across the literature is that mainstream mental health services often remain overly individualised, failing to acknowledge collectivist family structures and the relational nature of Pacific wellbeing (Fa'alogo-Lilo & Cartwright, 2021; Patterson et al., 2018). Families report being excluded from treatment planning, discharge processes, and follow-ups, despite being primary long-term supporters (Patterson et al., 2018). Service

providers similarly identify lack of support for family as a barrier in community mental health services, reflecting limited or superficial understanding of Pasifika cultural contexts and values (Fa'alogo-Lilo & Cartwright, 2021). Pacific families are therefore positioned as integral to recovery, underscoring the importance of family-inclusive practices that engage families meaningfully and early, while remaining responsive to diversity in family circumstances and young people's preferences (Agnew et al., 2004; Samu & Suaalii-Sauni, 2009; Suaalii-Sauni et al., 2009).

At the same time, the literature suggests that strengthening family relationships through culturally responsive approaches, particularly those that support communication while respecting cultural values, may improve mental wellbeing and suicide prevention outcomes for young Pacific people, especially Pacific young women (Uelese, 2025). Auva'a-Alatimu (2024) further demonstrates that culturally grounded interventions that integrate Pacific values and relational approaches can help reduce stigma, normalise conversations about mental health, and improve engagement when delivered in culturally meaningful ways. The need to restore and protect relational harmony is emphasised as central to healing, with disruptions to extended family relationships and weakened traditional structures linked to increased distress (Tamasese et al., 2006; Tucker-Masters & Tiatia-Seath, 2017). Family can therefore function as both a protective and risk factor: conflict, bereavement, and pressures may elevate vulnerability, whereas family inclusion and encouragement can accelerate recovery and strengthen resilience (Tucker-Masters & Tiatia-Seath, 2017).

Across this body of work, a consistent pattern emerges, indicating that family involvement is foundational to Pacific mental health and help-seeking, yet it is neither simple nor uniformly supportive. Pacific families are key sites of identity and care, but the effectiveness of family involvement depends on trust, communication, stigma dynamics, and the Vā in which distress is disclosed and responded to. Despite extensive recognition of the importance of family in Pacific wellbeing, there remains limited research examining how family dynamics are negotiated in real-time by young Pacific adults when making decisions about seeking mental health support. These findings highlight the need for mental health services and community support that are family-inclusive, culturally grounded, and responsive to the realities of young Pacific adults as they navigate mental distress within complex relational worlds.

2.10 Gaps in the Literature, and Study Rational

The literature offers clear insight into the mental health experiences of Pacific people in Aotearoa New Zealand, documenting persistent inequities in outcomes and access. Pacific communities experience high psychological distress but lower diagnosed disorder rates and

reduced service engagement (Ataera-Minster et al., 2025; Foliaki et al., 2006; Mulder et al., 2020). These disparities reflect intersecting cultural, structural, and systemic factors, including stigma, limited culturally responsive services, low awareness of support, and broader socioeconomic inequities (Ataera-Minster & Trowland, 2018; Fa'alili-Fidow et al., 2016; Fa'alogo-Lilo & Cartwright, 2021) Despite these epidemiological and structural insights, gaps remain in understanding how young Pacific adults navigate these challenges in their everyday lives.

A key limitation in the literature is its emphasis on population-level disparities and service-use patterns rather than the lived experiences of young Pacific adults seeking support. Although quantitative studies identify inequities in mental health outcomes and access (Ataera-Minster et al., 2025; Mulder et al., 2020), they provide limited insight into the relational and cultural influences on help-seeking. Pacific research underscores that wellbeing is relational and embedded in family, community, and spirituality (Statistics New Zealand & Ministry of Pacific Island Affairs, 2011; Tamasese et al., 2006), yet how these structures shape young adults' navigation of services remains underexplored. Similarly, much Pacific mental health research focuses on broader populations or specific groups such as adolescents, service users, or families (Tiatia-Seath, 2014; Tucker-Masters & Tiatia-Seath, 2017), leaving fewer studies centred on young Pacific adults. This life stage involves negotiating cultural expectations alongside wider societal norms in Aotearoa New Zealand (Foliaki et al., 2006; Vaka et al., 2022), creating distinct pressures around identity, belonging, and autonomy that shape interpretations of distress and decisions to seek support. The limited focus on this group represents an important gap.

Another gap in the literature concerns how young Pacific adults navigate cultural and social expectations within their communities. Research highlights the centrality of collectivist values, family obligations, respect for elders, and community responsibilities in shaping Pacific wellbeing (Statistics New Zealand & Ministry of Pacific Island Affairs, 2011; Tiatia-Seath, 2014), often providing strong support and belonging. However, these same expectations can create tension around mental health, particularly when stigma, shame, or generational differences limit open discussion of emotional distress (Fa'alogo-Lilo & Cartwright, 2021; Uelese, 2025). Despite recognition of these challenges, little qualitative research examines how young Pacific adults negotiate these competing cultural expectations when deciding whether and how to seek support. The literature also points to persistent mismatches between Pacific worldviews of wellbeing and the Western biomedical frameworks that shape Aotearoa New Zealand's mental health system (Suaalii-Sauni et al., 2009; Samu & Suaalii-Sauni, 2009). Pacific models emphasise holistic, relational, and spiritual understandings of wellbeing, whereas mainstream services prioritise individualised,

symptom-focused care (Tiatia-Seath, 2014). Although these differences are well noted, little is known about how young Pacific adults navigate these contrasting frameworks in practice, including how they reconcile cultural beliefs, family expectations, and service structures when deciding whether to seek support.

Existing research highlights the central role of families in Pacific mental health, with family members often serving as primary supports and key actors in recognising distress and facilitating care (Agnew et al., 2004; Tucker-Masters & Tiatia-Seath, 2017). However, family involvement can also complicate help-seeking when stigma, fear of judgement, or hierarchical communication discourage disclosure (Fa'alogo-Lilo & Cartwright, 2021; Uelese, 2025). Despite this, little is known about how young Pacific adults decide whether to involve family when accessing services, particularly when cultural expectations may conflict with personal wellbeing. A further gap concerns other relational support systems such as peers, churches, and community networks. Evidence shows that Pacific individuals often turn to informal support before engaging with formal services (Foliaki, 1997; Roy et al., 2023), reflecting collective understandings of health. Yet limited research explores how young Pacific adults move between these informal networks and formal mental health services, especially within urban contexts like Auckland.

Taken together, the literature shows that Pacific peoples' access to mental health services is shaped by more than structural availability. It involves navigating cultural beliefs, family expectations, stigma, spirituality, identity, and institutional systems. Yet despite this recognition, there is still limited qualitative research centring the voices of young Pacific adults and how they negotiate these intersecting influences.

2.11 Chapter Summary

This chapter has critically examined the literature on Pacific mental health in Aotearoa New Zealand, with a focus on young Pacific adults and their engagement with mental health services. The literature consistently shows that Pacific people experience disproportionately high levels of psychological distress while remaining underrepresented in formal service use. While these disparities are often framed through socioeconomic disadvantages, they are also shaped by cultural, relational, and structural factors that influence how distress is experienced and how help-seeking decisions are made. Taken collectively, these strands of evidence highlight the complex interplay between cultural worldviews, social expectations, and systemic inequities.

Pacific understandings of mental health are holistic and relational, grounded in connections between the individual, family, community, culture, and spirituality. In contrast, mainstream

services are largely influenced by Western biomedical models that prioritise individualised and symptom-focused care. This misalignment contributes to perceptions of cultural unsafety, mistrust, and disengagement, indicating that access is not simply about availability but about how well services align with Pacific worldviews. This tension underscores the importance of culturally responsive approaches that recognise relationality as central to Pacific wellbeing.

Stigma and shame further shape mental health experiences and help-seeking, operating across interpersonal, cultural, and structural levels. For young Pacific adults, these dynamics are compounded by intersecting identities and broader social pressures. However, stigma is not static; it is actively negotiated, resisted, and reinterpreted within social and relational contexts. The literature also highlights that young Pacific adults are not passively positioned between cultures but actively navigate complex and shifting expectations across cultural, familial, and societal contexts. Identity is fluid and relational, shaped through ongoing negotiation rather than fixed cultural boundaries. Family remains central within this process, functioning as both a key source of support and, at times, a site of tension. As such, help-seeking is a relational process, requiring young people to balance cultural obligations, family expectations, and individual wellbeing. These insights make it clear that Pacific youth mental health can only be understood within the relational and cultural systems that shape their everyday lives.

Despite these insights, important gaps remain. Much of the literature relies on population-level data or descriptive accounts of culture, with limited attention to how young Pacific adults actively navigate these intersecting influences in their everyday lives. In particular, there is insufficient exploration of how cultural identity, family dynamics, stigma, spirituality, and structural barriers intersect in shaping real-time help-seeking decisions. This gap signals the need for research that centres youth voices and captures the lived, relational processes through which support is sought or delayed.

This study addresses these gaps by exploring how young Pacific adults in Auckland navigate the tensions between their cultural beliefs and social expectations while attempting to access mental health services. By centring lived experiences, this research aims to contribute to a more nuanced, culturally grounded understanding of help-seeking and to inform more responsive and equitable mental health services in Aotearoa New Zealand. In doing so, it advances Pacific mental health scholarship by foregrounding the relational, cultural, and contextual realities that shape young people’s pathways to care.

Chapter 3: Methodology

This study implements a qualitative research approach to develop an in-depth insight into participants cultural backgrounds, lived experiences, and social contexts. This method is fundamental to responding to multifaceted public health concerns, as it enables the exploration of social and cultural influences, including community beliefs, cultural identity, gender roles, stigma, and socioeconomic backgrounds (Mack et al., 2005), all of which are central to this research.

The methodology for this study is deliberately grounded in Pacific epistemologies and conceptual frameworks to ensure culturally appropriate and meaningful engagement with Pacific participants. These methodologies are understood as living, relational knowledge systems that reflect Indigenous intellectual sovereignty and the interconnectedness of people, land, spirituality, and history, particularly through Talanoa (Moanaroa Pacific Research Network, 2025). This aligns with Pacific ontological and epistemological perspectives that emphasise relationality, collective responsibility, and the interdependence of spiritual, social, and cultural life, in which knowledge is co-constructed through lived experience (Ponton, 2018). Accordingly, this study employs the Ūloa methodology (Vaka, 2016) alongside the Talanoa method (Vaioleti, 2006) to examine how young Pacific adults in Auckland navigate the tensions between cultural beliefs and social expectations while accessing mental health services. The use of these Pacific methodologies is not only culturally appropriate but methodologically necessary, as the research seeks to understand experiences that are deeply embedded within relational, cultural, and spiritual contexts.

This chapter outlines the application of the Ūloa framework within the research design, the participant recruitment process, and the use of Talanoa as a method for qualitative data collection.

This study is guided by the following research question:

> *How do young Pacific adults in Auckland navigate the tensions between their cultural beliefs and social expectations within Pacific communities while attempting to access mental health services?*

To address this question, the study is guided by the following objectives:

- To explore how young Pacific adults understand and experience mental health within their cultural contexts
- To examine the influence of cultural and social expectations on help-seeking behaviours
- To investigate participants' experiences with accessing mental health services in Auckland

- To identify the barriers and facilitators shaping engagement with mental health services

These research question and objectives informed the selection of Pacific methodologies, ensuring that the research approach remained culturally grounded, relational, and responsive to participants lived experiences.

3.1 Ūloa Methodology

Ūloa is a culturally grounded model of practice developed by Sione Vaka (2016) to support Tongan individuals experiencing mental distress. This model aligns with the concept of Teu le Vā, which emphasises the nurturing and maintenance of relational spaces to achieve collective wellbeing and optimal outcomes for all stakeholders (Airini et al., 2010). Drawing on the traditional Tongan communal fishing practice known as Ūloa, the model adopts this collective activity as both a metaphor and structural framework for service delivery. In doing so, it situates mental health care within Tongan cultural values, relational practices, and communal responsibility, rather than relying solely on Western biomedical paradigms (Vaka, 2016).

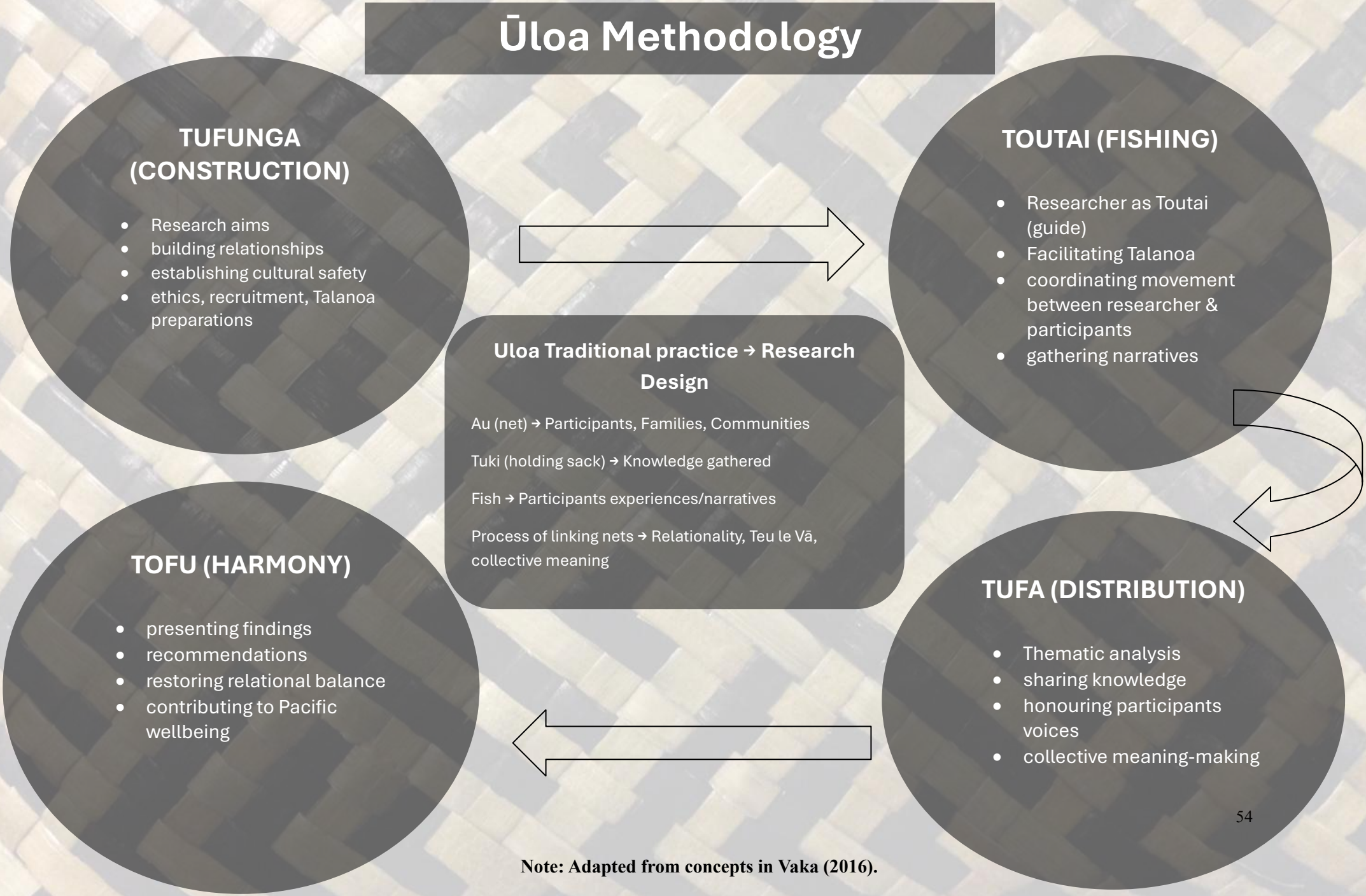
Ūloa is a collective fishing practice grounded in cooperation and shared responsibility, where community members work together to harvest fish for collective benefit. Rather than relying on a single net, the practice brings together individual *Au* (coconut leaf net) sections, each prepared by participants under the direction of the *Toutai*, or lead fisher. During the process, individuals position themselves according to the guidance of the *Toutai* and connect their net sections through coordinated movement and physical connection. As the group moves inward, the fish are gathered into the *Tuki*, the central holding sack. Once the catch is secured, it is shared among participants and their families, reflecting the spirit of working together and reciprocity that guide the practice.

Beyond its practical function, Ūloa reflects key social and spiritual values. The physical linking of participants represents relational bonds and collective unity, while the shared movement through the water expresses a reciprocal relationship with the natural and spiritual environment (Vaka, 2016). Within Pacific frameworks, relational spaces (*Vā*) are understood as sacred and must be actively nurtured and maintained. This aligns with the concept of *Teu le Vā*, which emphasises the ongoing responsibility to care for relationships in order to sustain harmony, collective wellbeing, and effective collaboration (Airini et al., 2010).

Ūloa is structured into four key phases: *tufunga* (construction), *toutai* (fishing), *tufa* (distribution), and *tofu* (peace and harmony). Vaka (2016) explains that each component can be interpreted within the New Zealand context. The *au* represents the family, also symbolised by the *Fale* (house); the complete *au*, comprising multiple sections, represents the wider community; the *Tuki* symbolises mental health services and providers; the *Toutai* represents the mental health practitioner; and the fish represent service users. These components are interconnected with other Tongan concepts, including *Talanoa*, *Loto*, *Fala*, and *Fale*. In this study, the four phases of the Ūloa framework informed the overall research design illustrated in figure 1.

As a Tongan researcher, the Ūloa methodology was particularly appropriate for this study because it aligns closely with the cultural values, practices, and linguistic traditions that shape my lived experience. It is grounded in a non-Western epistemological perspective, one that centres Pacific relationality, collective responsibility, and culturally embedded understandings of mental health which resonated strongly with both my positionality and the aims of the research. Ūloa offers a framework that moves beyond biomedical interpretations of distress, instead privileging Pacific ways of knowing and being. Implementing this methodology ensured that the study design upheld cultural safety, relational accountability, and Pacific ethical principles throughout all phases of the research. By drawing on a model that reflects the cultural logic of cooperation, respect, and shared wellbeing, the qualitative design was able to embed Pacific values and relational practices in a way that is both methodologically robust and culturally appropriate for young Pacific adults.

Figure 1: Ūloa Methodology Research Design



Note: Adapted from concepts in Vaka (2016).

3.1.1 Research Design

Tufunga – Construction

Tufunga refers to the preparatory phase of the Ūloa process, emphasising assessment, coordination, and collective planning. During this stage, participants, resources, and the wider research environment are carefully considered to mateuteu (prepare) and ensure effective organisation. The Toutai provides leadership and guidance, while decisions are made collaboratively with attention to cultural and contextual appropriateness. In the context of this study, the Ūloa framework directly informs the Tufunga phase by shaping how preparation is conceptualised and enacted. Just as Tufunga involves constructing and readying the au before entering the water, the research process requires intentional, culturally grounded preparation to ensure relational safety and methodological coherence.

In this study, Tufunga represents the planning and consultative phase of the research design. This phase guided the foundational work required to establish a culturally safe and relationally grounded research environment. It involved clarifying the research aims, building relationships with participants, establishing cultural safety, completing ethics approval, conducting recruitment, and preparing for Talanoa. These activities ensured the research was grounded in trust, respect, and relational integrity, consistent with Pacific approaches to knowledge and wellbeing. By applying Tufunga as a methodological guide, the preparatory work becomes more than procedural—it becomes a culturally embedded process that mirrors the collective readiness central to Ūloa.

Participant recruitment criteria were developed to align with the research aims. Eligible participants were aged 18 to 25, identified with a Pacific ethnicity, resided in Auckland, and had experienced mental distress and accessed (or attempted to access) mental health services. Individuals who had only just turned 18 were excluded, as their experiences of navigating life as young Pacific adults were still emerging and did not yet reflect the developmental stage central to this study. Those residing outside Auckland were also excluded, as the research focused specifically on the Auckland context. An exception was made for one participant who, although Auckland-based, was temporarily living in Hamilton due to professional sports commitments. Travel arrangements were made to ensure that the Talanoa took place in a culturally safe and comfortable environment for the participant.

