

**Supporting mental health recovery for Māori whaiora:
The success stories of Māori whaiora and non-Māori
clinicians.**

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Abstract

Māori people experiencing mental health issues have been historically under-served by mental health services. In the last three decades the development of Kaupapa Māori health services has provided a culturally responsive option for Māori. However, many Māori are still using mainstream mental health services and there is a need to develop a greater understanding of effective cross-cultural practice within the broader service system.

This research, *Supporting mental health recovery for Māori whaiora: The success stories of Māori whaiora and non-Māori clinicians*, sought stories of positive cross-cultural engagement in a mainstream service lacking in Māori cultural resources. The hermeneutic methodology was informed by appreciative inquiry and brought a Māori interpretive lens. The stories of 13 people (7 whaiora and 6 clinicians) who felt something good had happened in their cross-cultural work were analysed to uncover the phenomenon of the relationship. Aspects of Māori and non-Māori experience were drawn from the stories and further illuminated by Māori cultural notions, relevant literature, and nuanced by the personal pre (and ever growing) understandings of the researcher.

Exploring positive stories provided an opportunity to shed light on the cross-cultural practices, marked first by difference, misunderstanding and tension which, the participants revealed, lead to trust, respect and collaborative working. Tension and success appeared to be two sides of the same coin within the cross-cultural exchanges. Maintaining distance, giving time, acknowledging gaps in knowledge, respectful listening and giving power to the other were shown to be important steps. The willingness to share and blend points of view lead to new ways of creating recovery pathways and upheld the mana (status) and expertise of the other.

Recommendations for practice and teaching include the importance of reflecting on one's own history and prejudices, learning to dwell with uncertainty and the discomfort caused by difference. Clinicians are encouraged to see and hear, beyond ethnicity, the human they are working with. Future researchers are challenged to resist fault-finding and problem-solving and instead pursue an understanding of positive encounters. Cross-cultural research can extend knowledge and enhance already existing positive cross-cultural health care engagements to benefit Māori and other cultures in Aotearoa/New Zealand.

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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 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.

Inez Tracie Awatere-Walker (signature)

Date:

Nga mihi - Acknowledgements

Before the beginning and after the end.
And all is always now.
(from *Burnt Norton*, T.S Eliot)

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Chapter One

Introduction

E tipu e rea, mo nga ra o te ao,
Ko to ringa ki nga rākau a te Pākehā,
Hei oranga mo to tinana.
Ko to ngakau ki nga taonga a o tipuna,

Hei tikitiki mo to mahunga.
Ko to wairua ki te Atua,
Nana nei nga mea katoa.

Grow, child, in the days of your world,
In your hands the tools of the Pākehā,
To support and sustain you.
In your heart the treasures of your
ancestors,
As a plume for your head.
Your spirit given to God,
The source of all things.

(Sir Apirana Ngata, 1874-1950, Ngāti Porou)

Supporting mental health recovery for Māori whaiora: The success stories of Māori whaiora and non-Māori clinicians.

This research sought to uncover how mental health recovery is positively supported for Māori whaiora by non-Māori clinicians. The research question was simply “How is mental health recovery positively supported for Māori whaiora by non-Māori clinicians?” The research, therefore, sought to reveal the day-to-day practice of a group of mental health clinicians, and how that practice aligned with the ideals of cultural safety and competence. Hera (2013) stated: “Cultural safety fits better [than cultural competence] with a patient centred stance. The patient can and should determine what is culturally important to his or her needs” (p.49). This research did reveal the specific day-to-day clinician actions that supported cultural safety for the whaiora they worked with in Hawkes Bay, Aotearoa/New Zealand.

The term ‘Tangata whaiora’, shortened to ‘whaiora’, is used here to refer to people seeking wellness after experiencing significant mental health issues. Using an appreciative approach, stories were gathered from former Māori whaiora and non-Māori clinicians at the Hawkes Bay Community Mental Health teams. The therapeutic work around which the research revolves assists adults living with

moderate to severe mental health problems such as psychotic illness, major depression, anxiety disorders, alcohol and other drug misuse, and distress caused by traumatic life events. The research involved gathering success stories from both clinicians and whaiora. Analysis, drawing on a hermeneutic approach, looked for understandings such as what worked, how personal worldviews influenced or hindered working together, to what extent internal self-generated schema or external learnings such as bicultural training influenced process, what common discourse threads were apparent, and the nature of contextual factors that guided successful therapeutic engagement. The interest for this research came from my desire to understand how non-Māori can work successfully with Māori in a community mental health setting. Overarching the whole process were Māori values, insights and process.