A sample size of six to eight participants was considered appropriate for enabling in-depth engagement with lived experiences within a qualitative framework. Participant information sheets and consent forms were prepared (refer to Appendix B and C), outlining the purpose of the study and key ethical considerations, including confidentiality, privacy, and the assurance that Talanoa would end immediately if participants felt unsafe at any point. The Tufunga stage was therefore crucial in laying a strong cultural and ethical foundation for the study, ensuring participant safety and supporting the integrity and accuracy of the data collection process. Through the lens of Ūloa, this foundation

reflects the careful construction of the au, ensuring that all components are prepared, aligned, and culturally attuned before moving into the subsequent phases of the research.

Toutai – Fishing

Effective leadership is central to coordinating collective action within the Ūloa process. The *Toutai* maintains oversight, ensuring that participants remain connected and work in unison. When challenges arise, the *Toutai* responds by adapting the collective process to restore balance and progress. The Ūloa is therefore understood as a shared undertaking, where individual actions contribute to collective outcomes. Within the study design, this phase of the Ūloa framework informs how leadership, relational guidance, and coordinated movement are enacted by the researcher, shaping both the structure and relational dynamics of the qualitative process.

In this study, I positioned myself as the *Toutai*, guiding the research process while remaining grounded in cultural values, ethical responsibilities, and participant wellbeing. This involved facilitating Talanoa in a relational and respectful manner, creating culturally safe spaces for participants to share their experiences, and responding flexibly to participants' needs. While providing structure and direction, the research prioritised shared understanding and relational engagement, consistent with Pacific approaches to knowledge production. This reflects Talanoa as a participatory methodology, where knowledge is co-constructed through dialogue rather than extracted from participants (Ravulo, 2025). By adopting the role of the Toutai, the research design mirrors the coordinated guidance central to Ūloa, where the lead fisher ensures alignment, safety, and collective purpose. In the research context, this meant intentionally nurturing relational spaces, maintaining participant connection, and guiding the flow of Talanoa in ways that upheld cultural integrity.

Participants were recruited through posters (see appendix E) distributed across community centres, public libraries, recreational facilities, and churches, as well as through word-of-mouth networks. A total of seven participants were recruited. Interested individuals contacted me via email or personal referral, and mutually agreed arrangements were made regarding suitable times and locations. Participants were provided with an information sheet (see appendix B) outlining the purpose of the study and ethical considerations, including confidentiality and privacy.

Talanoa sessions were conducted at AUT South Campus Library or at alternative locations that were accessible and comfortable for participants. Each session began with an introductory phase aimed at establishing a culturally safe and relational environment, allowing participants to share at their own pace. This process reflected the principle of *Tauhi Vā*, emphasising the intentional nurturing of relationships. Talanoa was therefore approached not simply as a method of data collection, but as a relational process through which knowledge was co-constructed. This relational orientation aligns with

the Toutai phase, where the researcher guides participants through a shared movement – Talanoa, ensuring that each individual remains connected to the collective purpose of the study.

Sessions ranged from approximately 40 minutes to two hours, allowing flexibility to accommodate participants' availability and depth of discussion. While most sessions were conducted in Auckland, one was held in Hamilton due to a participant's commitments, and two were conducted at or near participants' place of work. Within the Ūloa framework, each participant contributed their *Au*, symbolising the significance of individual lived experiences. These were collectively interwoven through the facilitative guidance of the toutai, contributing to the generation of shared data. In this way, the study design reflects the Ūloa logic of weaving individual au sections into a collective net, where the researcher—as toutai—supports the integration of diverse lived experiences into shared, co-constructed knowledge.

Tufa – Distribution

Following the completion of the Ūloa, the fish are gathered in the *Tuki*, counted, and distributed according to communal protocols to ensure equitable benefit. In this study, *Tufa* represents the analytical phase, where knowledge is understood as a collective outcome that is ethically interpreted and shared. Within the study design, the Tufa phase informs how analysis is approached as a communal and relational responsibility, emphasising that meaning is not individually owned but collectively generated and respectfully distributed.

The *Tuki* metaphorically represents the data collected through Talanoa sessions. Data was analysed using a qualitative thematic approach supported by NVivo software. Transcripts were systematically coded, allowing patterns and meanings relevant to the research questions to emerge. These codes were then refined into broader themes that informed the study's findings. In alignment with the principles of *Tufa*, NVivo was utilised as an analytical tool rather than a determinant of meaning, ensuring that interpretations remained grounded in participants lived experiences and cultural contexts. This reflects the Ūloa logic of gathering the collective "catch" and distributing it with care, where the researcher assumes ethical responsibility for interpreting and sharing knowledge in ways that honour participants and their cultural realities. The analytical process prioritised respectful interpretation, shared meaning-making, and ethical accountability. This approach aligns with Indigenous methodologies that emphasise narrative as a means of contextualising and humanising experiences (Behrendt, 2019). Through Tufa, the study design frames analysis as a culturally grounded act of distribution, transforming raw narratives into shared knowledge that contributes to collective understanding and wellbeing.

Tofu – Peace and Harmony

Tofu represents the ongoing maintenance of balance and harmony throughout the Ūloa process. Achieving this requires careful coordination between researcher, participants, and context to support a positive collective outcome. Within the research, this stage reflects the commitment to ensuring that the process and outcomes contribute to wellbeing, stability, and relational alignment. In the context of the study design, *Tofu* guides the concluding phase of the research, shaping how findings are interpreted and presented. It underscores the ethical responsibility to restore balance, honour participants' contributions, and ensure that the knowledge produced upholds relational integrity and supports collective wellbeing.

The study was conducted in a manner that prioritised cultural safety, ethical integrity, and participant care, particularly when discussing experiences of mental distress. The research design aimed to produce findings that are not only academically rigorous but are also meaningful and beneficial for young Pacific adults and the wider Pacific communities. Ethical approval was obtained from the AUT Ethics Committee (AUTEC), and all participants provided informed consent prior to participating. Cultural safety, confidentiality, and the right to withdraw were upheld throughout the research process. By aligning the research with the principle of Tofu, the study design ensures that the final outcomes contribute positively to understanding, practice, and future mental health service development, reflecting the Ūloa commitment to restoring harmony and supporting collective wellbeing.

3.2 Qualitative Research Approach

This study adopts a qualitative research approach to gain an in-depth understanding of participants' cultural backgrounds, lived experiences, and social contexts, all of which are essential for addressing complex public health issues. By prioritising participants' voices, qualitative research is well suited to examining how social and cultural factors shape experiences of health and access to mental health and wellbeing services. In this study, the approach enables exploration of key influences such as community beliefs, cultural identity, gender roles, stigma, and economic circumstances (Mack et al., 2005), which are central to understanding how young Pacific adults navigate mental health services. Emphasising depth and context supports a culturally grounded and nuanced analysis aligned with the research aims. Furthermore, the use of Pacific methodologies contributes to decolonising knowledge production by valuing Indigenous perspectives and challenging the dominance of Western frameworks in academic research (Thaman, 2003). These methodologies are not only culturally appropriate but methodologically necessary, as the experiences under study are embedded within relational, cultural, and spiritual context.

3.3 Positionality

In qualitative research, particularly within Pacific research methodologies, the positionality of the researcher is a critical component of the research process. Positionality recognises that researchers are not neutral observers; rather, they bring their own identities, experiences, values, and cultural perspectives into the research (Gurr et al., 2024). This reflects the Indigenous standpoint theory, which asserts that all knowledge is shaped by cultural values and lived experiences, challenging assumptions of neutrality that often reinforce colonial power structures (Behrendt, 2019). Within Pacific worldviews, knowledge is relational and situated, meaning that who I am and how I relate to participants actively shape shared meaning-making. Reflexive research practice therefore strengthens Pacific research by aligning with Indigenous ways of knowing. Central to this approach is recognising one's positionality as a researcher and the ethical responsibilities that accompany it (Keli et al., 2026). Given that this study employs the Ūloa methodology (Vaka, 2016) and Talanoa method (Vaioleti, 2006), both of which emphasise relationality, reciprocity, and cultural accountability, it is essential that I situate myself within the research.

I am a New Zealand–born Tongan woman who spent the first decade of my life in Japan before returning to Aotearoa and settling in East Tamaki Makaurau at the age of eleven. As one of the only Pacific Island students in my Japanese primary school, alongside my younger brother, I experienced a prolonged sense of social and cultural isolation. This sense of marginalisation continued upon returning to Auckland, where limited English proficiency further intensified feelings of exclusion throughout my intermediate and secondary schooling. The combined effects of language barriers, cultural disconnection, and unresolved isolation contributed to experiences of depression and a diminished sense of belonging. With limited awareness of available mental health services and little understanding of mental health within my cultural context, my lived experiences closely reflect the issues this research seeks to explore.

At the same time, I acknowledge that my role as the researcher positions me within a space of relative power. My educational background, ethnicity, religious affiliation as a Methodist, Tongan identity, and gender may influence how participants perceive me and what they feel comfortable sharing. I also recognise that my own experiences of mental health, cultural expectations, and navigating support services may shape how I interpret participants narratives. To ensure that my assumptions did not overshadow participants voices, I approached each Talanoa session with humility, openness, and ongoing reflexivity. Central to this approach was a commitment to honouring and nurturing the Vā between myself and the participants, recognising it as a relational space that requires care, respect, and ethical attentiveness.

Storytelling, as a central Indigenous methodology, enables lived experiences to be shared in ways that are relational, humanising, and transformative, ensuring that the participants voices remain central to knowledge production (Behrendt, 2019). My relationship to this research is therefore both personal and scholarly. I have not only witnessed but also experienced the challenges that Pacific young adults face when navigating cultural expectations, stigma, and the complexities of accessing mental health services. In addition, my work as a research assistant with Pacific Island family's study has further deepened my understanding of these tensions and strengthened my commitment to this research.

While this personal connection enhances my engagement with the study, it also requires ongoing reflexivity to ensure that my experiences do not shape or overshadow participants narratives. Accordingly, I positioned myself not as an authority, but as a listener and learner, guided by the principles of Ūloa. This framework emphasises collective navigation, shared responsibility, and the co-construction of knowledge, reinforcing an approach that centres relationality and reciprocity throughout the research process.

3.4 Talanoa Method

This study utilised the Talanoa method as articulated by Timote Vaioleti (2006), which emphasises open, respectful, and relational dialogue grounded in Pacific epistemologies. Vaioleti is widely recognised for advancing Talanoa from a cultural way of life into a formal research methodology. Conceptually, *Tala* refers to informing, telling, relating, or conversing, while *Noa* denotes something ordinary, open, or unrestricted. Together, these concepts reflect a process of open, informal, and relational communication.

Talanoa is not only a research method but a way of life grounded in Pacific relationality, reciprocity, and collective meaning-making. It challenges Western linear approaches to knowledge by privileging non-linear, dialogical engagement (Ravulo, 2025). This approach is particularly appropriate for this study, as conventional Western interview methods often prioritise structured questioning and researcher control, whereas Talanoa enables participants to guide the conversation in culturally meaningful ways, resulting in richer and more contextually grounded data. In alignment with the Ūloa methodology, Talanoa supported a collective and relational approach to knowledge generation, where participants narratives were understood as interconnected contributions rather than isolated accounts.

Central to this process is the principle *Tauhi Vā*, which guided the intentional nurturing of relationships between the researcher and participants throughout data collection. This relational engagement is further underpinned by key Pacific values embedded within Talanoa practices, including *Faka'apa'apa* (respect, humility, and consideration), *Anga lelei* (kindness, generosity, and dignity), *Mateuteu* (preparedness and cultural competence), *Poto he anga* (wisdom in action), and *'Ofa fe'unga* (appropriate compassion and empathy) (Ravulo, 2025). These values informed how Talanoa was conducted, ensuring that engagement with participants remained culturally grounded, ethical, and responsive to context.

By fostering culturally safe spaces grounded in trust, reciprocity, and mutual respect, Talanoa enabled the generation of rich, contextually situated data that reflect participants lived experiences while upholding Pacific values of relational accountability.

3.5 Chapter Summary

This chapter has outlined the methodological approach underpinning the study, grounded in Pacific epistemologies and informed by the Ūloa methodology and Talanoa method. By situating the research within culturally responsive and relational frameworks, the chapter has demonstrated how the research design, data

collection, and data analysis processes were aligned with Pacific values of relationality and cultural accountability. The application of the four Ūloa components; *Tufunga*, *Toutai*, *Tufa*, and *Tofu,* provided a coherent structure through which the study was designed, conducted, analysed, and ethically managed.

The use of Talanoa facilitated open and respectful dialogue, enabling the generation of rich, contextually grounded data that reflect participants lived experiences. Reflexivity and positionality were central to the research process, ensuring ongoing accountability to cultural, ethical, and relational responsibilities. The integration of qualitative thematic analysis, supported by NVivo software, further strengthened the analytical depth of the study while maintaining alignment with Pacific ways of knowing. In doing so, this research contributes to the broader project of decolonising knowledge production by centring Indigenous epistemologies and challenging the dominance of Western frameworks within academic inquiry (Thaman, 2003).

Collectively, these methodological approaches ensured that the study was conducted in a culturally safe, ethically rigorous, and methodologically robust manner. The following chapter presents the findings of the study, drawing on participants' narratives to illuminate how young Pacific adults in Auckland navigate mental distress and engagement with mental health services.

Chapter 4: Findings

This study explored how young Pacific adults in Auckland navigate the tensions between their cultural beliefs and the social expectations within their Pacific communities while attempting to access mental health services. This chapter presents the findings of seven participants who took part in individual Talanoa sessions across Auckland. The analysis developed key themes, including holistic understandings of mental health, identity and silence, navigating cultural expectations, the role of family and community, and the influences and strategies that shape help-seeking. Each theme is supported by subthemes that provide deeper insight into how participants interpret, negotiate, and respond to cultural and social expectations and pressures, and how they engage with mental health services.

Consistent with the Talanoa methodology, participants' narratives are presented in a way that centres their voices while recognising the relational and contextual nature of their experiences. These findings demonstrate that navigating mental health is not a linear or individual process, but one that is deeply embedded within relationships, cultural values, and broader social environments.

The quotations included in this chapter were intentionally kept brief. During the Talanoa sessions, participants often shared their thoughts through long, layered, and sometimes indirect narratives before arriving at their central point. To present their contributions clearly and coherently, I selected the portions of their statements that most directly reflected the key ideas relevant to each theme. This approach allowed me to highlight the most meaningful parts of their Talanoa without misrepresenting or diminishing the depth of what was shared.

Although the quoted sections are short, the accompanying discussion expands on the broader context of each participant's contribution. In doing so, I aimed to reflect their full train of thought and the richness of the Talanoa, drawing on the wider conversation to ensure that readers can understand how participants arrived at their key points. The use of shorter quotations therefore supported clearer thematic analysis while still honouring the substance and significance of participants' voices.

Taken together, these themes illustrate a non-linear and relational pathway through which young Pacific adults navigate help-seeking. This relational structure is visually represented in Figure 2, which synthesises the five key themes and their interconnections.

4.1 Participant Background

The seven participants responded to the study advertisement and voluntarily participated in the Talanoa sessions. Table 1 presents an overview of participants' characteristics, including their ethnic background, occupation, age, ethnicity, and gender. Providing this information offers contextual insight into the cultural and social environments that shape the participants' perspectives and experiences of mental health and service access and utilisation. While all participants fell within the study's age range of 18 to 25, only one participant was 18 years old, while the remaining participants were slightly older within this range. This difference in life stage may shape how experiences and perspectives are expressed. One participant identified as MVPFAFF+,

reflecting Indigenous gender-diverse identities within Pacific communities. Participants were also engaged in diverse occupations, ranging from students to professions such as law, nursing, and mental health specialists.

The Talanoa sessions produced rich and nuanced narratives. The participants shared both common and differing understandings of mental health, described various experiences of navigating cultural and social expectations, and outlined multiple pathways through which they managed or sought support for their mental health and wellbeing. These findings are interpreted with consideration of the participants' diverse cultural, social, and professional backgrounds.

Table 3: Participant characteristics

Participant	Occupation	Ethnicity	Gender	Age
1FI	Lawyer	Samoan	Female	24
2FI	Mental Health Specialist/ Social Worker	Tongan	Female	25
3FI	Mental Health Occupational Therapist	Tongan	Female	25
4MI	Student	Samoan	Male	18
5MI	Student	Tongan	Male	24
6FI	Project Manager/Engineering Student	Cook Island	Female	25
7P	Registered Nurse	Tongan	MVPFAFF+	24

4.2 Holistic Understanding of Mental Health and Wellbeing

Participants' understandings of mental health reflected a holistic worldview shaped through the intersection of cultural beliefs, family teachings, spiritual values, and broader social experiences. Rather than framing mental health as an individual or clinical phenomenon, participants described wellbeing as relational and multidimensional, encompassing emotional, spiritual, cultural, and interpersonal aspects of life. Within this framing, mental health was understood as embedded in everyday relationships, responsibilities, and identity, and inseparable from the social and cultural contexts in which it is experienced. This section contributes a novel insight by showing how young Pacific adults conceptualise mental health not as an individual or clinical state, but as a relational and evolving process that unfolds across everyday life, relationships, and cultural contexts.

Mental Health as Emotional and Psychological Wellbeing

Participants commonly framed mental health as an awareness of their internal state, encompassing thoughts, emotions, and overall *"headspace"*. While these descriptions appeared simple, they reflected a nuanced understanding of mental wellbeing as fluid and context-dependent, shaped by everyday experiences and emotional demands. Rather than relying on clinical or diagnostic language, participants drew on familiar and embodied terms that centred how they felt and how they interpreted those feelings in daily life. As participants

explained, mental health was about "*your brain… your feelings and emotions*" (3FI) or "*where your headspace is*" (4MI).

Participant 2FI articulated a clear distinction between mental health and mental illness, describing mental health as part of general emotional wellbeing characterised by everyday fluctuations in mood, stress, and coping capacity. She referred to this as "*the emotional*" side of wellbeing, in contrast to mental illness, which she described as "*the more severe psychological side*" that significantly disrupts functioning (2FI). Importantly, she did not view mental illness as a sudden or isolated condition. Instead, she described it as emerging gradually through the accumulation of unaddressed pressures and emotional strain rather than an immediate escalation of ordinary stress:

> "*No one can just get straight to that stage of having mental illness… it's a buildup of things where it could have been prevented*" (2FI).

This perspective illustrates how participants understood mental distress as developing relationally over time, shaped by sustained life experiences rather than formal diagnostic thresholds. Emotional awareness and coping were therefore positioned as central to maintaining wellbeing, rather than as secondary to clinical intervention. These accounts demonstrate an emergent, non-clinical differentiation between mental health and mental illness, in which emotional awareness, coping, and prevention were positioned as central to wellbeing. This framing reflects participants' own theorisation of mental distress as cumulative and relational, rather than defined by diagnostic thresholds.

Spirituality, Culture, and Intersecting Beliefs

Building on these emotional understandings, participants emphasised the role of spirituality and cultural belief systems in shaping how mental health and wellbeing were interpreted. For many, spiritual beliefs were closely intertwined with cultural identity and family practices, forming an influential framework through which experiences of distress and wellbeing were understood. Christian beliefs and values were often closely linked to cultural traditions, with some participants noting that religious teachings and cultural beliefs were frequently blended in ways that shaped understandings of mental health.

Spirituality was described as providing meaning, grounding, and guidance, while also introducing complexity when spiritual explanations for distress coexisted with psychological understandings. Participant 2FI reflected that her "*faith and beliefs changed [her] attitude and perspective on mental health… they work hand in hand*" (2FI), indicating that spiritual and psychological frameworks were not viewed as separate but interconnected.

Participants also described tensions that arose when cultural traditions and religious beliefs intersected. Participant 3FI explained that her Tongan upbringing influenced her spiritual understanding in ways that later "*took [her] away from what [she] believe[s] now is the true Christian*" (3FI). She noted that families often merge cultural beliefs with Christianity, using spiritual narratives to explain behaviours or experiences:

"*They're mixing it with Christianity… they're using Christianity to make up for what they believe*" (3FI).

Within these intersecting belief systems, mental health difficulties were at times interpreted through spiritual or supernatural explanations rather than psychological or biomedical frameworks. Participants described community beliefs that associated mental illness with curses, possession, or spiritual wrongdoing. Participant 2FI explained that "*the Tongan community have a certain belief about people who have mental health issues; [they] are cursed in a way*" (2FI), noting that mental illness was sometimes understood as a form of "*karma*" (2FI).

These beliefs were reflected in participants' own family experiences. Participant 6FI recalled that her aunt's schizophrenia was initially interpreted as spiritual interference rather than mental health condition:

"*For the longest time, they thought she was possessed; she was cursed*" (6FI).

Despite these challenges, spirituality remained integral to participants' broader understandings of wellbeing. Participant 3FI described spirituality as being "*rooted in everything*" (3FI), reflecting its foundational role in shaping how participants understood themselves, their families, and their experiences. Participants navigated multiple belief systems, drawing on cultural, spiritual, and psychological frameworks in ways that sometimes provided comfort and resilience, and at other times generated tension when interpretations conflicted. Importantly, spirituality was neither uniformly protective nor solely stigmatising. Instead, participants' narratives reveal how spiritual, cultural, and psychological explanations for mental distress were actively negotiated, contested, and reinterpreted over time

Negotiating Family Values and Personal Perspectives

Family environments were described as foundational to participants' early understandings of mental health. Values, behaviours, and communication patterns learned at home shaped how participants interpreted emotions, responded to distress, and understood appropriate ways of coping or seeking support. As Participant 3FI explained:

"*Everything starts from home… what you're taught at home impacts where you distribute*" (3FI).

These early teachings influenced participants' sense of responsibility within family and community contexts. However, many participants described shifts in perspective as they encountered new social environments beyond their immediate cultural settings. Experiences in education, work, and diverse social groups prompted reflection on values that had previously been taken for granted. Participant 3FI noted that engaging with people outside her cultural community "*made [her] question a lot of [her] values,"* and that this process ultimately *"makes [her] stronger*" (3FI).

Rather than rejecting cultural values, participants described this negotiation as a process of adaptation and growth. Cultural expectations were actively reinterpreted in response to changing environments, allowing

participants to develop a greater sense of autonomy while maintaining connection to family and community. This negotiation process highlights family not as a fixed influence, but as a dynamic site where mental health meanings are transmitted, questioned, and reshaped as young Pacific adults move across social and cultural spaces.

Evolving Understandings of Mental Health

As participants moved through different stages of life and social contexts, their understandings of mental health expanded. Early perceptions were often shaped by family experiences or limited exposure to mental health education. Over time, engagement with peers, youth communities, and wider social conversations contributed to broader perspectives. Participant 6FI reflected on this shift, explaining:

> "*I always associated mental health with disorders… now I think mental health is just that; it's health. Mental health deserves just as much attention as every other part of your wellbeing*" (6FI).

This reframing reflects a movement away from illness-focused understandings toward more preventative and holistic perspectives. Mental health was increasingly recognised as an ordinary and ongoing aspect of wellbeing, rather than something relevant only in times of crisis.

Holistic Pacific Frameworks and Self-Awareness

Participants also drew on Pacific wellbeing frameworks, particularly Fonofale and Te Whare Tapa Whā, to articulate their understandings of mental health. These models emphasise the interconnected nature of wellbeing, integrating physical, spiritual, mental, and social dimensions. For participants, such frameworks offered culturally meaningful ways of interpreting distress and understanding mental health within a broader system of relationships. As Participant 3FI stated, "*Fonofale, that's the mental health*" (3FI).

These frameworks were described as practical tools rather than abstract concepts. Participant 6FI noted that while Te Whare Tapa Whā provides a strong foundation, applying it meaningfully requires intentional reflection:

> "*Te Whare Tapa Whā… is a very good basic model, but it requires a lot of thinking for you to be able to apply every day and understand how holistic your being is*" (6FI).

Self-awareness and identity were also central to participants' understandings of wellbeing. A strong sense of self was described as enabling more effective navigation of challenges and clearer interpretation of difficult situations. As Participant 7P explained:

> "*If you know who you are and you know what you want, then that influences how you see things when it becomes challenging*" (7P).

Participants' engagement with Pacific wellbeing frameworks illustrates how models such as Fonofale and Te Whare Tapa Whā operate as lived, reflective tools that support self-awareness and everyday sense-making, rather than remaining abstract or institutional concepts. These reflections illustrate how mental health was understood as shaped not only by emotional processes, but by belonging to culture, family, spirituality, and community. Pacific wellbeing frameworks therefore functioned as everyday reference points that supported participants in maintaining balance and making sense of their experiences.

Taken together, participants' accounts show that mental health was understood as a holistic and relational experience grounded in emotional awareness, cultural identity, spirituality, family relationships, and social context. Rather than a fixed clinical condition, mental health was experienced as dynamic, developing and shifting across life stages and everyday circumstances. Participants drew on multiple interpretive frameworks to make sense of wellbeing, reflecting both continuity in cultural values and adaptation to new social environments. These findings extend existing understandings of Pacific mental health by foregrounding young Pacific adults as reflexive agents who actively interpret, negotiate, and adapt multiple frameworks of wellbeing across the life course. This relational and cyclical understanding of wellbeing aligns with the thematic structure illustrated in Figure 2, which depicts how participants navigated mental health and help-seeking across interconnected cultural, relational, and identity-based influences.

4.3 Identity, Silence, and the Suppression of Self-Expression

The findings highlight how participants navigated significant tensions between their sense of personal identity and the cultural, religious, and social structures that shape life within their Pacific communities. These tensions influenced whether and how participants expressed or suppressed mental health-related thoughts, feelings, and experiences. Across the Talanoa sessions, participants described pressures to conform, the weight of silence within families and communities, and the emotional labour involved in managing multiple, and at times conflicting, identities.

This theme illustrates how cultural expectations shape self-expression and contributes to the suppression of mental health conversations among young Pacific adults. Importantly, silence emerged not merely as a cultural norm, but as an active mechanism through which emotional expression is regulated and mental health communication is shaped within Pacific communities. This finding extends existing literature by reframing silence not as the passive absence of dialogue, but as a culturally regulated practice that structures emotional expression, defines relational boundaries, and governs the conditions under which mental health concerns can be voiced.

Suppressing Identity to Maintain Cultural Expectations

Participants frequently described feeling the need to suppress aspects of themselves in order to maintain cultural harmony and meet expectations embedded within their families and communities. This suppression was not always explicit, but was shaped by deeply ingrained norms of respect, obedience, and

emotional restraint that guided how young Pacific adults were expected to behave. For many, these expectations created an internal tension between personal expression and cultural appropriateness.

Participant 3FI reflected on how discussing mental health required careful navigation of her identity, explaining that she often felt compelled to "*suppress [her] identity*" (3FI) in order to remain respectful within her cultural context. She further elaborated that aspects of her Tongan identity shaped how she expressed her views, noting that "*sometimes my Tongan identity… [means] I don't really appreciate what we hold priority over other things*" (3FI). Her reflections illustrate how cultural expectations guide not only what young Pacific adults feel they can voice, but also how they position themselves relationally when speaking about mental health.

For some participants, cultural expectations directly shaped their willingness to seek help. Participant 7P explained that ideals of independence and self-reliance often discouraged her from accessing support, even when services were readily available in her workplace, noting that "*if I know I can do it, then that's what stops me… I don't really get an influence to access [support]*" (7P). Participant 2FI similarly described the cumulative burden of internalising expectations of endurance and perseverance within her family, reflecting on how these norms shaped her sense of responsibility and limited her ability to prioritise her own wellbeing (2FI). Together, these narratives demonstrate how cultural norms surrounding strength, restraint, and self-sufficiency can delay help-seeking, even in contexts where support is accessible.

Collectively, these narratives reveal the persistent tension between cultural expectations and personal wellbeing. Participants were often required to prioritise collective values, such as maintaining harmony, showing strength, and upholding family reputation, over their own emotional needs. This limited their ability to openly communicate distress or ask for support. Yet importantly, participants did not reject their cultural identities. Instead, they described an ongoing negotiation in which they balanced authenticity with cultural appropriateness.

These experiences highlight that identity is not fixed, but continually shaped through interactions with cultural norms, relational obligations, and personal experiences. In this context, suppression becomes a strategy for preserving belonging and honouring cultural expectations, even when it comes at the expense of personal expression and emotional openness.

Conflicts Between Culture, Christianity, and Personal Identity

Participants also described tensions between cultural expectations and Christian beliefs, particularly when these frameworks conflicted with their personal identities or professional roles. Participant 3FI reflected on the difficulty of reconciling her identity as a mental health clinician with the teachings of her Christian upbringing, explaining that she often felt compelled to "*suppress [her] identity*" (3FI) in order to remain aligned with religious norms. She recalled that, "before I was a clinician… I was conflict[ed] between study and Christian faith. I didn't care about my identity. I had to suppress my identity" (3FI). Her account illustrates

the challenges of navigating professional knowledge within cultural and religious contexts that may interpret mental distress through moral or spiritual lenses rather than psychological frameworks. This tension frequently required participants to manage competing expectations around how emotions should be expressed, what constitutes acceptable support, and whether help-seeking is legitimised.

For Participant 7P, who identified as MVPFAFF+, these tensions were even more evident. Navigating multiple identities required her to simultaneously manage expectations from her Tongan community, her religious communities, and the MVPFAFF+ community. She described the complexity of holding both her cultural and sexual identities, emphasising that neither was secondary nor separable from her sense of self, stating that "*the foundation to my identity is the fact that I am Tongan… and also my sexual orientation*" (7P). Her reflection highlights identity as an ongoing and relational negotiation, shaped by intersecting cultural, spiritual, and social expectations.

Faith emerged as both a source of conflict and a grounding force in her life. Participant 7P further described how religious teachings often positioned her sexual identity in morally challenging ways, creating internal tension, yet faith simultaneously provided hope, meaning, and resilience. As she explained, "*my whole faith… is really conflicting with MVPFAFF+. But being faithful… keeps me going*" (7P). Despite these contradictions, faith remained central to her identity. Rather than distancing herself from spirituality, she drew on her beliefs to interpret adversity through a narrative of endurance and divine purpose, reflecting that "*God gives the toughest challenges to the strongest soldiers*" (7P).

Participant 7P's narrative illustrates the complex ways Pacific MVPFAFF+ individuals navigate overlapping cultural, spiritual, and gender or sexual identities. Rather than destabilising her sense of self, these tensions contributed to a multifaceted identity in which cultural belonging, resilience, and faith were deeply interconnected, shaping how she understood and navigated her wellbeing.

Silence Within Families and Communities

Silence emerged as a powerful and recurring analytic theme across the Talanoa with participants, functioning not merely as the absence of speech but as an active relational practice that regulates emotional expression within Pacific families and communities. For many participants, silence operated as a culturally reinforced norm that governed when, how, and by whom emotions could be expressed or withheld. This practice was closely tied to broader expectations of respect, relational harmony, and the preservation of a collective image of strength. As Participant 2FI observed, there are "*many unspoken expectations within our culture*" (2FI), highlighting how silence functions as a socially learned and culturally meaningful mechanism that shapes communication, emotional disclosure, and relational conduct.

Silence operated as more than a passive absence of speech, functioning instead as a relational practice that shaped interactions within families and communities. By favouring harmony and respect, these expectations

often limited open emotional expression and contributed to contexts where distress was managed privately rather than shared. Participant 6FI reflected on how this pattern of silence affected her family relationships, explaining:

> "*Silence on my part and silence on the people that I thought would care about me… created walls*" (6FI).

Her reflection highlights how silence, though rooted in relational care, can unintentionally create emotional barriers and deepen feelings of disconnection.

Participants further highlighted that silence extended beyond the home and was embedded within wider Pacific spaces, where it functioned as a recognised cultural practice associated with attentiveness, respect, and the maintenance of social order. In these contexts, silence was not passive; rather, it actively structured interactions and regulated participation within the vā. As Participant 6FI observed,

> "*In every kind of Pacific space I've been in, there's always silence at the beginning*" (6FI),

reflecting the collective and sacred significance accorded to quietness within Pacific cultural settings. Participant 7P reinforced this view, explaining that it was not specific beliefs but "*the whole act of silence*" that shaped understandings of mental health in Pacific contexts, noting that "*it don't influence the way you see mental health… it's more the whole act of silence*" (7P). Her reflection highlights how silence functions as a regulatory practice, shaping what can be spoken, how Talanoa is enacted, and whose voices are recognised.

This culturally embedded silence thus performs a dual function. On one hand, it acts as a protective and relational strategy, supporting composure, respect, and harmony across generations and hierarchies. On the other hand, it constrains opportunities for open dialogue about emotional distress, limits expressions of vulnerability, and restricts help-seeking. By prioritising relational stability and collective dignity, participants often felt compelled to suppress personal struggles, reinforcing silence as both a valued cultural practice and a significant barrier to mental health expression and support.

Negotiating Multiple Identities Across Communities

Participants' identities were shaped through their navigation of multiple communities: cultural, professional, educational, and social- each carrying its own expectations and influences. These contexts offered differing expectations, values, and norms, requiring participants to shift how they understood and expressed themselves. Participant 6FI explained that being part of a multicultural space that celebrated individuality helped her embrace her identity and strengthen her sense of purpose:

> *"Being in such a multicultural space… helped me embrace my own… it's why I'm passionate about Pacific outcomes" (6FI).*

Participant 3FI similarly described how moving between different communities exposed her to contrasting perspectives that *"critically challenge each other"* (3FI). Navigating these environments required her to reflect deeply on her own values, and although this process was sometimes uncomfortable, she regarded it as integral to her personal and cultural development. As she explained, engaging with diverse viewpoints *"made [her] question a lot of [her] values… but it just makes [her] stronger"* (3FI). Her experience illustrates how

encounters with differing cultural contexts can prompt meaningful self-reflection and contribute to a strengthened sense of identity.

Participants also described the need to tailor how they discussed mental health depending on the cultural setting they were in. Within Pacific communities, direct or explicit conversations about emotional distress were often regarded as inappropriate or disrespectful. As a result, participants adopted more careful, indirect, and relationally sensitive forms of communication. Participant 3FI captured this challenge, explaining that she *"ha[s] to be very culturally sensitive about it,"* which means she *"can't be straightforward about it"* (3FI). Her experience illustrates how cultural norms surrounding respect and relational harmony shape the ways young Pacific adults express and share their mental health experiences.

These experiences reflect the ongoing negotiation between authenticity and cultural appropriateness that participants consistently described. They also demonstrate that identity is fluid and context-dependent, requiring ongoing emotional labour to balance cultural belonging with personal honesty.

Across the Talanoa sessions, participants spoke about how cultural expectations, religious beliefs, and community norms shaped their willingness and ability to express themselves openly. Expectations of strength, resilience, and silence contributed to the suppression of emotional expression and restricted opportunities for open conversations about mental health. For many, navigating multiple identities: cultural, religious, professional, and sexual- created additional layers of tension that influenced how they understood and communicated their mental wellbeing.

These findings illustrate the emotional labour involved in negotiating identity within Pacific communities and highlight the significant roles that silence and cultural expectations play in shaping help-seeking behaviours among young Pacific adults. The need to Tauhi Va, protect relationships, maintain harmony, and uphold cultural values often meant that distress was held privately, reinforcing cycles of emotional restraint and limiting access to support. These findings suggest that suppression and silence function as negotiated strategies rather than passive cultural inheritances, highlighting how young Pacific adults actively manage identity, vulnerability, and relational accountability within culturally structured environments.

4.4 Navigating Cultural Expectations and Social Pressures

Participants continually worked to balance cultural norms, family pressures, and personal wellbeing. While earlier findings highlighted the emotional strain this created, the following theme focuses on *how* participants actively navigate these pressures. Rather than inheriting cultural expectations without reflection, participants described how they negotiated, adapted, and invested emotional energy as they moved between cultural worlds. Their narratives reveal the intentional strategies they used to uphold expectations of strength, protect family reputation, manage competing values, and cope with stigma and judgement. These narratives illustrate that

identity navigation for young Pacific adults is an active and dynamic process, one that requires constant adjustment to maintain wellbeing while preserving the Va/ meaningful cultural relationships.

Expectations to Be Strong, Obedient, or Resilient

Participants described navigating deeply rooted cultural expectations that demanded strength, obedience, and emotional endurance. These expectations shaped how they responded to stress and emotional challenges, often determining whether they felt able to speak openly about distress.

Participant 3FI highlighted how older generations reinforced the belief that resilience alone was sufficient for managing mental health, explaining that messages such as "*you don't need mental health; you just need to be resilient*" shaped expectations for young people to "*stick to the same resilience and be the same as them*" (3FI). Participant 2FI similarly described the expectation within traditional Tongan families to endure hardship without complaint, noting that the prevailing attitude was to "*just suck it up and keep going no matter the cost, even if it's at the cost of your own well-being and mental health*" (2FI). These pressures often pushed participants beyond their emotional limits. Reflecting on this cumulative burden, Participant 2FI added that the expectation to "*just stay the course, just hack it*" eventually became untenable, admitting, "*I couldn't hack it anymore*" (2FI).

Participants also experienced racialised expectations, often reinforced through stereotypes portraying Pacific people as inherently strong, resilient, and able to withstand hardship. These assumptions were expressed not only by non-Pacific individuals but also, at times, by Pacific people themselves, reflecting internalised cultural and racialised norms. As Participant 4MI observed, "*people think that we're Islander… strong physically and mentally*" (4MI), highlighting how such stereotypes shape perceptions of Pacific identity. For Pacific men in particular, these expectations were especially restrictive. Gendered cultural norms positioned men as unwaveringly strong and self-reliant, leaving little room for vulnerability or help-seeking. Participant 4MI described this as "*a really bad stereotype… for men to be strong the whole time and not being able to share any kinds of weakness*" (4MI), illustrating how these narratives constrain emotional expression and discourage engagement with mental health support.

While some participants actively challenged these expectations, others internalised or reproduced them in their everyday lives. Participant 7P described a more resistant stance, explaining that she refused to allow social expectations to dictate her behaviour, noting that "*social expectations never get to me*" (7P). Yet, even as she articulated this sense of independence, she also acknowledged that internalised expectations of self-reliance could still inhibit her from seeking support. As she explained "*If I know I can do it, then that's what stops me*" (7P), highlighting the subtle ways in which cultural norms around independence and endurance continued to shape her help-seeking decisions. Her reflections illustrate how Pacific youth may outwardly resist social pressures while still being influenced by deeply embedded cultural narratives about strength and self-sufficiency.

In a wider sense, participants navigated cultural expectations of toughness by selectively resisting, internalising, or strategically managing them. Their experiences highlight the emotional labour required to uphold resilience while protecting their wellbeing. These findings demonstrate that resilience, in this context, is not simply an inherent personal trait but is a socially constructed expectation that young Pacific adults must continuously negotiate and manage.

Prioritising Family Reputation and Collective Wellbeing

Alongside expectations of strength, participants also navigated pressures to prioritise family reputation and collective wellbeing above their own needs. These expectations strongly shaped how participants conducted themselves within their families and wider communities, often requiring them to minimise or suppress personal challenges in order to uphold cultural and family obligations. Participant 2FI reflected on this enduring sense of responsibility, noting that

> "*I'm not just thinking about myself, I'm constantly thinking about my family… it's always them before me*" (2FI).