This research is a professional doctorate, rather than a traditional PhD. The choice was made consciously after reflection on its intended purpose, to “see the things themselves” (Gadamer, 1979, p.269), from within the practice and day-to-day context of mental health work. Rolfe and Davies (2009), said, amongst other benefits of practice-based doctorates, “[it] places the production of knowledge in the context of the situation to which it will ultimately be applied”, and they go on to describe it as a mode of knowledge-production in which “the link between theory and practice are more apparent, and because research takes place in the workplace, knowledge-production and diffusion are interlinked” (p.1268). This enquiry topic has been coming up in conversations throughout the hospital and in the community. Māori and non-Māori colleagues within and outside of mental health, student nurses on placement, patients of the service and members of the wider community, who read about the research in the local newspaper, have shared their thoughts and experiences with me. I and my colleagues reflect more on our work and there is a growing sense of curiosity about what we are doing that works well in cross-cultural healthcare. It is envisaged that the findings and discussion generated by this thesis will have an ongoing positive effect on practice in the mental health workplace and be of benefit for health service users and their relatives.

This is a hermeneutic study, underpinned by the philosophical notions of Gadamer to explore emergent meanings. It is further informed by Appreciative Inquiry to bring a

positive, strength-based lens to the questioning and analysis. The analysis was further nuanced by my own lived experience of being Māori. Māori understandings became increasingly important in guiding the analysis of the data as I gained a developing confidence in my own cultural heritage as Māori. The sub text of this thesis has been a personal journey of reclaiming my own heritage.

The hermeneutics of Hans-Georg Gadamer [1900-2002] provided useful guidance as to the method of interpretative analysis as I sought to uncover what understandings people bring to the mental health treatment relationship and to come to see how subsequent new understandings between them led to a positive mental health outcome. The paradigm of interpretivism has the assumption that to understand how a non-Māori clinician works successfully with a Māori whaiora part of the truth is to be found in the self-understandings of the clinician and the whaiora.

Cultural discussions about the stories and interpretations with a cultural supervisor Mrs Te Ata Munro, a woman learned in Te Ao Māori, whose first language is te reo Māori, and who is also a registered nurse, provided additional insights to the analysis.

A summary of my beginning position

In almost 20 years of practice as a Clinical Psychologist, mostly in mental health settings, I have probably had about 200,000 therapy-oriented conversations with patients, their whanau (family) or other support people. These conversations are with people from all walks of life, and indeed many of these people had very little in common with me. Of those thousands of conversations my hope is that most helped people to achieve relief from their symptoms and some degree of recovery. Those conversations were not always straightforward and we did not always share the same views, interpretations or conceptualisations of mental illness. I do not believe all those people left my consulting room totally convinced by my psychologist's view of their illness, but it is my role to introduce new ideas about their illness and how it may be best managed. To do this it is necessary to create a disturbance in their illness-maintaining beliefs – to produce a new way of viewing their illness.

Sometimes it is not possible to accept their view, such as the belief that they deserve their distress because of their behaviour or their view that nothing will change to help them to feel better. The patient and I will often have different understandings of

mental illness but there is a need for us to find common ground within which to work together. The usual process is that the patient will explain their understanding of their illness, and I will present a psychological framework for their illness. It is successful if we both leave the session with richer understandings than those we had at the outset. I try to see how they experience their illness, what it means to their life and why they struggle to recover. I hope they leave with a belief in recovery and the means to achieve it. The preunderstandings I hold about mental illness is that recovery from mental illness is more likely when there is collaboration and shared understanding between the patient and the clinician.

Recovery is the outcome mental health practitioners actively seek for their patient. My interest is in the way Māori whaiora and Non- Māori clinicians work that makes recovery happen. What happens in that dyad, possibly without full awareness, that brings about a good outcome?

My whakapapa, brought to my research

Ko Hikurangi te maunga	Hikurangi is the name of the mountain
Ko Waiapu te awa	The river is Waiapu
Ko Mangahanea te marae	Our place to gather is Mangahanea
Ko Hinetaora te wharehau	Our ancestral house is Hinetaora
Ko Frank Edwards taku papa	My father was Frank Edwards
Ko Mere Awatere taku whaea	My mother was Mere Awatere
Ko Ngati Porou te iwi	Ngati Porou is our tribe
Ko Inez Awatere-Walker ahau	I am Inez Awatere-Walker