Participant 3FI's narrative illustrates how prioritising family reputation and collective wellbeing shaped her experiences of responsibility, distress, and help-seeking. She described feeling persistently torn between her own academic responsibilities and her father's expectations, explaining that she was "*conflicted between responsibilities and then study and then his wishes,*" and that regardless of her efforts, "*it's never enough for them*" (3FI). This tension reflects a broader emphasis on upholding family expectations, where personal needs are deferred to protect collective expectations and social order

Within this context, Participant 3FI indicated that family pressure influenced not only her daily decision-making but also her engagement with support services. She noted that the pressure to meet family expectations and protect family standing often overwhelmed her awareness of available help, stating that "*family pressure really blocked out what is available*" (3FI). This suggests that prioritising collective wellbeing can limit opportunities for individual help-seeking, particularly when external support is perceived as secondary to family responsibility.

She further described the complexity of relying on family for support while simultaneously experiencing it as a source of distress. She reflected that "*the advice they're going to give me will conflict with what I believe,*" highlighting how family guidance, though well-intentioned, could clash with her own needs and values (3FI). Notably, she identified that "*the trigger is the same people that support me*" (3FI), illustrating the dual role of family as both protectors of collective wellbeing and contributors to emotional strain. This dynamic made it difficult for her to openly express vulnerability or seek support outside the family, demonstrating how cultural norms prioritise family unity and social standing, even when this requires personal emotional sacrifice

Participants navigated these expectations by carefully balancing loyalty to their families with acts of self-protection, often suppressing their own needs in order to maintain family harmony and safeguard the

family's reputation within their cultural communities. These narratives reinforce that help-seeking is not an individualised process but is shaped by collective considerations, relational accountability, and a strong desire to protect family standing. Overall, participants' narratives highlight the significant emotional labour involved in navigating cultural and familial obligations, illustrating how family relationships can simultaneously provide support and care while also shaping the conditions under which help-seeking feels possible. In this sense, the prioritisation of family functioned as a relational context that both enabled strength and connection and constrained the expression of vulnerability and access to support.

Negotiating Between Home Values and School/Peer Influences

Participants described navigating value systems that differed across home, school, university, and peer spaces, prompting ongoing shifts in how they carried themselves and made sense of who they were. Home environments typically emphasised cultural obligations, respect, and collective responsibility, while educational and peer contexts introduced alternative norms around autonomy, self-expression, and help-seeking. Participant 2FI described how the cumulative pressures of university demands alongside her responsibilities as an adult daughter eventually prompted her to seek support, explaining that "*uni stress… obligations and responsibilities as an adult daughter… that was the turning point where I felt like I needed to access support*" (2FI).

Exposure to new ideas within educational and peer spaces encouraged participants to question, reinterpret, and at times, challenge the values they were raised with. Participant 3FI reflected that moving between communities with contrasting worldviews prompted her to reassess long-held beliefs, a process she described as ultimately strengthening her sense of self (3FI). Rather than viewing these tensions as destabilising, she understood them as opportunities for growth, resilience, and deeper clarity about her cultural identity.

Participant 6FI similarly described how engagement with diverse peer groups supported the development of her sense of self. She reflected that "*all my peers are multicultural,*" and that being in spaces which celebrated both individuality and cultural heritage helped her to "*embrace [her] own*" identity (6FI). For her, peer environments offered alternative frameworks for belonging that affirmed differences while still valuing cultural roots.

Participants also highlighted generational contrasts that further complicated the negotiation between home and external influences. Participant 6FI reflected on the "*stark contrast*" she observed between older and younger Pacific communities and described how recognising that "*our parents are experiencing life for the first time too*" (6FI) helped her contextualise these differences. This reframing enabled her to better understand the limitations and pressures shaping parental perspectives.

Collectively, these narratives illustrate how participants negotiated the space between home values and school or peer influences by integrating, reframing, and selectively challenging beliefs rather than choosing one system over the other. Their experiences demonstrate adaptability across cultural, social, and generational

contexts, highlighting identity formation as an ongoing, dynamic process shaped through constant negotiation between competing worlds.

Balancing Cultural Identity with Personal Beliefs

As participants moved across different cultural, educational, and social communities, they engaged in ongoing and active work to balance their cultural identities with their personal beliefs. This balancing process was dynamic rather than fixed, shaped by the relational and social contexts they were navigating and the values expected of them in each space. Participant 3FI described how her sense of identity shifted depending on her environment, explaining that exposure to diverse viewpoints encouraged both questioning and affirmation of her beliefs. She reflected, "*it changes… sometimes it helps me challenge, but it won't change it. It just makes me have more facts to back up why I believe this certain way*" (3FI). Her account highlights how engagement with differing perspectives strengthened rather than diminished her sense of self.

For other participants, cultural identity was closely tied to deeply embedded values that guided decision-making and shaped life choices. For Participant 7P, the Tongan value of *tauhi vā,* nurturing and maintaining relational space, was a central organising principle underpinning her responsibilities and actions. She described this value as foundational to how she understood giving back, explaining, "*Tongan value of tauhi vā… that's my giving back*" (7P). She further linked this cultural obligation to her professional aspirations, describing her pursuit of nursing as a practical and culturally grounded expression of care for her family and community:

> "M*y way of giving back is… being a nurse… being able to support health-wise at home if need be*" (7P).

These na rratives illustrate how participants balanced cultural belonging with personal authenticity by selectively drawing on cultural values, adapting communication styles, and modifying how aspects of their identity were expressed across contexts. Rather than rejecting cultural expectations or accepting them uncritically, participants actively negotiated ways to honour their heritage while remaining true to their own beliefs. In doing so, they demonstrated that identity for young Pacific adults is fluid, responsive, and continually shaped through relational, cultural, and personal commitments rather than fixed or singular positions.

Managing Stigma and Fear of Judgement

While expectations of strength emphasised emotional endurance, pressures surrounding family reputation introduced additional moral and relational risks associated with help-seeking. Within this context, participants described experiences of stigma and fear of judgement related to mental health within their families and wider communities. Many reflected on how these dynamics shaped their early understandings of mental health and continued to influence their decisions about seeking support later in

life. Participant 3FI explained that mental health difficulties were often framed by older generations as a sign of weakness, reinforcing expectations of constant strength and resilience. As she noted, "*mental health portrays itself as someone who makes you weak… our people like to be resilient*" (3FI). Such beliefs contributed to environments in which emotional vulnerability was discouraged, and distress was expected to be endured rather than expressed.

Participant 6FI similarly described how stigma informed her initial perceptions of mental health, emphasising that silence and judgement underpinned how mental wellbeing was discussed or avoided within her community. She reflected that her early understanding was shaped by beliefs that mental health was "*not there*," that distress was dismissed as "*all in your head,*" and that conversations were characterised by "*judgement*" and "*silence*" (6FI). These narratives illustrate how stigma operated not only through direct expressions of judgement, but also through the lack of space for open conversations about emotional wellbeing.

In response to these dynamics, participants described adopting various strategies to manage stigma and protect themselves from judgement. These often involved being selective about who they confided in or seeking support beyond immediate family and culturally familiar spaces. For some, peer environments, particularly those involving younger Pacific people, offered safer and more affirming contexts for discussing mental health. Participant 6FI explained that "*being around other younger people… helped give me the confidence to access it without shame*" (6FI), illustrating how generational shifts in attitudes created alternative pathways to support.

Across this theme, participants demonstrated significant emotional labour as they navigated cultural expectations, family obligations, generational differences, and community-based stigma. Their strategies: selective disclosure, negotiating values, balancing identity, and accessing alternative support spaces, reflect the complex work required to maintain cultural belonging while safeguarding personal wellbeing.

Taken together, these findings show that mental health decision-making for young Pacific adults is fundamentally relational and shaped by their social environments. Managing stigma was not described as an individual choice alone, but as an ongoing negotiation between collective responsibility, cultural identity, and the need for emotional safety and understanding. Importantly, participants did not portray themselves as trapped by these expectations. Instead, they described making deliberate, context-specific decisions about when to endure, when to resist, and when to seek support, reflecting forms of agency exercised within, rather than outside of, these relational constraints.

4.5 The Role of Family and Community in Shaping Mental Health Help-Seeking

Family, church, and community stood at the heart of how participants made sense of mental health, shaped their responses to distress, and influenced their pathways to support. These relational spaces provided grounding and belonging, while also reinforcing silence, stigma, and expectations around how emotions should

be expressed. Participants' narratives revealed the ongoing negotiation between collective obligations, cultural norms, and personal wellbeing, showing that help-seeking unfolds within Pacific relational worlds rather than as an individual act. This affirms that mental health experiences are deeply woven into the cultural, family, and communal systems surrounding young Pacific adults.

Family as the First Site of Learning

Participants described family as the first and most influential space in which their understandings of mental health were formed. Within many households, narratives of resilience, silence, and emotional restraint shaped how distress was recognised and whether seeking support was considered appropriate. Older generations were often remembered as emphasising resilience as the expected way of coping. Participant 2FI reflected that mental health "*wasn't really valued or acknowledged back then because no one was educated about what mental health is*" (2FI), highlighting generational differences in knowledge and awareness.

For many participants, silence and shame were prominent features of their family environments. These norms shaped how emotions were managed and limited opportunities for open communication about distress. Participant 1FI recalled feeling unable to confide in trusted adults, stating that "*the adults in my life… suck*" (1FI), while Participant 3FI described how feelings of shame discouraged her from reaching out for support:

> "*I was ashamed… that stopped me from seeking help*" (3FI).

These family environments established foundational norms around toughness, emotional containment, and self-reliance, shaping how participants learned to manage vulnerability and understand mental health from an early age. Such early experiences often had long-term implications, influencing how participants perceived distress, whether they viewed help-seeking as legitimate, and how they navigated their mental wellbeing throughout adolescence and into adulthood.

Family Obligation and Collective Responsibility Over Self

Participants frequently prioritised family needs above their own wellbeing, reflecting deeply embedded Pacific values of collectivism, reciprocity, and relational responsibility. Decision-making was often framed through consideration of family roles and obligations, with personal needs positioned as secondary. Participant 2FI described this orientation clearly, noting

> "*I'm not just thinking about myself… it's always them before me*" (2FI).

Participant 3FI further illustrates the strain of managing competing demands, particularly when academic responsibilities intersected with parental expectations. Her experiences highlighted the emotional tension that emerged when individual goals were weighed against perceived familial duty.

This prioritisation of family over self often delayed or constrained engagement with mental health services. Seeking support was sometimes perceived as self-focused or misaligned with expectations of duty, endurance, and collective responsibility. For many participants, decisions about help-seeking involved careful consideration of the potential impact on family reputation, relational harmony, and their ability to fulfil expected roles. These narratives underscore how mental health help-seeking for young Pacific adults is negotiated within relational contexts where collective wellbeing is consistently foregrounded over individual need.

Family as Both the Source of Harm and Support

Participants described family as occupying a dual and sometimes contradictory role in their lives, providing comfort, grounding, and a strong sense of belonging, while also functioning as a source of stress and emotional burden. Several participants reflected on being exposed to adult responsibilities or emotional labour at a young age.

Participant 6FI described an early role reversal within her family, explaining

> "My mum pretty much used us as therapists… you're like 14 and you're like, what do I do with this?" (6FI).

Such experiences contributed to emotional strain during formative years, blurring boundaries between care, responsibility, and childhood. Others highlighted family conflict, high expectations, or relational tension as key contributors to their mental health challenges. At the same time, these same family members remained central to participants' sense of identity, motivation, and purpose. Participant 3FI captured this emotional complexity clearly, reflecting that her family were "*the reasons why I want to go, but they're also the same reason I want to stay*" (3FI). Her account illustrates the profound tension of navigating relationships that are simultaneously supportive and distressing.

This duality often complicated help-seeking. Participants described uncertainty about engaging with external services when the source of distress was embedded within family relationships themselves. The emotional closeness within Pacific families meant that distress was inseparable from the relationships surrounding it, with support and strain often present at the same time. Participants shared that seeking help felt incomplete when it did not engage with the family dynamics shaping their everyday realities.

These findings highlight the complexity of Pacific family systems, where the same relational structures that provide care, identity, and belonging can also contribute to emotional strain. Together, participants' narratives reinforce that mental health and help-seeking for Pacific young people are deeply relational processes, shaped by family dynamics that cannot be understood solely in terms of harm or support, but rather through their coexistence.

Fear of Shame, Blame, and Collective Reputational Harm

Concerns about shame and the potential for collective reputational harm strongly shaped participants' reluctance to access mental health services. Mental distress was often understood through a collective lens, where an individual's struggles were not viewed as personal challenges but as reflections of the entire family. Participant 2FI articulated this clearly, explaining that "*people are never looking at just the individual… they're always looking at the parents*" (2FI). She further expressed fear that seeking help would cause her family to be perceived as "*dysfunctional*" (2FI), revealing how deeply participants internalised the belief that their actions could compromise their family's public image. These fears were reinforced by community norms that discouraged open discussion of mental health and framed help-seeking as a sign of weakness, poor upbringing, or familial failure. Within such contexts, seeking support risked exposing families to judgement not only about the individual, but about parenting, values, and moral standing. Participants described feeling responsible for protecting their families from scrutiny, which often resulted in silence, self-containment, and delayed or avoided help-seeking.

These narratives highlight the collective nature of Pacific identity, where individual experiences are tightly interwoven with family reputation, social perception, and communal standing. Shame and judgement were understood to extend beyond the individual to parents, siblings, and extended kin. As a result, participants frequently withheld distress or managed it privately in order to prevent blame or embarrassment from falling on their families. This demonstrates how stigma operates not only at an individual level, but within broader relational and cultural systems, shaping how young Pacific adults interpret distress, evaluate risk, and make decisions about accessing mental health care.

Church and Spiritual Communities

Church and spiritual communities played a significant role in shaping participants' understandings of mental health and their responses to emotional distress. For many, faith provided grounding, meaning, and moral guidance, influencing how distress was interpreted and addressed within families and communities. Participant 7P reflected on how Christian teachings shaped collective norms and expectations, noting that

> "*Christian values influenced… their expectation*" (7P).

Prayer was commonly described as the first and most familiar response to distress, reflecting the centrality of spirituality within many Pacific households. For some participants, turning to faith felt natural and supportive, with Participant 7P explaining, "*I wanted my family to pray about it*" (7P). These practices positioned spirituality as a primary coping resource and an initial pathway for managing emotional challenges.

However, participants also described how spiritual interpretations could at times overshadow or replace clinical understandings of mental health. Mental illness was sometimes conceptualised as a curse: "*they think it's a curse… mala*" (7P) or framed as punishment linked to the "*sins of the parents*" (6FI). Such interpretations

reinforced silence, heightened feelings of shame, and contributed to delays in seeking professional support, particularly when distress was moralised or spiritualised rather than recognised as a mental health concern.

Together, these narratives illustrate the dual role of church and spiritual communities in participants lived experiences. While faith offered comfort, hope, and culturally meaningful support, faith-based explanations could also unintentionally create barriers to accessing care. These findings highlight the importance of understanding spirituality not as inherently supportive or harmful, but as a complex and influential context within which young Pacific adults make sense of distress and decide how, when, and where to seek help.

Relational Breakdowns Across Community and Service Settings

Some participants described encountering harmful or dismissive responses from adults in their communities; individuals they expected to be safe, supportive, and trusted figures. These experiences were described as particularly damaging given the authority and moral standing community leaders often hold within Pacific contexts. Participant 1FI recalled reaching out to a youth leader during a moment of acute distress, sharing, "*I want to kill myself*," and being "*given a number for a crisis line*" (1FI). Rather than receiving empathy, relational support, or a follow-up, she was left to manage her distress on her own. This interaction highlighted a lack of engagement beyond procedural referral, and Participant 1FI described how the experience eroded her trust in adults within her community space. Instead of feeling supported, she came to believe that community leaders were not equipped to respond meaningfully to young people's mental health needs.

Participants' narratives also revealed that these dismissive or minimal responses often mirrored the patterns they later encountered in formal mental health services. Participant 1FI described being met with comments such as "*Hopefully it gets better*" (1FI) or questions like "*Why do you want to kill yourself?*" (1FI), which felt emotionally insufficient at moments of acute vulnerability. For participants in crisis, such responses intensified feelings of isolation rather than providing comfort or safety. She ended a conversation abruptly, stating, "*Because of this convo, bye*" (1FI), illustrating how quickly disengagement occurred when support felt invalidating.

Participants also noted that both community leaders and service providers sometimes relied on procedural actions rather than relational care. Being redirected to crisis lines, handed worksheets, or offered generic activities, such as being told to "*Draw a heart and write the names of everybody in there that you think love you*" (1FI), which felt disconnected from their lived realities. While some later understood the intent behind these approaches, in the moment they were experienced as developmentally inappropriate or emotionally out of touch.

Repeated encounters of this nature contributed to cumulative harm and what participants described as "*service fatigue*." As one participant expressed, "*I've honestly tried so many avenues… I was like 'I'm over this*'" (1FI). Each unsuccessful attempt compounded distrust and reinforced the perception that adults in both community

and service settings were unable to provide meaningful support. This was particularly damaging for participants already navigating cultural stigma around help-seeking.

Cultural mismatch further shaped disengagement. Participants emphasised the importance of relational and cultural resonance, noting that some leaders and practitioners responded in ways that felt disconnected from Pacific ways of relating. As one participant explained, "*Her responses… did not sit well with me because I knew she didn't understand where I was coming from*" (2FI). Another reflected, "*I felt like I was talking to a doctor*" (6FI), highlighting how overly clinical or interrogative approaches created emotional distance. First impressions were described as decisive: *"First impressions are everything"* (2FI; 3FI). When early interactions felt unsafe or overwhelming, participants were unlikely to return.

In contrast, participants valued interactions where they felt heard, validated, and understood. They described positive experiences as those where "*They help us take it all out*" (3FI) or where "*You finally had someone who could put into words what I was feeling*" (7P). These moments did not necessarily involve diagnoses or solutions, but rather relational presence, mentoring, and meaning-making. Participants also expressed a preference for culturally grounded, activity-based approaches: "*Just someone to go Talanoa with… through activity based*" (3FI), which felt safer and more aligned with Pacific relational norms.

Some participants exercised agency by disengaging from leaders or services that felt unhelpful or invalidating. As one stated plainly, "*You're not helping me*" (7P). While disengagement is often framed negatively, participants described it as a form of self-advocacy, particularly for those confident enough to articulate their needs. They also expressed concern for peers who might not feel empowered to do the same.

Together, these narratives highlight significant gaps in mental health literacy, relational responsiveness, and cultural alignment within some church and youth environments. Dismissive or inadequate responses from trusted leaders can have lasting consequences for young people's willingness to seek help, shaping not only their engagement with community spaces but also their broader perceptions of safety, trust, and relational support.

Family Gatekeepers and Facilitators to Access

Alongside the barriers outlined earlier, participants emphasised that siblings often played a crucial role in enabling access to mental health support. Across narratives, siblings emerged as uniquely positioned relational figures who could both maintain cultural legitimacy and enable emotional openness, making them critical facilitators of help-seeking in ways parents and elders often could not.

Participant 5MI explained that he would not have engaged in counselling without his sister's intervention, stating

> "*If it wasn't for my sister, I would have probably not gone into it personally*" (5MI).

Following the death of their younger brother, his sister organised a group counselling session for the family. Participant 5MI reflected that this collective, family-centred approach made him more open to receiving support, suggesting that shared experiences of grief and collective participation reduced the stigma associated with help-seeking.

Similarly, Participant 6FI described how encouragement from her sister played a pivotal role in her decision to access counselling. She noted "*I had a good family support… and was encouraged by my sister to try it at least*" (6FI). Shared vulnerability between siblings emerged as particularly influential, helping to normalise emotional openness and reduce feelings of shame. As Participant 5MI explained, "*just my sister being open… that kinda made me open too*" (5MI).

For several participants, grief acted as a significant catalyst for change. Participants such as D and E described how the loss of loved ones disrupted usual patterns of coping and prompted families to collectively seek professional support. In these moments, family members functioned not only as gatekeepers but as facilitators, actively enabling access to mental health services.

Overall, these narratives highlight the complexity of family influence within help-seeking. While certain dynamics created obstacles, family could also be a powerful source of encouragement when support was offered through relational connection and shared experience. Siblings, in particular, emerged as pivotal figures in reducing stigma and opening pathways to care, pointing to the importance of relational and family-inclusive models of mental health support for young Pacific adults.

Protecting Family by Seeking Help in Silence

Several participants described seeking help quietly, not due to an absence of family support, but to shield their families from potential feelings of failure, shame, or responsibility. Participant 7P explained that she intentionally withheld her struggles from her family, stating, "*I wouldn't tell them… I don't want my family to feel like they weren't enough to support me*" (7P). Her experience reflects the emotional labour involved in balancing personal wellbeing with relational responsibility, where silence was used as an act of protection rather than disengagement.

Seeking help in silence allowed participants to preserve family harmony and uphold collective dignity while still addressing their own mental health needs. This practice highlights the complexity of help-seeking within collectivist contexts, where decisions are shaped not only by personal distress but by careful consideration of relational impact and family wellbeing.

Intergenerational Trauma and the Desire to Break Cycles

Participants often framed their help-seeking as an intentional attempt to disrupt intergenerational patterns of trauma, silence, and unresolved emotional pain. They understood their own struggles not as individual events,

but as part of broader family histories shaped by adversity, constrained emotional expression, and longstanding gaps in mental health support. Participant 3FI articulated this motivation clearly, stating "*we need to end this cycle… we can't continue it [onto] our next generation*" (3FI). Her reflection highlights a forward-looking orientation, where seeking support was not only about personal wellbeing, but about creating different possibilities for the future generations.

At the same time, participants emphasised that individual help-seeking alone was insufficient to create meaningful change. Many pointed to the need for family-wide or community-wide engagement, noting that breaking intergenerational patterns required collective shifts in attitudes, knowledge, and communication. Without broader changes in how families and communities understand and respond to mental health, individual efforts were experienced as limited or unsustainable.

Taken together, participants' experiences demonstrate that mental health help-seeking is shaped by the interconnected influences of family, church, and community. These relational systems provided grounding, identity, and support while also reinforcing silence, stigma, and expectations of resilience that often delayed access to care. Families played a dual role as both sources of comfort and pressure, siblings and peers frequently acted as key facilitators of support, and community contexts shaped what could be spoken about and by whom. Help-seeking therefore emerged as a deeply relational process, guided not only by individual need but by collective values, shared histories, and a strong desire to protect family harmony while fostering change for future generations.

4.6 Influences and Strategies Shaping Help-Seeking

Table 4 outlines the key influences that motivated participants to seek support, illustrating how help-seeking was often initiated through relational modelling and culturally grounded encouragement rather than through individual decision-making alone. The subtheme 'Family as a Motivational Influence' demonstrates how siblings played a central role in normalising therapy and disrupting intergenerational silence. For Participant 1FI, witnessing a sister "actively break generational curses" reframed help-seeking as an act of strength and responsibility. This highlights how family members can shift perceptions of mental health support by modelling vulnerability and openness.

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Table 4: Influences that motivate help-seeking

SUB THEME	QUOTE	ANALYTIC INTERPRETATION
Family as a Motivational Influence	"B*ecause my sister's in therapy… having them actively break generational curses… made me want to do something about it*" (1FI).	Siblings played a key role in motivating participants to seek support, with their openness to therapy, helping normalise help-seeking and disrupt intergenerational silence. This shows how role modelling and shared vulnerability can reframe support-seeking as an act of strength.
Role of Religious and Community Leaders	"*It was a reverend… the way they promoted it at a youth camp spoke to me and made me reach out*" (2FI).	Faith-based and community leaders shaped participants' willingness to seek support when their guidance felt culturally grounded. For Participant 2FI, a reverend's encouragement helped her see prayer and professional care as complementary, making help-seeking feel culturally safe.
Personal Reflection and Self-Motivation	"*It comes back to mental health… how can we manage ourselves?*" (6FI)	Moments of personal reflection motivated participants to seek support as they recognised the limits of coping alone, with Participant 6FI viewing help-seeking as part of learning to manage emotional challenges more effectively.
Influence of Peer and Social Circles	"*When my sisters asked for counselling again, I was like, oh, I'm not really hesitant*" (5MI).	Peers shaped participants' willingness to seek support, with positive stories from friends or siblings, reducing hesitation and normalising counselling. These shared experiences helped ease uncertainty and opened more accessible pathways into mental health care for young Pacific adults.

The subtheme 'Role of Religious and Community Leaders' shows how faith-based figures can legitimise mental health support when their guidance aligns with cultural and spiritual values. Participant 2FI described how a reverend's encouragement at a youth camp made her feel that prayer and professional care could coexist, positioning help-seeking within a familiar spiritual framework. This demonstrates how culturally grounded leadership can reduce stigma and create safer entry points into care.

In 'Personal Reflection and Self-Motivation', participants described moments of clarity where they recognised the limits of coping alone. Participant 6FI's reflection "*how can we manage ourselves*?" captures a shift toward viewing help-seeking as part of learning to manage emotional challenges more effectively. Finally, 'Influence of Peer and Social Circles' highlights how shared experiences within sibling and peer networks reduced hesitation and normalised counselling. For Participant 5MI, repeated encouragement from sisters made him "*not really hesitant*," showing how social modelling can ease uncertainty and open accessible pathways into care. Together, these influences demonstrate that help-seeking is relationally driven, emerging through interactions with trusted figures who validate, model, or encourage engagement with mental health services.

Table 5: Strategies for navigating tensions and seeking support

SUB THEME	QUOTE	ANALYTIC INTERPRETATION
Selective Disclosure	"*I'd definitely say I wouldn't have told anyone unless I had so much trust that they wouldn't judge me*" (6FI),	Participants were highly selective about when and to whom they disclosed their mental health struggles, sharing only what felt safe. Breaches of privacy and the need for deep trust underscored how disclosure operated as a cautious, relational strategy.
Using Spirituality as a Coping Mechanism	*"I went straight to my family about it… I wanted my family to pray about it"* (7P).	Spirituality was a central coping strategy, with prayer, church involvement, and faith offering comfort and direction. For Participant 7P, turning to family and prayer was the immediate response, showing how faith grounded resilience and shaped pathways to support.
Relying on Cultural Values to Maintain Balance	"*They understand how everything connects to my mental health… you talk about everything because it does impact your health*" (3FI).	Participants grounded their wellbeing practices in cultural values such as tauhi vā, respect, and service, using these to navigate tensions between obligations and personal needs. These values anchored coping in familiar relational frameworks, shaping how Pacific concepts of connection and balance supported wellbeing.
Turning to Professional Services When Culturally Safe	"*My first experience… a full Pacific by Pacific counselling service… that's what drew me to access more of their services*" (2FI).	Participants were more willing to engage with services when these felt culturally safe, with experiences like Participant 2FI's Pacific-by-Pacific counselling strengthening trust and ongoing engagement. Shared values reduced the need to explain relational contexts, showing how culturally grounded care improves access and the quality of help-seeking.

Table 5 presents the strategies participants used to navigate tensions and move toward support, showing how young Pacific adults actively managed cultural expectations, relational obligations, and personal needs while seeking help. The subtheme 'Selective Disclosure' illustrates how participants were highly cautious about sharing their struggles, disclosing only within relationships where deep trust and non-judgement were assured. Participant 6FI's statement that she would not have told anyone "*Unless I had so much trust that they wouldn't judge me*" reflects how disclosure operates as a protective strategy shaped by cultural expectations around privacy, reputation, and collective responsibility.

The subtheme 'Using Spirituality as a Coping Mechanism' shows that faith was often the first response to distress. Participant 7P's decision to "*go straight to my family*" and ask them to pray demonstrates how

spirituality and family are intertwined as sources of comfort, guidance, and resilience. Rather than being separate from mental health, spirituality provided a framework through which distress was interpreted and managed.

In 'Relying on Cultural Values to Maintain Balance', participants grounded their wellbeing practices in relational concepts such as Tauhi vā, respect, and service. Participant 3FI's reflection that "*everything connects to my mental health*" shows how Pacific values anchor coping in interconnectedness and balance, rather than individualised symptom management. These cultural values helped participants navigate tensions between obligations and personal needs by situating wellbeing within familiar relational frameworks.

Finally, 'Turning to Professional Services When Culturally Safe' highlights that participants were more willing to engage with services when these felt culturally grounded. Participant 2FI's positive experience with a "*full Pacific by Pacific counselling service*" strengthened trust and ongoing engagement, reducing the need to explain relational contexts and making help-seeking feel less risky. This underscores the importance of culturally safe care in improving access and the quality of support for young Pacific adults.

Together, the narrative and tables illustrate a coherent pathway: interpersonal influences motivate help-seeking, while culturally grounded strategies shape how young Pacific adults navigate the tensions involved in accessing support. Strengthening the connections between these elements clarifies how the findings are organised and demonstrates that help-seeking is a non-linear, relational process deeply embedded within Pacific cultural worlds.

4.7 Chapter Summary

In summary, the Talanoa sessions illustrate that the mental health experiences of young Pacific adults are shaped by the dynamic interplay of cultural expectations, family relationships, spirituality, identity, and relational responsibility. Participants' narratives demonstrate that mental distress and help-seeking cannot be understood in isolation from the Pacific social, cultural, and spiritual contexts in which they are embedded. Their understandings of mental health were holistic and continually evolving, shaped by early family teachings, faith-based beliefs, and exposure to diverse perspectives across educational, professional, and social environments.

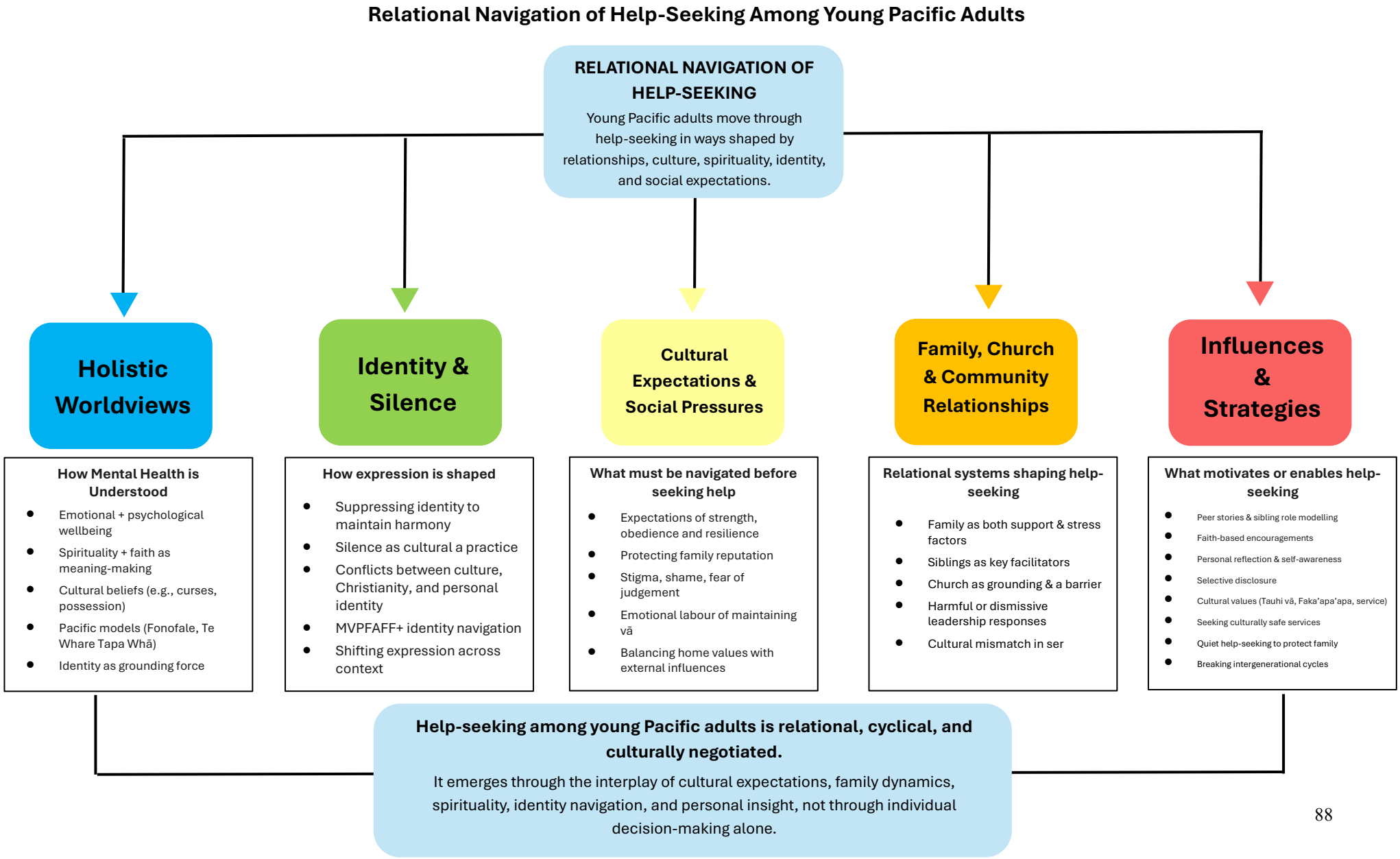
The findings highlight the significant emotional labour involved in navigating expectations of strength, silence, obedience, and collective responsibility. Participants moved between multiple roles, communities, and identities, often suppressing aspects of themselves in order to protect family reputation or maintain relational harmony. Importantly, participants were not passive recipients of these pressures. Instead, they actively negotiated cultural expectations, drawing on values such as *Tauhi Vā*, leaning on spirituality, and engaging in personal reflection to interpret their experiences and sustain their wellbeing.

Family and community emerged as both protective and constraining forces. While silence, stigma, and fear of shame frequently limited help-seeking, relationships with siblings, peers, and trusted faith or community

leaders also served as a critical enabler of support. Participants described a range of strategies that helped them navigate cultural and relational tensions, including selective disclosure, seeking support beyond immediate family networks, using spirituality as a source of comfort and guidance, grounding themselves in cultural values, and engaging with professional services when these were experienced as culturally safe.

Taken together, these findings demonstrate that help-seeking among young Pacific adults is a relationally situated and culturally negotiated process rather than an individual act. Understanding these complexities is essential for the development of mental health services that honour Pacific worldviews, recognise the centrality of family and community, and provide culturally responsive and safe pathways that support young Pacific people to seek help without compromising cultural identity or relational obligations. Figure 2 provides a summary of this study's findings on the relational navigation of help-seeking among young Pacific adults and outlines how these findings contribute to the existing literature.

Figure 2: Relational Navigation of Help-Seeking Among Young Pacific Adults



Chapter 5: Discussion

5.1 Introduction

This discussion chapter is guided by the study's central research question, which examines how young Pacific adults in Auckland navigate tensions between cultural beliefs, community expectations, and access to mental health services. The chapter interprets the findings in relation to existing literature on Pacific mental health, cultural expectations, spirituality, identity, and help-seeking among young Pacific adults in Aotearoa New Zealand. Its purpose is to critically analyse the findings, articulate their significance, and situate them within the broader field of Pacific mental health and wellbeing scholarship. While the previous chapter foregrounded participants' narratives in their own words, this chapter shifts toward analytical interpretation, drawing connections between lived experiences and the cultural, relational, and structural contexts that shape Pacific mental health.

From a academic perspective, this discussion contributes to Pacific mental health literature by demonstrating that help-seeking practices among young Pacific adults are best understood not as linear pathways or solely individualised decisions, but as relational processes that are continuously negotiated. The findings challenge deficit-oriented framings that position culture, family, or community primarily as barriers to care. Instead, they highlight how help-seeking strategies are shaped through relational accountability, cultural continuity, and context-specific decision-making, as young Pacific adults actively weigh responsibilities, risks, and sources of support. By foregrounding navigation, agency, and relational ethics, this chapter reframes help-seeking as a culturally grounded process of adaptation and meaning-making rather than avoidance or disengagement.

The findings further demonstrate that young Pacific adults engage with mental wellbeing through deeply relational and culturally grounded frameworks. Participants' understandings of mental health were holistic, encompassing emotional, spiritual, cultural, and relational dimensions shaped by family teachings, church contexts, and broader social experiences. Young Pacific adults described navigating expectations of strength, silence, and family responsibility, while also drawing on relational support, spirituality, and personal reflection to make deliberate decisions about seeking help. These experiences reflect the dynamic and evolving nature of Pacific identity, where cultural continuity intersects with contemporary social contexts, urban environments, and intergenerational change.

The chapter is structured around the key themes identified in the findings: holistic understandings of mental health; identity, silence, and emotional regulation; navigating cultural expectations and social pressures; the role of family and community relationships; and the influences shaping help-seeking practices. Each theme is discussed in relation to relevant literature, highlighting areas of integration, tension, and contribution. This discussion is also situated within the broader

policy and strategic context shaping Pacific mental health service provision in Aotearoa New Zealand. National frameworks such as ‘Ala Mo‘ui (Ministry of Health, 2018) and Ola Manuia (Ministry of Health, 2020) articulate commitments to holistic, culturally grounded, and relational approaches to Pacific wellbeing, emphasising collective health, spirituality, and community connection. While these strategies signal an important ideological shift toward Pacific worldviews within mental health systems, they provide limited insight into how such policy aspirations are experienced by young Pacific adults in their everyday navigation of distress and support. By concentrating on participants lived experiences, this chapter critically examines the extent to which policy commitments to cultural responsiveness, relational wellbeing, and equity are reflected, negotiated, or constrained in practice within Auckland’s contemporary urban context. The chapter concludes with an integrated conceptual analysis, implications for practice and policy, limitations of the study, and recommendations for future research. Through this discussion, the chapter aims to deepen our understanding of how young Pacific adults navigate mental health within complex relational and cultural environments and to inform the development of culturally grounded, youth-centred approaches to mental health support.

5.2 Holistic Understanding of Mental Health Among Young Pacific Adults

This study contributes new insight into Pacific mental health by demonstrating that young Pacific adults conceptualise wellbeing as a holistic, relational, and culturally embedded experience that is actively interpreted and negotiated in everyday life. Rather than simply affirming established holistic frameworks, the findings show how young Pacific adults engage with and apply these understandings across family, church, peer, and institutional contexts. Mental health was not framed as an individualised psychological state, but as something emerging through the dynamic interaction of emotional, spiritual, cultural, and relational dimensions. Participants commonly articulated wellbeing through everyday emotional and cognitive experiences, reflecting an embodied and intuitive understanding of mental health as relationally situated rather than individually contained.

These holistic understandings closely align with national Pacific health strategies such as *Ola Manuia*, which conceptualise mental wellbeing as inseparable from spiritual, relational, cultural, and collective dimensions of life (Ministry of Health, 2020). Participants’ accounts therefore resonate strongly with policy narratives that seek to move beyond individualised and biomedical models of mental health. However, this study extends the literature by showing that while policy frameworks often present holism as a coherent and aspirational ideal, participants experienced it as something that must be continually enacted and negotiated across multiple social domains. A key contribution of this research lies in demonstrating that holism is not simply adopted as a

cultural template, but actively worked through in context-specific and relationally accountable ways.