When I registered as a Clinical Psychologist in 1996 there were very few Māori in the profession, certainly less than ten of us. I whakapapa to Ngāti Porou from my mother, to the Awatere and Haenga whanau who came from Tuparoa near Ruatoria on the East Coast of the North Island of Aotearoa/New Zealand. My grandfather Whare Retimana Awatere and my nanny Rerepo Awatere (née Haenga) had 13 children, my mother being the eldest, and lived on a farm at Ruatoria before moving to Gisborne 130km south in their old age. My mother Mere Arihi Te Huinga Awatere and my New Zealand-born English father Frank Edwards had us five children and we were raised in a very bicultural household. I have early memories of struggling to fit into either the Māori world, where we were teased for having to wear our shoes outside, or the Pākehā world on account of our brown faces and beautiful

pronunciation of te reo Māori (Māori language). Our mother had been punished at school in the 1930s for speaking Māori and had to relearn it in the 1980s, but it was not part of the school curriculum when I and my siblings were at school. We children grew up feeling slightly out of place in both the Māori and Pākehā worlds and instead inhabited some third space in-between. I still feel neither entirely comfortable nor alienated from either cultural world. The third space allowed a generation of us 'half-castes' to feel inconspicuous and ordinary but it also inhibited in-depth knowledge of both Māori and Pākehā ways. Being in the third space does however have the distinct advantage of being able to see bicultural issues from the perspective of living in both spheres. As a psychologist and a Māori researcher this bipartisanship has tended to persuade me to accept nothing at face value but to try to see the issue from more than one perspective.

Reflecting on culture

In the early days of my psychology career I was often concerned whether, as a Māori woman, I would be able to work effectively with people who were different from me – people who were not Māori, males, older or younger people, people from overseas – all of them with their different culture, ethnicity, history and lived experience. It wasn't until I lived and worked in the United Kingdom for a few years recently that I was struck by how willingly people formed a therapeutic relationship with me despite our obvious cultural differences. I worked with British people, clients from all over the European Union, English and Irish Roma Gypsies (who call themselves Travellers), as well as people from more diverse religions and faiths than I had previously encountered in Aotearoa/New Zealand. I began to question whether those ethnic, gender, age, religious and cultural differences were barriers to therapeutic engagement at all. Upon returning to work in mental health in Aotearoa/New Zealand it became quickly apparent that many of my colleagues were Pākehā and/or from overseas and how they seemed able to form rapport with Māori whaiora and seemed to be successful in helping them to achieve recovery. When talking with these non-Māori colleagues about my observation and interest they usually shrugged and said "I treat everyone the same" and were not aware of taking much notice of cultural difference or altering their way of working. It seemed to be no barrier to recovery for their Māori, Pasifika and other culturally different people they cared for.

Early reading into cross-cultural practice indicated to me that cross-cultural research discourse has always focussed on cultural absence, i.e. not enough being done (Kingi, 2005). Kingi also says that because of the diversity of Māori cultural identity, attempts at better engagement and responsiveness to Māori patients may require certain assumptions to be dispensed with. Further, while academic and research focus has tended to be on the absence of culture – not enough being done, there has been at times too much done, when anecdotal evidence suggests over-enthusiastic application of Māori processes may have had a negative impact. The proposed research seeks to take Kingi's suggestion further to explore how recovery can occur even when environments lack a strong focus on Māori resources or processes

Assumptions and Preunderstandings

Before I began this research in earnest one of my supervisors interviewed me to assist me to identify what I already believed about cross-cultural mental health work. Experiences ranged from my childhood awareness of cultural difference to my professional involvement as a psychologist in Aotearoa/New Zealand and abroad. The pre-understandings I held included:

- To truly assist someone to recover in mental health there must be trust and openness on the part of the clinician as well as the client. A certain amount of self-disclosure is necessary.
- A clinician must be aware of their prejudices and pre-understandings and be willing to share those with their client.
- No two people from within the same professional culture or ethnic culture are perfectly alike.
- Bicultural practice cannot be learned from a book or a lecture. Bicultural awareness is an experiential process. It must be experienced and reflected upon in an ongoing way.
- Dialogue is the foundation to understanding another person.

My assumptions are therefore that if there is no conscious difference in a clinician's practice with culturally different people, there is unintended or unnoticed behaviour which facilitates good rapport and recovery. A further assumption is that

communication, and in particular, dialogue, must be the foundation for non-Māori mental health clinicians to work successfully with culturally different people.