Consistent with Suaalii-Sauni et al. (2009), who position Pacific notions of self as fundamentally socio-centric, participants framed mental health in relation to family teachings, cultural values, spiritual beliefs, and relational obligations. Established Pacific wellbeing models such as Fonofale (Pulotu-Endemann & Tu'itahi, 2009) and Te Whare Tapa Whā (Rochford, 2004) similarly emphasise balance across interconnected spiritual, physical, mental, and social dimensions, with family and spirituality forming the foundation of wellbeing. While existing literature often presents these frameworks as stable cultural models, this study adds a new insight by illustrating how young Pacific adults actively interpret, adapt, and mobilise these frameworks in response to contemporary realities. Rather than treating holism as fixed, participants used these models as flexible resources for making sense of distress, wellbeing, and help-seeking across diverse and evolving social environments. To deepen this relational framing, global Indigenous scholarship also highlights the centrality of cultural identity and collective belonging in shaping youth wellbeing. Barker et al. (2017) argue that cultural continuity, shared identity, and community-based support act as protective factors against distress among Indigenous youth in Canada, paralleling the ways Pacific young adults in this study drew on cultural teachings, spirituality, and relational networks to interpret and sustain wellbeing. International youth mental health literature further reinforces this perspective. Patel et al. (2018) emphasise that mental health is shaped by social, cultural, and environmental determinants rather than individual pathology, aligning closely with Pacific holism. Rickwood et al. (2005) similarly highlight that young people's ability to recognise and articulate distress is shaped by emotional competence and social learning, supporting this study's finding that Pacific youth draw on relational, spiritual, and cultural knowledge to interpret their wellbeing.

Spirituality emerged as a particularly significant domain in which this adaptive engagement was visible. While previous research has documented the influence of spiritual worldviews on Pacific mental health beliefs (Foliaki, 1997; Vaka et al., 2009), this study demonstrates that young Pacific adults do not engage with spiritual explanations of distress uncritically. Participants described evaluating beliefs related to curses, possession, or karma in relation to their emotional experiences, relational contexts, and personal meaning. Where spiritual interpretations provided comfort, coherence, or emotional grounding, they were sustained; where they conflicted with lived experience, participants described questioning, re-working, or resisting them. This finding extends existing scholarship by positioning spirituality within Pacific holism as an evolving and reflexive process of meaning-making rather than a fixed determinant of wellbeing.

These findings must also be understood within broader generational shifts in mental health literacy and openness. Participants' understandings of mental health reflected increased exposure to education, peer discussions, and wider societal conversations about wellbeing, aligning with research on changing help-seeking patterns among Pacific youth (Fleming et al., 2020; Uelese, 2025). Rather than simply absorbing new information, participants actively integrated these influences into existing cultural and relational frameworks, using emerging language and knowledge to reinterpret cultural teachings, challenge stigma, and expand their understandings of mental health beyond illness-focused narratives while still maintaining cultural continuity.

Participants' reflections on self-awareness and identity add depth to Pacific mental health scholarship by showing how holism is lived and worked through in everyday life. Rather than indicating a move toward individualism, self-awareness operated as a relational practice that helped participants understand themselves while remaining accountable to family, culture, and community. Through this process, young Pacific adults were able to balance personal wellbeing with cultural expectations, demonstrating that individual insight and collective values are not in tension but intertwined. These findings challenge binary framings of self and community, illustrating instead how young Pacific adults bring these orientations together in ways that renew and extend existing models of Pacific wellbeing.

Taken together, this discussion reinforces that Pacific mental health cannot be understood outside its cultural, spiritual, and relational foundations. Importantly, this study demonstrates that holism is not only preserved but actively negotiated by young Pacific adults. Participants engaged with cultural, spiritual, and psychological frameworks in deliberate, context-specific ways that reflect both continuity and generational change. In doing so, this research positions young Pacific adults not merely as recipients of Pacific wellbeing frameworks, but as active contributors to their ongoing adaptation and renewal.

5.3 Identity, Silence, and the Suppression of Self-Expression

This study offers new insight into Pacific mental health by highlighting the significant tensions young Pacific adults actively navigate as they negotiate personal identity within cultural, religious, and social contexts that shape expectations around emotional expression and mental wellbeing. The findings demonstrate that silence, emotional restraint, and selective self-expression are not simply inherited cultural norms, but strategic and context-dependent practices through which participants manage relational accountability, maintain cultural belonging, and protect personal wellbeing. These practices reflect longstanding Pacific values that prioritise respect, relational harmony, and the safeguarding of collective reputation, while

also drawing attention to the ongoing relational and emotional labour involved in negotiating these expectations in everyday life.

Participants described silence as a deeply embedded cultural practice shaping how emotions are communicated within Pacific spaces. Silence was commonly interpreted as a marker of respect, maturity, and emotional self-control, often occurring prior to interaction and functioning as a relational cue that maintains the *vā* and reinforces social order (Agnew et al., 2004). At the same time, this study extends existing literature by demonstrating how participants explicitly recognised silence as a constraining opportunity for open dialogue about distress. Silence operated not only as a cultural value, but as a mechanism that limited emotional expression and delayed help-seeking, reinforcing stigma in ways well documented within Pacific mental health research (Statistics NZ & Ministry of Pacific Island Affairs, 2011; Suaalii-Sauni et al., 2009; Uelese, 2025). Although contemporary Pacific mental health strategies increasingly acknowledge stigma and emphasise culturally safe, voice-centred approaches (Ministry of Health, 2020), participants' accounts suggest that silence remains deeply embedded within everyday relational contexts. These findings contribute by showing that policy recognition of stigma, on its own, does not disrupt the relational and intergenerational practices through which silence is enacted and sustained. Studies conducted internationally also show that silence, emotional restraint, and selective disclosure are common strategies used to manage stigma and social expectations. Rickwood et al. (2005) identify embarrassment, fear of judgement, and limited emotional competence as major barriers to youth help-seeking, mirroring participants' concerns about appearing weak or burdensome. Research with African American adolescents similarly shows that boys suppress emotional expression to maintain social status and avoid stigma (Lindsey et al., 2010), reinforcing that silence is both culturally shaped and strategically enacted across diverse youth populations. Youth research in other contexts also demonstrates that silence and emotional withdrawal are common responses to distress. Biddle et al. (2004) found that young adults experiencing mental distress often avoid disclosure due to stigma, self-reliance, and fear of burdening others, dynamics that closely mirror Pacific participants' concerns about appearing weak or disrupting relational harmony.

Participants further described the suppression of self-expression as a deliberate strategy used to meet expectations of obedience, resilience, and emotional restraint. This suppression was particularly pronounced in discussions of mental health, where fears of appearing weak, burdensome, or disrespectful shaped decisions about disclosure. Several participants reflected on minimising or concealing aspects of their identity during periods of distress, illustrating the tension between personal authenticity and culturally accepted forms of emotional expression. While these experiences align with existing literature showing that Pacific youth often hide distress to protect family reputation and avoid judgement (Ataera-Minster & Trowland, 2018;

Faleafa, 2010), this study advances the literature by demonstrating that suppression is not simply imposed, but actively and strategically negotiated. Participants described selectively suppressing, reframing, or revealing aspects of themselves depending on context, audience, and relational safety, highlighting the fluid and situational nature of Pacific identity and the agency exercised within cultural constraints.

For participants with intersecting identities, particularly MVPFAFF+ individuals, these negotiations were intensified. Navigating expectations across Pacific cultural spaces, faith environments, and MVPFAFF+ identities required balancing competing moral, cultural, and spiritual messages, while also drawing strength, meaning, and grounding from spirituality. These experiences reflect existing scholarship on the compounded stigma faced by Pacific Rainbow communities (Clark et al., 2014; Veale et al., 2019), while also extending it by foregrounding resilience practices, identity affirmation, and strategic navigation that remain underrepresented in Pacific mental health research.

Importantly, this study challenges portrayals of silence as purely deficit-based by showing moments where silence is resisted or reinterpreted. While prior literature emphasises the persistence of intergenerational silence within Pacific families, several participants described intentional acts of vulnerability, choosing to disclose distress despite cultural expectations of restraint. These decisions were shaped by relational trust, personal values, and exposure to mental health literacy, suggesting that silence is not uniformly internalised but is selectively questioned across time and context. These findings emphasise that disclosure is context-dependent and highlight the circumstances in which cultural norms are adapted rather than reproduced.

Collectively, these findings illustrate that silence, suppression, and emotional restraint remain central features of Pacific mental health experiences, while also revealing the diverse ways young Pacific adults actively negotiate, adapt, and at times resist these norms. By engaging in reflexivity, assessing context, and managing identity strategically, participants influenced how emotion, identity, and wellbeing were expressed and contained. In doing so, they emerge not as passive recipients of cultural expectations, but as active agents contributing to the ongoing reinterpretation of Pacific relational worlds in contemporary contexts.

5.4 Navigating Cultural Expectations and Social Pressures

This study advances understandings of Pacific mental health by showing that young Pacific adults do not simply experience cultural expectations as fixed limitations but actively navigate a complex and multifaceted system of cultural, familial, and social pressures that shape emotional expression, interpretations of distress, and pathways to support. Participants described enduring

expectations of strength, obedience, resilience, and family responsibility, reflecting foundational Pacific collectivist values, respect-based hierarchies, and cultural obligations well documented in the literature (Agnew et al., 2004; Mila-Schaaf & Hudson, 2009; Uelese, 2025). Rather than simply reproducing these expectations, participants' accounts highlight the everyday work involved in managing, adapting, and at times resisting these norms in relation to their mental wellbeing.

These expectations are navigated within a broader policy environment shaped by national Pacific health strategies such as Ala Moʻui (Ministry of Health, 2014), Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025 (Ministry of Health, 2020), and more recent directions articulated in the Ministry of Health's Draft Mental Health and Wellbeing Strategy 2026–2036 (Ministry of Health, 2026). Collectively, these frameworks emphasise empowerment, self-determination, culturally grounded approaches, and community-based, whānau-centred models of care to address the social and cultural determinants of mental wellbeing. Although this policy trajectory reflects a meaningful move toward strength-based and preventative approaches, this study demonstrates that such intentions do not necessarily lessen relational or familial pressures in young people's daily lives. Participants' accounts suggest that young Pacific adults frequently bear the emotional and relational labour of responding to early distress, navigating fragmented systems of care, and balancing policy discourses of individual empowerment with enduring cultural expectations of loyalty, respect, and collective responsibility. This finding highlights a gap between policy-level aspirations and the relational contexts in which mental wellbeing is negotiated, suggesting that prevention, access, and service effectiveness cannot be realised through individual resilience and self-management alone. Broader youth mental health research also demonstrates that cultural expectations of strength, self-reliance, and emotional restraint shape help-seeking behaviours. Gulliver et al. (2010) identify self-reliance, stigma, and fear of burdening family as major barriers to help-seeking among young people, closely reflecting the pressures described by Pacific participants. Studies with Chinese youth and adults also demonstrate strong preferences for self-management, avoidance of disclosure, and reliance on culturally familiar supports (Shi et al., 2020), illustrating that cultural norm around emotional restraint and family responsibility influence help-seeking across diverse cultural contexts. These international patterns strengthen this study's argument that Pacific youth are not simply constrained by cultural expectations but actively navigate them, assessing relational consequences and weighing cultural obligations against personal wellbeing.

Global reviews of adolescent mental health interventions emphasise that effective support must address social, cultural, and relational determinants rather than rely solely on individual-level strategies. Das et al. (2016) highlight that youth mental health outcomes improve when interventions engage families, communities, and broader social systems, reinforcing this study's

argument that Pacific youth cannot be expected to navigate distress independently within environments shaped by strong cultural expectations and relational obligations. Rather than focusing solely on individuals, the findings suggest a need for implementation approaches that engage families and communities, recognise intergenerational dynamics, strengthen culturally responsive early supports, and support the wider health, education, and social service workforce to share responsibility for mental wellbeing. This would bring system-level priorities closer to the everyday realities of Pacific young people.

Cultural messages discouraging vulnerability, often emphasising perseverance, endurance, and emotional restraint, were strongly embedded within participants' accounts and reflect longstanding generational beliefs identified in previous research (Foliaki, 1997; Vaka et al., 2009). These expectations were closely tied to concerns about breaching tapu, experiencing shame, or disrupting relational harmony, all of which can discourage open discussion of distress. Importantly, this study moves beyond simply identifying these norms by showing how young Pacific adults actively assess, reinterpret, and respond to them across different contexts.

Participants described selectively resisting, internalising, or adapting cultural expectations depending on relational safety, perceived consequences, and their own wellbeing. Moments of tension between cultural loyalty and mental health needs revealed the significant emotional labour involved in protecting family reputation while managing personal distress, echoing and extending existing literature on stigma and reputational harm within Pacific communities (Statistics NZ & Ministry of Pacific Island Affairs, 2011; Subica et al., 2019). Participants' use of self-protective strategies, such as concealing distress, delaying disclosure, or seeking support outside the family, demonstrates purposeful navigation rather than uncritical compliance or avoidance.

The findings further reveal the complex role of Pacific family systems as both sources of care and sources of pressure. While participants valued the strength, belonging, and guidance provided by family relationships, they also described how familial expectations intensified emotional strain. Moving beyond the home, participants navigated educational, social, and peer contexts with different value systems, which created opportunities for reflection, reinterpretation, and identity development. This aligns with Mila-Schaaf and Hudson's (2009) concept of "negotiated spaces," but this study contributes additional depth by demonstrating how such navigation operates specifically in relation to mental health decision-making, emotional expression, and help-seeking practices.

These dynamics are best understood within the context of contemporary urban Pacific identities. Growing up in Auckland exposed participants to diverse cultural influences, evolving mental

health discourse, and social norms that often diverged from those held by the older generations. This urban positioning generated tensions, particularly feelings of being "in-between", while also offering resources for agency by enabling young Pacific adults to draw on multiple worldviews when interpreting distress and deciding how to seek support.

This study makes a key contribution by reframing urban Pacific identity as a resource for navigation rather than a sign of cultural erosion. Recognising Pacific identities as fluid, adaptive, and context-responsive is essential to understanding how young Pacific adults actively navigate mental health and wellbeing within contemporary cultural and social settings.

5.5 The Role of Family and Community in Shaping Help-Seeking

Family, church, and community played a pivotal role in shaping how participants understood mental health and their decisions to seek support. While these relational systems offered stability, identity, and cultural continuity, they simultaneously upheld norms of silence, stigma, and expectations that frequently inhibited or delayed help-seeking. This dual role aligns with Pacific scholarship that emphasises relationality and collectivism as foundational to Pacific wellbeing (Agnew et al., 2004; Pulotu-Endemann & Tu'itahi, 2009).

Participants consistently described family as the primary space in which understandings of mental health were formed, shaped by generational beliefs about resilience, silence, and shame. These patterns reflect the intergenerational transmission of mental health norms identified in existing literature (Faleafa, 2010; Uelese, 2025), in which expectations of emotional restraint, stigma surrounding distress, and parental communication styles shape how young Pacific people learn to manage, conceal, or minimise their emotions across generations. Help-seeking was further influenced by family obligation and collective responsibility, as participants often placed family needs and reputation above their own wellbeing. Such dynamics reflect findings in the literature showing that collectivist values can inhibit or delay service engagement (Ataera-Minster & Trowland, 2018). Family simultaneously served as a site of support and emotional strain. Although participants valued the strength and connection found within close family relationships, they also reported pressure, conflict, and emotional burden, reflecting the multifaceted relational dynamics found in Pacific mental health research (Foliaki, 1997; Samu & Suaalii-Sauni, 2009).

Church and spiritual communities similarly played a significant role in shaping beliefs about mental health. For some, faith offered grounding and guidance, yet spiritual interpretations of distress sometimes reinforced stigma or delayed help-seeking, reflecting the dual influence of spirituality identified in previous research (Suaalii-Sauni et al., 2009; Vaka et al., 2009). Collectively, these findings reaffirm the central role of family and community in Pacific mental health experiences, while revealing the complex interplay of support, obligation, stigma, and

relational responsibility that shapes how young Pacific adults navigate help-seeking. Youth help-seeking studies from other cultural contexts also highlight the central role of family and social networks. Rickwood et al. (2005) found that adolescents consistently rely on informal supports, especially family and friends, before approaching professionals, echoing participants' relational preferences. Research with African American adolescents similarly shows that family members often recognise distress early and provide initial support (Lindsey et al., 2010). Parenting studies further demonstrate that emotional support and authoritativeness increase adolescents' willingness to seek professional help (Maiuolo et al., 2019), aligning with this study's findings on Pacific family influence. Youth studies in other contexts similarly show that family dynamics strongly influence help-seeking decisions. Biddle et al. (2004) found that fear of burdening family members and concerns about stigma often deter young people from seeking professional support, echoing Pacific participants' experiences of balancing personal distress with collective responsibility and family reputation.

Participants' reflections also underscored the ongoing impact of systemic barriers on help-seeking. Even when young Pacific adults felt ready to seek support, concerns about cultural misunderstanding, lack of Pacific clinicians, and previous negative experiences with services shaped their willingness to engage. These concerns mirror longstanding critiques of mental health systems that prioritise Western diagnostic models and fail to account for Pacific relational, spiritual, and cultural contexts. Participants' strategies for navigating services, such as seeking recommendations from peers, researching clinicians online, or delaying engagement until distress escalated, reflect attempts to mitigate these systemic limitations.

These experiences reflect longstanding structural concerns identified within Pacific mental health policy, including limited cultural safety within mainstream services, a shortage of Pacific clinicians, and inequities embedded in service delivery models (Ministry of Health, 2020). Despite ongoing policy commitments to Pacific-led approaches and culturally responsive care, participants' accounts suggest that such aspirations are unevenly realised in practice, shaping not only individual experiences but collective family and community attitudes toward help-seeking. As a result, the burden remains with young Pacific adults to assess whether services are culturally safe, adapt their help-seeking to align with family and community expectations, and strategically navigate systems not yet consistently designed around their cultural and relational realities. This dynamic highlights how decisions to seek help are often mediated through family and community contexts rather than made in isolation. These findings reinforce the need for culturally safe, relationally grounded, and Pacific-led mental health services that actively engage families and communities as partners in care, reduce the intermediary burden placed on young people, and support help-seeking as a collective and relational process rather than an individual responsibility.

Conceptual frameworks of youth help-seeking also support the idea that accessing support is a multi-stage, negotiated process. Rickwood & Thomas (2012) describe help-seeking as involving

recognition of need, expression of distress, identification of support options, and engagement with services, each shaped by relational, cultural, and contextual factors. This aligns closely with Pacific participants' accounts of navigating multiple decision points influenced by family expectations, cultural values, relational trust, and personal readiness. Wider youth help-seeking research also highlights the importance of trusted relationships and social networks in shaping young people's decisions to seek support. Gulliver et al. (2010) found that confidentiality concerns, fear of stigma, and limited trust in professionals significantly reduce youth engagement with services, while positive past experiences and supportive relationships encourage help-seeking. Rickwood et al. (2005) likewise emphasise young people's preference for familiar, trusted sources of support, reinforcing this study's finding that Pacific youth rely heavily on relational networks when navigating mental health systems.

5.6 Influences and Strategies Shaping Help-Seeking

The findings of this study demonstrate that young Pacific adults navigate a complex interplay of relational, cultural, spiritual, and personal influences when deciding whether and how to seek mental health support. In both Faleafa's (2010) and Auva'a-Alatimu et al.'s (2024) research, relational networks are shown to be central to Pacific help-seeking, with close and extended kin as well as peers frequently acting as the first and most trusted sources of support. This resonates strongly with the findings of the present study, where participants highlighted the influential role of these relationships, particularly siblings and peers, whose openness to therapy and willingness to discuss mental health helped to normalise help-seeking and challenge intergenerational norms of silence. Observing others engage in counselling services served as a form of relational role-modelling, reinforcing the importance of collective learning and shared experience within Pacific communities (Manuela & Sibley, 2013).

Cultural and spiritual guidance also shaped help-seeking, with trusted religious and community leaders influencing participants' decisions when messages were delivered in ways that aligned with Pacific values, spirituality, and relational ethics. This reflects broader evidence that culturally grounded mental health promotion is more effective when embedded within familiar spiritual and communal structures (Kapeli, 2026). Alongside relational and cultural influences, participants described moments of personal realisation that emerged when self-reliance became unsustainable, prompting them to seek external support. These experiences highlight a nuanced shift from collective responsibility toward individual agency, illustrating how Pacific youth weave together both relational and personal motivations when navigating distress. Importantly, participants employed a range of strategies to manage cultural tensions surrounding mental health, including selective disclosure, boundary-setting, and seeking support outside immediate family networks to protect family harmony and avoid shame.

These strategies demonstrate the adaptability and agency of young Pacific adults as they navigate stigma, relational expectations, and cultural obligations while still pursuing pathways to wellbeing. Indigenous scholarship reinforces the relational and cultural foundations of youth wellbeing. Barker et al. (2017) highlight that cultural identity, collective belonging, and community-based support act as protective factors for Indigenous youth, underscoring the importance of culturally grounded frameworks in shaping mental health experiences.

Youth help-seeking research from other cultural contexts reflects similar dynamics. Rickwood et al. (2005) note that peers are the most common informal support for young people and that positive peer influence increases openness to professional help, similar to participants' reliance on siblings and friends. The help-negation effect, in which distress leads to reduced help-seeking behaviour, is likewise well established (Rickwood et al., 2005), resonating with Pacific youths' tendency to withdraw under cultural expectations of strength. Gulliver et al. (2010) further emphasise the role of mental health literacy, trusted relationships, and positive experiences in enabling help-seeking, reinforcing this study's finding that Pacific youth depend on relational trust and culturally aligned guidance. Global evidence also emphasises that youth mental health is shaped by social and cultural determinants that require multi-level, relationally grounded responses (Das et al., 2016). Together, these international patterns strengthen the argument that Pacific youth wellbeing cannot be understood through individualised or biomedical models alone, but through relational, cultural, and context-specific processes.

Viewed collectively, the findings extend existing literature by showing that help-seeking among young Pacific adults is neither linear nor solely shaped by cultural constraints. Rather, it is an active, negotiated process influenced by social relationships, cultural alignment, spiritual meaning, and personal insight.

5.7 Integrated Conceptual Analysis

Across all themes, this study makes a central conceptual contribution by demonstrating that young Pacific adults navigate mental health through dynamic, relational, and culturally negotiated processes. These processes involve ongoing balancing between personal wellbeing and collective expectations. Rather than framing mental health as an individualised or purely psychological issue, participants' accounts show that wellbeing is fundamentally relational. This aligns with Pacific frameworks such as Fonofale (Pulotu-Endemann & Tu'itahi, 2009) and Teu le Vā (Airini et al., 2010), as well as broader socio-centric identity models that understand the self as inseparable from family, spirituality, community, and the obligations that sustain relational harmony. Importantly, this study extends these frameworks by illustrating how such relational foundations are not only inherited but actively navigated through everyday help-seeking and meaning-making practices.

Cultural expectations of strength, silence, and family responsibility shaped participants' emotional expression, interpretations of distress, and pathways to care, reinforcing longstanding Pacific values of resilience, respect, and the protection of collective reputation. A key contribution of this research lies in clarifying how silence itself is relationally and temporally negotiated, rather than uniformly imposed or passively maintained. Participants described engaging with silence in selective and strategic ways across time and context, sometimes sustaining it to honour family or cultural expectations, and at other times disrupting it to protect personal wellbeing. This underscores silence as a relational practice, shaped by accountability to others and continually renegotiated as relationships, responsibilities, and life circumstances evolve.

Importantly, this study shows that young Pacific adults are not passive recipients of cultural norms. Instead, they engage in intentional relational navigation, actively reinterpreting and adapting expectations across home, school, church, peer groups, and professional settings. Help-seeking emerged as a relationally accountable process, shaped by family guidance, peer modelling, spiritual beliefs, and moments of reflexive self-assessment. Decisions to seek support were rarely understood as purely individual acts; rather, they were carefully weighed against relational obligations, potential consequences, and perceived impacts on family and community. This highlights the presence of culturally negotiated pathways to care, where the timing, form, and legitimacy of help-seeking are assessed through relational lenses.

Identity was similarly shown to be context-dependent and continually negotiated. Participants drew on both Pacific values and contemporary influences to manage mental health while maintaining a sense of cultural belonging. Strategic identity management, such as codeswitching between cultural and institutional spaces, functioned as a protective strategy that enabled access to support while preserving relational accountability. This finding advances existing literature by illustrating how agency operates within, rather than outside of, collectivist cultural frameworks.

In summary, this study contributes to a nuanced understanding of Pacific mental health by conceptualising it as an active, negotiated, and relationally accountable process among young Pacific adults living in Auckland's contemporary urban environment. The findings demonstrate that wellbeing is not simply transmitted through cultural tradition, but is continually shaped through relational negotiation, culturally mediated help-seeking pathways, and evolving interpretations of silence, responsibility, and care. By foregrounding relational navigation as central to mental health engagement, this research offers a culturally grounded lens for rethinking pathways to care and makes a meaningful contribution to Pacific mental health scholarship.

Broader youth mental health scholarship also conceptualises wellbeing as relational and socially embedded. Patel et al. (2018) argue that mental health is shaped by social, cultural, and

environmental determinants, reinforcing the idea that wellbeing cannot be understood in isolation from relational contexts. Rickwood et al. (2005) and Gulliver et al. (2010) further demonstrate that help-seeking behaviours are influenced by stigma, trust, emotional competence, and social networks, aligning with this study's finding that Pacific youth navigate mental health through relationally grounded, context-specific processes.

Overall, the findings demonstrate that while contemporary Pacific mental-health policies increasingly recognise holistic, relational, and culturally grounded wellbeing, their realisation depends on how young Pacific adults navigate these ideals within lived relational and institutional contexts. Participants' accounts reveal that translating policy aspirations into practice requires substantial relational labour, cultural negotiation, and strategic identity management. This study therefore underscores the importance of Pacific-led, youth-centred approaches that recognise silence, relational accountability, and cultural obligation not as deficits to be corrected, but as embedded realities that actively shape pathways to mental-health care.

5.8 Chapter Summary

This chapter examined how young Pacific adults in Auckland navigate mental health within complex cultural, relational, spiritual, and structural contexts. Across the themes, a consistent pattern emerged: participants' experiences of distress, identity, and help-seeking are deeply embedded in socio-centric Pacific worldviews that prioritise relational harmony, collective responsibility, and cultural continuity. However, rather than being passive recipients of these norms, young Pacific adults demonstrated agency, reflexivity, and adaptability as they negotiated expectations of strength, silence, and family obligation alongside their own wellbeing needs.

The discussion highlighted how holistic Pacific understandings of mental health continue to shape young people's interpretations of distress, while also evolving through exposure to education, peers, and shifting social norms. Participants' narratives revealed the emotional labour involved in balancing cultural loyalty with personal authenticity, particularly in contexts where expectations of silence, fear of shame, and concerns about family reputation constrained open expression. At the same time, the findings illustrated how relational networks, especially siblings, peers, and trusted community figures, played a pivotal role in normalising help-seeking behaviors and challenging intergenerational patterns of stigma.

Family, church, and community emerged as both protective and constraining forces, offering belonging and guidance while also reinforcing norms that could delay or discourage engagement with mental health services. These relational influences intersected with systemic barriers, including limited cultural safety within services, a shortage of Pacific clinicians, and participants' experiences of cultural misunderstanding. Together, these factors shaped help-seeking

environment that required young Pacific adults to navigate multiple layers of cultural, relational, and institutional complexity.

Overall, this chapter has argued that Pacific mental health experiences among young Pacific adults in Auckland are best understood as dynamic, negotiated, and contextually responsive. Participants drew on cultural values, spiritual beliefs, relational support, and personal insight to make sense of their wellbeing, demonstrating that Pacific identity is not fixed but is continually shaped through everyday relational interactions. By situating these findings within existing Pacific scholarship and international youth mental health research, this chapter deepens understanding of how young Pacific adults navigate distress and support in contemporary urban environments such as Auckland. It also underscores the need for culturally grounded, relationally attuned, and Pacific-led approaches that recognise the relational labour, cultural negotiation, and collective accountability embedded in Pacific pathways to mental health care.

Chapter 6: Study Conclusion

This study explored how young Pacific adults in Auckland navigate the tensions between cultural expectations, relational obligations, and access to mental health services. Grounded in Pacific methodologies and centred on participants lived experiences, the research provides a nuanced understanding of how mental health is interpreted, experienced, and acted upon within relational and cultural contexts.

The findings indicate that mental health for young Pacific adults is not experienced as an individual or isolated phenomenon but is instead embedded within the interconnected domains of family, spirituality, culture, and community. Participants described navigating complex tensions arising from expectations of strength, silence, and collective responsibility. At the same time, they drew on relational support, spiritual grounding, and personal reflection to interpret their experiences and inform their decisions regarding help-seeking.

6.1 Key Findings

A central finding of this study is that mental health is understood in holistic and relational terms. Participants conceptualised wellbeing as interconnected across emotional, spiritual, cultural, and relational domains, reflecting Pacific worldviews that emphasise balance, interdependence, and collective wellbeing. The study also highlights the role of silence and emotional restraint as culturally embedded practices that shape how emotions are managed and expressed. While silence can serve as a protective mechanism that preserves relational harmony, it may also restrict opportunities for open dialogue and contribute to delays in help-seeking.

Cultural expectations such as resilience, obedience, and family responsibility were found to impose a significant influence on how participants responded to experiences of distress. These expectations frequently required substantial emotional labour, as individuals worked to reconcile cultural obligations with their own wellbeing. Notably, participants were not passive recipients of these norms; rather, they actively negotiated, adapted, and reinterpreted them across diverse contexts.

Family and community functioned as both support and points of tension. Participants drew strength from relational connections but also faced stigma, generational differences, and cultural expectations that shaped their willingness to seek help.

Help-seeking was found to be a relational and negotiated process, shaped by peer influence, cultural alignment, spiritual meaning, and moments of personal realisation. Participants employed strategies such as selective disclosure and boundary-setting to navigate cultural expectations while still accessing support.

6.2 Contributions to Existing Knowledge

This study contributes to Pacific mental health scholarship by demonstrating that young Pacific adults actively navigate, rather than passively experience, the cultural and relational dynamics that shape their mental health journeys and help-seeking practices.

This research extends current scholarship through several important contributions. First, they reconceptualise silence as a practice that is both protective and restrictive, functioning simultaneously to maintain relational harmony and to limit opportunities for open emotional expression. Second, the study highlights the considerable emotional labour involved in negotiating cultural expectations of resilience, obedience, and collective responsibility. Third, it illustrates the fluid and continuously negotiated nature of Pacific identity, demonstrating how young adults draw on multiple cultural frameworks to interpret experiences of distress. Finally, this research emphasises that help-seeking is a relational process shaped by peer influence, cultural alignment, spirituality, and personal realisation, rather than a purely individual act. By centring lived experience, the study challenges deficit-based narratives and contributes to a more nuanced, strengths-focused understanding of Pacific youth mental health. Methodologically, this study demonstrates the value of Pacific-led, relational research approaches for generating culturally meaningful insights that may not emerge through conventional Western qualitative methods.

Overall, this thesis contributes a culturally grounded, relationally attuned conceptualisation of Pacific youth mental health that foregrounds navigation, agency, and relational accountability. By centring Pacific voices and lived experiences, it challenges deficit-based narratives and offers a strengths-focused, context-responsive framework for understanding how young Pacific adults interpret distress and engage with support.

6.3 Implications for Practice and Policy

The findings underscore the essential need for mental health services to be culturally grounded, relationally oriented, and aligned with Pacific worldviews. To achieve this, service models must extend beyond individualised approaches to care and integrate family, spirituality, and community as central and indispensable dimensions of support.

There is also a need to strengthen mental health literacy within Pacific communities in ways that are culturally meaningful and effective in reducing stigma. Churches, families, and community leaders hold significant influence in shaping beliefs and practices, and are therefore well positioned to facilitate more open, informed, and supportive conversations about mental health. At a policy level, sustained investment in Pacific-led services and workforce development is essential to ensuring that mental health systems are responsive to the needs of Pacific youth.

These implications closely align with current Pacific-focused policy directions, including *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025* (Ministry of Health, 2020) and the Ministry of Health's *Draft Mental Health and Wellbeing Strategy 2026–2036* (Ministry of Health, 2026), both of which emphasise prevention, community-based support, cultural responsiveness, and Pacific leadership. However, the findings of this study suggest that realising these policy aspirations requires greater attention to how help-seeking is shaped within family and community contexts. Strengthening relational and culturally grounded pathways, alongside workforce development and service reform, may therefore be critical to ensuring that policy intent translates into meaningful and accessible support for Pacific young people. Practitioners working with Pacific youth should therefore approach mental health not as an individual concern but as a relational, cultural, and community-embedded experience requiring collective engagement.

6.4 Study Limitations

Several limitations of this study should be acknowledged to contextualise the scope and interpretation of the findings. First, the study's small, purposively selected sample limits the generalisability of the findings. While this approach enabled rich, in-depth exploration of participants lived experiences, it cannot capture the full diversity of Pacific young adults in Aotearoa New Zealand. Pacific communities encompass multiple ethnicities, migration histories, languages, and cultural traditions; therefore, the perspectives represented here should be understood as illustrative rather than representative of all Pacific youth.

This study's Auckland-centric focus shapes the applicability of the findings. All participants resided in Auckland, home to the world's largest Pacific population and a well-established network of Pacific cultural, social, and community infrastructures. These urban conditions may differ significantly from those in smaller towns, rural regions, or areas with less-established Pacific communities. As such, the findings reflect an urban Pacific context and may not fully represent the experiences of Pacific young people living elsewhere in Aotearoa New Zealand.

Furthermore, the voluntary nature of participation introduces a self-selection bias. Individuals who chose to take part in this study explicitly focused on mental health may be more open, reflective, or comfortable discussing wellbeing than their peers. Pacific young people who hold more traditional views, who are reluctant to discuss mental health, or who have had negative experiences with services may be underrepresented, potentially shaping the themes that emerged.

This study's ethnic composition was limited. Although several Pacific ethnicities were represented, the sample was predominantly Tongan and Samoan, with only one participant identifying as Cook Islands Māori. As a result, the findings primarily reflect the perspectives of

Tongan and Samoan young adults and may not fully capture the experiences of Pacific youth from smaller or less-represented ethnic groups. Given the cultural diversity within Pacific communities, ethnic-specific norms, spiritual beliefs, and family structures may shape mental health experiences in distinct ways that were not fully explored.

This study also focused on lived experience rather than clinical or longitudinal data. The research examined subjective meanings, cultural interpretations, and relational dynamics rather than diagnostic categories, service-use trajectories, or long-term outcomes. While this aligns with the qualitative aims of the study, it limits the ability to draw conclusions about prevalence, severity, or changes in mental health patterns over time.

Finally, the study's scope centred on how young Pacific adults navigate mental health experiences, rather than examining broader social determinants in depth. Although structural factors such as poverty, racism, and systemic inequities were acknowledged, they were not the primary focus of analysis. As a result, the findings primarily reflect participants' interpretations and navigation of their mental health journeys, rather than offering a comprehensive account of the wider social, economic, and political conditions shaping those experiences. Future work that more fully integrates structural determinants such as racism, socioeconomic inequities, and systemic barriers will be essential for developing a comprehensive understanding of Pacific youth mental health.

6.5 Future Research Recommendations

This study identifies several areas where further research is required to deepen understanding of young Pacific adults' mental health and to strengthen culturally grounded approaches for support.

Future research should prioritise the experiences of MVPFAFF+ Pacific young people, whose perspectives remain significantly underrepresented in mental health scholarship. While this study included a participant with diverse identities, the findings indicate that MVPFAFF+ youth navigate unique intersections of cultural expectation, spirituality, gender, and sexuality that shape their wellbeing in distinct ways. Dedicated research that centres MVPFAFF+ voices, using culturally safe, gender-affirming, and community-led methodologies is essential for developing inclusive mental health frameworks that reflect the full diversity of Pacific youth.

Further investigation is also needed into ethnic-specific experiences within Pacific communities. Although this study included participants from several Pacific ethnic groups, the sample was predominantly Tongan and Samoan, with only one Cook Islands Māori participant. As a result, the perspectives of smaller Pacific communities, such as Tokelauan, Niuean, Kiribati, and others remain largely absent from both this study and the broader literature. While a small number of studies, including research conducted with Tuvaluan communities, have begun to illuminate culturally specific understandings of mental health, such work remains limited in scope. More

ethnic-specific and comparative research is therefore needed to examine how cultural norms, migration histories, and family structures shape mental health beliefs and help-seeking practices in distinct ways across diverse Pacific groups.

Another important direction for future research involves examining Pacific youth mental health beyond the Auckland context. As this study was conducted in an urban setting with strong Pacific community networks and comparatively greater access to Pacific-led services, it is essential to explore how Pacific young people in regional or rural areas navigate mental health within environments that may offer fewer cultural resources, limited service options, and different community dynamics.

Taken together, these research directions would contribute to a more nuanced, inclusive, and culturally grounded understanding of Pacific youth mental health, ensuring that future policies, services, and interventions reflect the full diversity and complexity of Pacific young people's lived experiences.

6.6 Final Reflections

Ultimately, this study affirms that supporting the mental health of Pacific youth requires approaches that honour the relational, cultural, and spiritual foundations of Pacific life. Mental health cannot be separated from the contexts in which young people live, learn, worship, and belong. Their wellbeing is shaped not only by individual experiences but also by the collective worlds of family, community, spirituality, and cultural identity that frame their everyday realities.

By focusing on Pacific voices and lived experiences, this research contributes to ongoing efforts to build mental health systems that are not only accessible but are also culturally meaningful and empowering for young Pacific adults. The insights shared by participants illustrate both the challenges and the strengths present within Pacific communities, highlighting the importance of approaches that are culturally grounded, relationally attuned, and Pacific-led. Such approaches are essential for achieving meaningful and sustainable changes in the mental health and wellbeing of our current and future Pacific youth.

This thesis reflects a broader movement toward reimagining mental health support in ways that uphold Pacific values, recognise the complexity of Pacific identities, and create space for young Pacific people to navigate their wellbeing with dignity, agency, and cultural safety. In doing so, it underscores the importance of continuing to listen closely to Pacific youth, to learn from their lived experiences, and to ensure that their voices remain central in shaping the future of mental health care in Aotearoa New Zealand. As Pacific communities continue to evolve across generations, this research affirms the importance of mental health approaches that honour cultural identity, relational ethics, and collective wellbeing. Supporting Pacific youth requires not only

responsive services but also sustained commitment to Pacific-led knowledge, leadership, and futures.