Refining the question

My initial interest in successful mental health work between culturally different people intensified when I returned to Aotearoa/New Zealand and took a role at the Hastings Community Mental Health team, a mainstream service and part of the Hawkes Bay District Health Board. This interest was further intensified by the recognition that although almost 37% of the patients seen there identified as Māori (Ministry of Health, 2010), but only 3 of the 28 clinicians were Māori. These demographics are explored more fully in the following chapter. This research therefore has sought to explore mental health recovery of Māori who had worked with a non-Māori clinician. The working title at that time was *Māori mental health recovery: non-Māori clinician's success stories*. The title was intentionally explicit as I sought to be transparent in my viewpoint which saw the recovery of Māori patients as the most important element but with the intention of seeking cross-cultural successes. Māori and non-Māori were specifically chosen as they represent a common cultural mismatch in Aotearoa/New Zealand which is often negatively commented on. The term success was also chosen intentionally to mark this project from the outset as being strengths-based and positively focused.

There was initially criticism and lack of support for this research from some Māori who were approached for consultation and advice at the time of writing the research proposal. Objections tended to be mainly concerned that the research focused on positive Māori/non-Māori clinical interactions rather than researching the problems and poor outcomes many Māori can experience when accessing health care. Questions were asked about the value of the research for Māori if it did not address problem areas and seek solutions. Further criticisms were that the research may be an attempt to undermine Kaupapa Māori mental health services (services delivered based on a Māori framework), concern that colonisation and historical oppression were being ignored and the suggestion that the research was attempting to deny that things can go wrong in cross-cultural relationships. There was also a suspicion from a Māori doctoral student that I was implying bicultural training and programmes were invalid. While this critique raised some important considerations, my primary

intent was not to challenge Kaupapa services and bi-cultural training, but to highlight the reality that many Māori are accessing mainstream services and there is a need to focus on what works well in this context, rather than a sole focus on the problems. Insights into what works well can then be shared and incorporated into training to maximise the benefits for Māori whaiora.

Support was also forthcoming for the research, largely due to its focus on successful outcomes. Clinical staff, both Māori and non-Māori, were unanimously in favour of the research believing it may provide an opportunity for them to prove their fitness to work with Māori – many felt they were under-estimated in this work. Support also came from Māori in the community who felt that their right to choose a mainstream service, or any service, was important, also commenting that they felt pressured to justify their choices to other people. An important source of support came from a kaumātua I initially consulted with who believed the research was important as it showed the heterogeneity of our community today. He also felt that each of us can simultaneously have multiple cultural identities and historical experiences in the same way we can have multiple roles in our day-to-day life which could seem contradictory to others (Turoa Haronga, personal communication). Ultimately, it was believed that exploring successful cross-cultural exchanges could inform more effective practice with Maori whaiora who access mainstream mental health services.

Following ongoing supervision discussions to craft the research further it became apparent that the working title made it appear there were to be stories from non-Māori clinicians only. The research question therefore became “How is mental health recovery positively supported for Māori whaiora by non-Māori clinicians?” and the title became *Supporting mental health recovery for Māori whaiora: The success stories of Māori whaiora and non-Māori clinicians*.

Community Mental Health context

The setting for this research is mainstream community mental health in Hawkes Bay, Aotearoa/New Zealand. The service is available for all people within the DHB catchment from Wairoa in the north to Waipukurau in the South – a population of approximately 150,000 in total, with 39,500 identifying as Māori (Robson et al., 2015). The service addresses moderate to severe mental illness and moderate to

severe alcohol and other drug addictions. The severity of a mental illness depends on the clinical presentation and the presence or absence of signs and symptoms, and their intensity, frequency and duration. Guidelines such as those used in the DSM (Diagnostic and Statistical Manual of Mental Disorders) refer to mild illness as having few, if any symptoms present, moderate meaning presenting with symptoms and functional impairment, and severe meaning many symptoms are present, symptoms are particularly severe or the symptoms result in marked impairment in social or occupational functioning. (Sadock, Kaplan & Sadock, 2007).

The service is staffed by registered health professionals including psychiatrists, medical officers, clinical psychologists, mental health nurses, social workers, occupational therapists, addiction counsellors, and non-registered community support workers and kaitakawaenga (Māori liaison and coordination workers). The ethnic make up of the team is dynamic but is predominantly represented by non-Maori people.

Community mental health accepts referrals from many external providers such as GPs, midwives, counsellors, police and Department of Corrections, as well as referrals from other parts of the hospital and self-referral. A comprehensive assessment of the person's functioning and experience of mental illness, including risk to themselves or others, leads to the conjoint development of a treatment plan or intervention. Treatment can include talking therapies, medication, cultural support, social support, psychoeducation, respite care or inpatient care. The overall aim is to assist people to remain in the community and to reduce the dysfunction and distress associated with having a mental illness. The vision and values of the service are He Kauanuanu - showing respect for each other, our staff, patients and consumers, Ākina - continuously improving everything we do, Rāranga Te Tira - working together in partnership across the community, and Tauwhiro - delivering high quality care to patients and consumers (HBDHB, n.d.).