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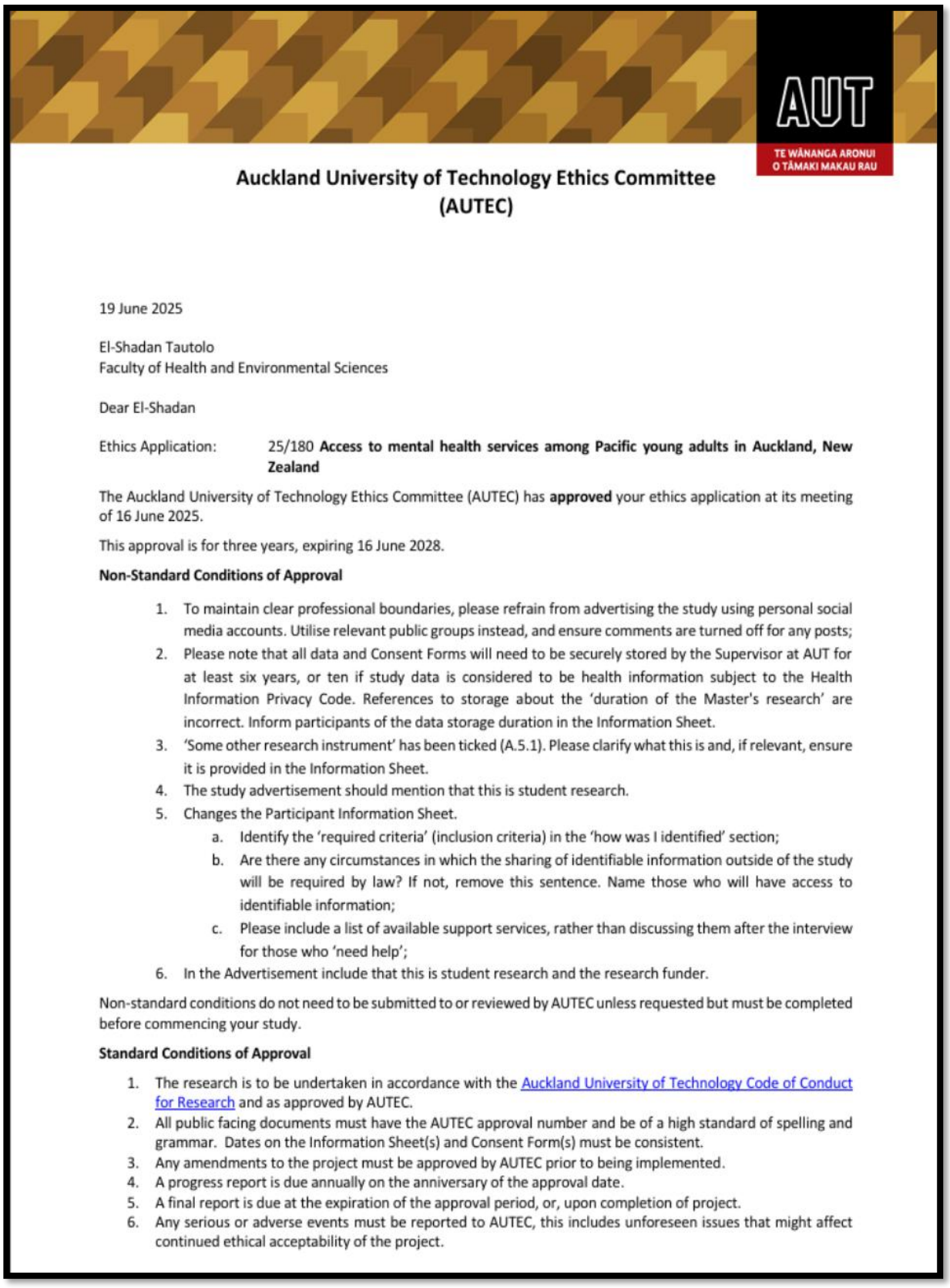
Appendices

Appendix A: Ethics Approval



AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Auckland University of Technology Ethics Committee (AUTEC)

19 June 2025

El-Shadan Tautolo
Faculty of Health and Environmental Sciences

Dear El-Shadan

Ethics Application: 25/180 **Access to mental health services among Pacific young adults in Auckland, New Zealand**

The Auckland University of Technology Ethics Committee (AUTEC) has **approved** your ethics application at its meeting of 16 June 2025.

This approval is for three years, expiring 16 June 2028.

Non-Standard Conditions of Approval

1. To maintain clear professional boundaries, please refrain from advertising the study using personal social media accounts. Utilise relevant public groups instead, and ensure comments are turned off for any posts;
2. Please note that all data and Consent Forms will need to be securely stored by the Supervisor at AUT for at least six years, or ten if study data is considered to be health information subject to the Health Information Privacy Code. References to storage about the 'duration of the Master's research' are incorrect. Inform participants of the data storage duration in the Information Sheet.
3. 'Some other research instrument' has been ticked (A.5.1). Please clarify what this is and, if relevant, ensure it is provided in the Information Sheet.
4. The study advertisement should mention that this is student research.
5. Changes the Participant Information Sheet.
    a. Identify the 'required criteria' (inclusion criteria) in the 'how was I identified' section;
    b. Are there any circumstances in which the sharing of identifiable information outside of the study will be required by law? If not, remove this sentence. Name those who will have access to identifiable information;
    c. Please include a list of available support services, rather than discussing them after the interview for those who 'need help';
6. In the Advertisement include that this is student research and the research funder.

Non-standard conditions do not need to be submitted to or reviewed by AUTEC unless requested but must be completed before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.

7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

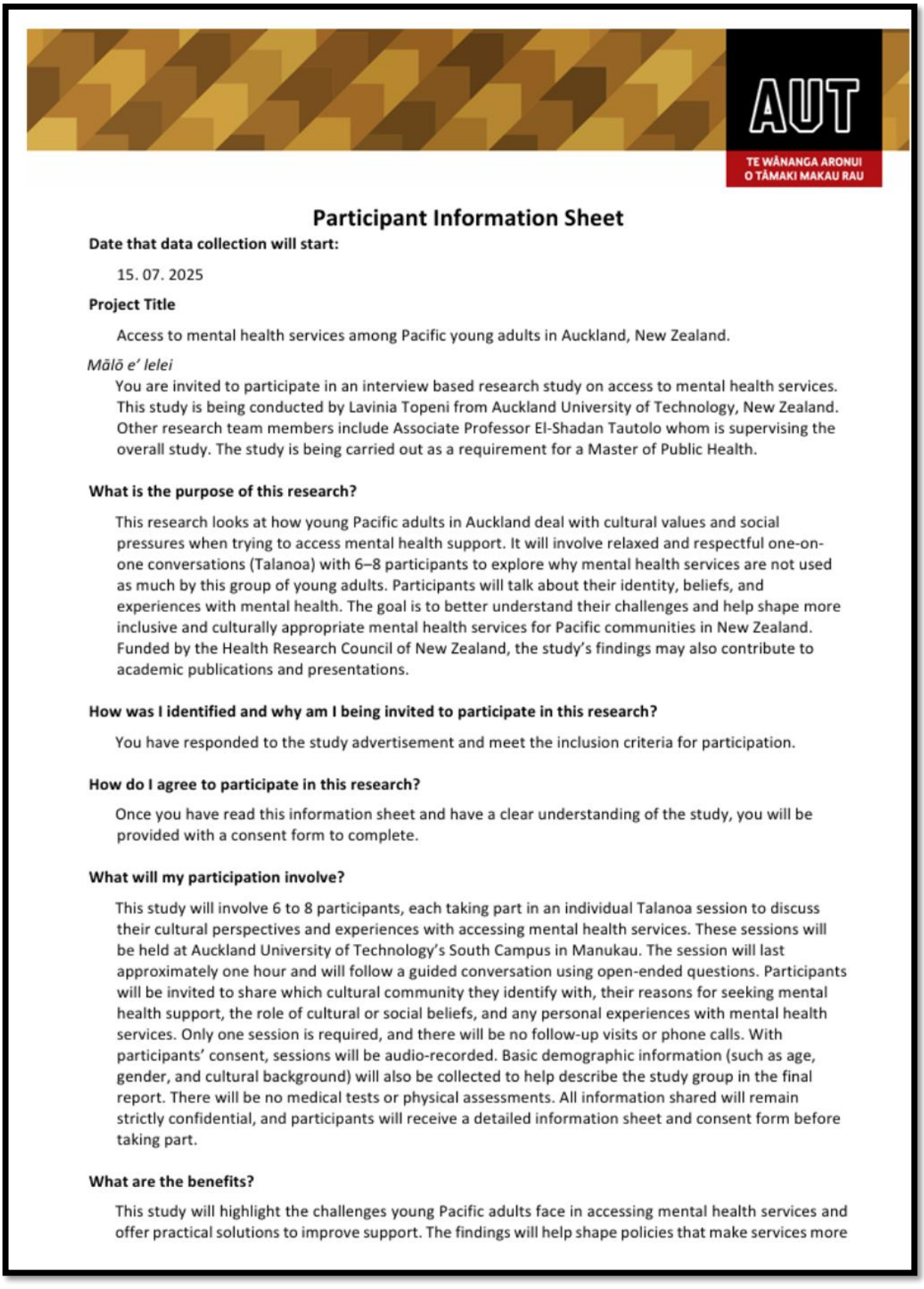
For any enquiries, please contact ethics@aut.ac.nz

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: tjd0791@aut.ac.nz; Meenal Rai

Appendix B: Participant Information Sheet



AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Participant Information Sheet

Date that data collection will start:

15. 07. 2025

Project Title

Access to mental health services among Pacific young adults in Auckland, New Zealand.

Mālō e' lelei

You are invited to participate in an interview based research study on access to mental health services. This study is being conducted by Lavinia Topeni from Auckland University of Technology, New Zealand. Other research team members include Associate Professor El-Shadan Tautolo whom is supervising the overall study. The study is being carried out as a requirement for a Master of Public Health.

What is the purpose of this research?

This research looks at how young Pacific adults in Auckland deal with cultural values and social pressures when trying to access mental health support. It will involve relaxed and respectful one-on-one conversations (Talanoa) with 6–8 participants to explore why mental health services are not used as much by this group of young adults. Participants will talk about their identity, beliefs, and experiences with mental health. The goal is to better understand their challenges and help shape more inclusive and culturally appropriate mental health services for Pacific communities in New Zealand. Funded by the Health Research Council of New Zealand, the study's findings may also contribute to academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

You have responded to the study advertisement and meet the inclusion criteria for participation.

How do I agree to participate in this research?

Once you have read this information sheet and have a clear understanding of the study, you will be provided with a consent form to complete.

What will my participation involve?

This study will involve 6 to 8 participants, each taking part in an individual Talanoa session to discuss their cultural perspectives and experiences with accessing mental health services. These sessions will be held at Auckland University of Technology's South Campus in Manukau. The session will last approximately one hour and will follow a guided conversation using open-ended questions. Participants will be invited to share which cultural community they identify with, their reasons for seeking mental health support, the role of cultural or social beliefs, and any personal experiences with mental health services. Only one session is required, and there will be no follow-up visits or phone calls. With participants' consent, sessions will be audio-recorded. Basic demographic information (such as age, gender, and cultural background) will also be collected to help describe the study group in the final report. There will be no medical tests or physical assessments. All information shared will remain strictly confidential, and participants will receive a detailed information sheet and consent form before taking part.

What are the benefits?

This study will highlight the challenges young Pacific adults face in accessing mental health services and offer practical solutions to improve support. The findings will help shape policies that make services more

culturally appropriate and inclusive, leading to better outcomes for our young Pacific adults and Pacific communities.

What are the costs?

There are no costs involved in taking part in this project. As a thank you for your time and participation, you will receive a $100 gift voucher.

Will the results of the study be published?

The results of this research will be published in a Master's thesis. This thesis will be available to the general public through the AUT library. Results may be published in peer-reviewed, academic journals. You will not be identifiable in any publication.

What are the discomforts and risks?

Some questions in the interview may bring up strong emotions or make you feel uncomfortable. If this happens, you can take a break or stop the interview at any time. Your wellbeing is important, and we will support you throughout the process. If you feel you need help after the interview, we can talk about support services available to you. The researcher will do their best to make sure you feel safe and cared for during the study.

How will these discomforts and risks be alleviated?

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call (09) 921 9292.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What will happen to information about me?

- The voice recordings and collected information are coded and can be re-identified.
- Your voice, name, age and ethnicity is identified through the voice recordings.
- Voice recordings and Information collected will be safe kept and deleted once research is completed. The handling and storage of research data complies with the Privacy Act 2020
- The information will be coded (assigned a participant number). The researcher will be keeping the list linking the code with the name, so that the participant can be identified by their coded data if needed.
- Consent is requested solely for the use of the participants coded information in this project.
- All information and voice recordings will be kept strictly confidential, and your privacy will be safeguarded.
- That by signing the consent form the participant is agreeing to the use of your information as stated in this Information Sheet. Identifiable information will only be disclosed outside of the study with the participant's permission, or as required by law.

Will I receive feedback on the results of this research?

Researcher will send a summary of the research to you at the end of the study, if you request this.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, El-Shadan Tautolo, elshadan.tautolo@aut.ac.nz, (+649) 921 9999 Ext.7527

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz*, (+649) 921 9999 ext 6038.

Researcher Contact Details:
Lavinia Topeni

Email: tjd0791@autuni.ac.nz

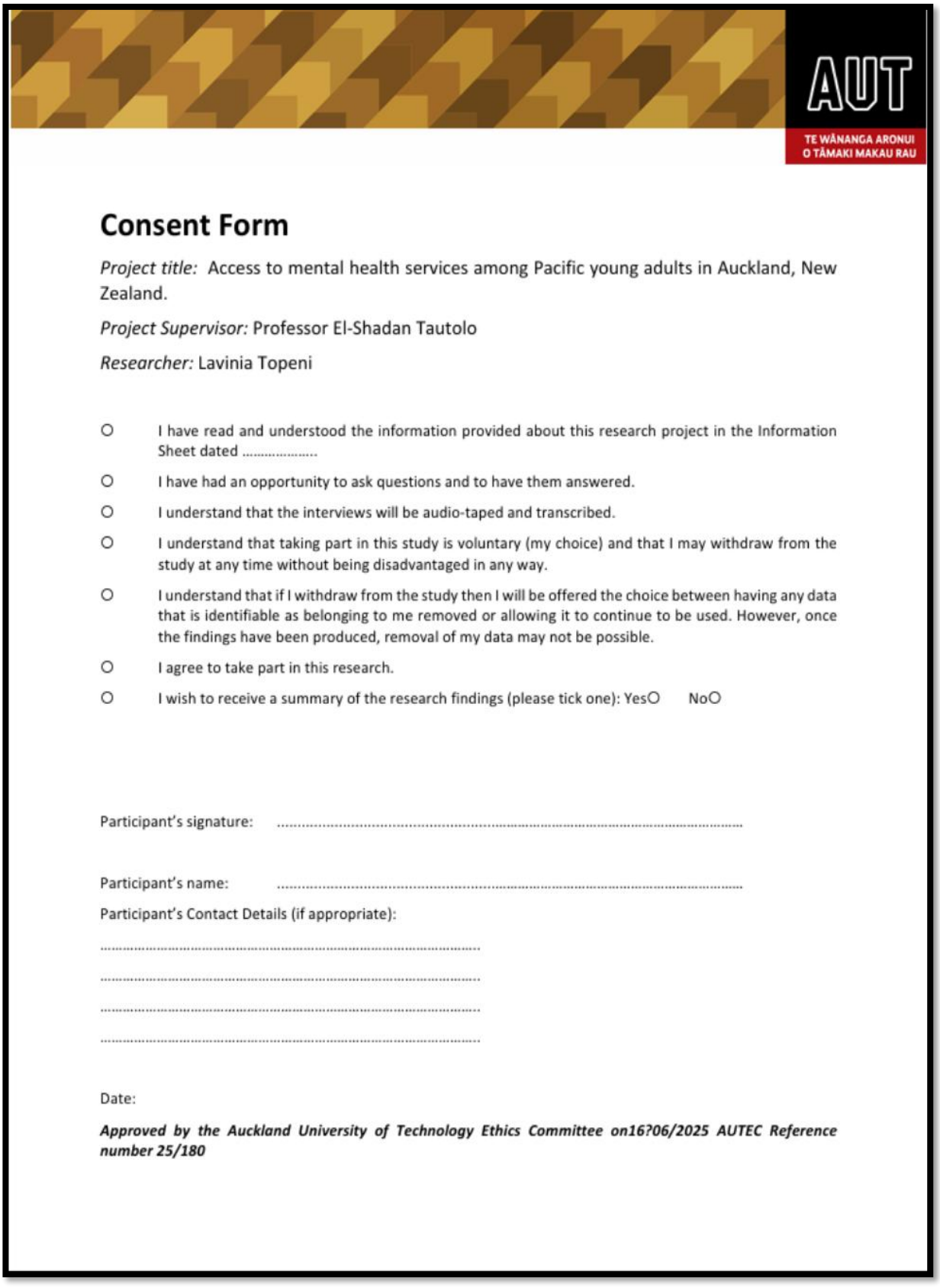
Project Supervisor Contact Details:
Professor El-Shadan Tautolo

Email: elshadan.tautolo@aut.ac.nz

Contact: (+649) 921 9999 Ext.7527

Approved by the Auckland University of Technology Ethics Committee on *16/06/2025*, AUTEC Reference number *25/180*.

Appendix C: Consent Form



AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

Consent Form

Project title: Access to mental health services among Pacific young adults in Auckland, New Zealand.

Project Supervisor: Professor El-Shadan Tautolo

Researcher: Lavinia Topeni

- ○ I have read and understood the information provided about this research project in the Information Sheet dated .....
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that the interviews will be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on16?06/2025 AUTEC Reference number 25/180

Appendix D: Inductive questionnaire used to guide the Talanoa session

INDUCTIVE QUESTIONS

Part I: Cultural and Community Influences

1. What cultural community do you currently identify with?
2. In what ways has this cultural community influenced your values, beliefs, or sense of identity?
3. What cultural beliefs or values shape your understanding of mental health?
4. How do social expectations within your community influence your decision to seek, or avoid, mental health services?

Part II: Understanding and Seeking Mental Health Services

1. What personal experiences or challenges led you to consider seeking mental health services?
2. What factors or events ultimately motivated you to take steps toward accessing these services?
3. What are common beliefs or attitudes within your community about mental health and individuals who seek mental health support?
4. How do these community beliefs influence individuals' willingness or reluctance to seek help for mental health concerns?

Part III: Reflections

1. How do you personally view the importance or value of seeking mental health support or services?
2. What beliefs or experiences have shaped your current attitude toward accessing mental health care?
3. What steps did you take to seek mental health services?
4. What was the outcome of your attempt? How did this experience affect your overall perception of mental health care?
5. Is there anything else you would like to share or elaborate on regarding your experience in today's Talanoa session?

Appendix E: Research Advertisement

Appendix F: AI Declaration

ARTIFICIAL INTELLIGENCE DECLARATION

Artificial Intelligence Guidelines:

Artificial Intelligence (AI) tools, including generative AI tools approved for use by AUT (AI Tool Register), can be used as learning tools when preparing to write your research proposal or research component. AI tools also have capability to assist with data modelling, data analysis and data visualisation. However, the research component you submit for examination must be substantively your own work. AI tools cannot solely be used to generate content when writing or creating an artwork/artefact, as this constitutes plagiarism. The formal guidelines for appropriate use of AI on the AI Hub must be followed. Also refer to the Using Artificial Intelligence in your Research: Self-Assessments, Checklists, and Sample Text, for examples and sample text.

If you do plan to use AI tools, this declaration should be submitted with the initial research proposal, Confirmation of Candidature, and when you submit your research component for examination. You must complete the template below for each AI output used detailing the following:

- **Chapters where AI was used in any way**
- **Purpose of AI Use**
- **AI Tool(s) Used**
- **Prompts Used**
- **Post-AI Processing Methods**

Specify the chapter number(s) in your research proposal/research component where AI was used.
Chapter number(s): Appendix E
Briefly explain why the AI tool was used (e.g., idea generation, summarization, data analysis, image creation, etc.).
Purpose of AI Use: Used AI to create the research advertisement images
Clearly state the AI tools used.
AI Tool(s) Used: **ChatGPT5**
Prompts or queries entered into the AI tool (only the instructive portion of the prompt is required). Include all relevant variations.
Prompts Used: **Create image of Pacific people talking**
A summary or description of the AI-generated output. (Optional: attach output in an appendix.)
Output Received:
Describe how the AI output was used, edited, or transformed.
Post-AI Processing Methods: **Edited on Canva to complete the research advertisement**

You may use this free text box to explain the intent for the use of the AI generated content. *For example, rather than stating what prompt(s) were used, you may articulate the purpose for which the prompt was used (supported by examples) here:*

STUDENT DECLARATION			
By signing you are confirming that the AI use stated in the table(s) above are accurate and follow AUT's recommended guidelines detailed in the AI Hub and Postgraduate Handbook.			
Student Name: **Lavinia Topeni**	**Signature:**	**Date:**	**28.04.2026**

AI Declaration Template V1.1 March 2026 Page 1 of 1