Bicultural training is mandatory for all staff in the service, including staff who identify as Māori. Treaty of Waitangi training must be completed within the initial orientation period of employment and Engaging Effectively With Māori must be attended every three years. There is also cultural advice and support for staff

available from kaitakawaenga and the Māori Health Unit. There remains an acknowledgment that training alone is insufficient to fully understand the Māori worldview (Te Pou, 2010) and culturally safe practice is a key responsibility of the health worker.

Selecting the approach

The research drew from congruent methodologies within the interpretive paradigm. It was always intended to be strengths-based, seeking to extend and enhance current knowledge about the process of recovery for whaiora in the mainstream mental health service. The drawing out of stories of successful engagement led me to include Appreciative Inquiry (A.I), with its assumption that there is something good in every organisation, which I have extended to include there being something good for whaiora in mainstream care. I believe the dynamic of a cross cultural relationship needed to be explored first by hearing the pre-reflective stories of the people who experienced it, that is, the story someone would tell me when I prompted them in the A.I manner to “tell me about a time when you felt talking with your clinician/whaiora had gone really well”. To then grasp and make explicit the meaning of the phenomenon, reflection was required. To uncover the understandings hidden within the stories I was drawn to hermeneutic phenomenology because of its purpose “to grasp the essential meaning of something” (Van Manen, 1990, p.77). Hermeneutics was chosen to aid me in the objectives of reflecting on the stories, hearing the voices of whaiora and non-Māori clinicians and understanding the cross-cultural horizons that made themselves present in their stories. The hermeneutic notions most strongly evident in this thesis are those of Hans-Georg Gadamer, a German philosopher who extended thinking into ‘meaning’ and how meaning in human interactions may be best explored.

“Everything which is not accessible to examination, which cannot be opened up to scientific method and so to regulation and control, is said to lie in the so-called grey areas where things cannot be treated with scientific exactitude” (Gadamer, 1996, p.133)

Finally the research needed to be carried out having regard to the voices of Māori service users and an opportunity for Māori knowledge to be articulated within the interpretations of this research. Overall, this study falls under the umbrella of hermeneutics, informed by Appreciative Inquiry with interpretations steeped in the cultural lens of Māori.

The justification for selecting Hermeneutics and Appreciative Inquiry

Researching and interpreting the experience of having successful interactions with someone is more than only noting the words used or describing the themes.

Polkinghorne (1983) clarifies the hermeneutic purpose is to seek “to understand human actions and expressions” (p.214) by an interpretive process. The method I chose to gather data was to seek stories from those who experienced the phenomenon. The AI perspective means I invited participants to talk about times when things had gone well. Stories are nuanced and complex compared with, for example, survey responses (yes/no or n/a) and in order for them to yield their meaning they require interpretation. The next consideration, beyond the need for the stories to be interpreted is the positioning of the one doing the interpretation, me. I come to the data, or stories, with my foreknowledge of being a clinician with Māori and English heritage and I cannot therefore stand outside the data. Hermeneutics, which interprets human experience from inside rather than describes it from the outside, maintains that there is no way for the knower to stand outside the life-world to observe it, and it therefore recognises that the stories which were first interpreted by the storyteller are then nuanced by the interpretation of the researcher, and will be further nuanced by the reader in a circular and potentially endless process.

The key terms used

Whaiora

Deciding what to call the users of mental health services is open to debate. An informal survey of clinicians found no clear agreement. ‘Patient’ tended to be favoured by medical doctors and nurses, and ‘client’ or ‘service user’ by allied health (i.e. non-medical clinicians). What was more clear was that the name most often used for Māori patients or clients was ‘whaiora’. The accepted meaning of ‘whaiora’ is a person seeking wellness, and I have used this throughout the thesis.

Non-Māori

It was no less difficult deciding what to call the clinicians who are not Māori. Many of them were not born in Aotearoa/New Zealand and there was a mix of New Zealand-born people, new arrivals and those who had settled decades before. There was no clear agreement on how they referred to themselves with the tendency to be a variation on ‘New Zealander’ or ‘Kiwi’, and none called themselves ‘Pākehā’. I

have therefore decided to use ‘non-Māori’ to refer to anybody who does not have Māori heritage. There is occasional reference to the ethnic background of a non-Māori if they have included this as part of their story.

Clinician

Mental health services are made up of either registered clinicians, i.e. doctor, psychologist, occupational therapist, social worker, or alcohol and other drug therapist, and non-registered counsellors and support workers. Whilst I do refer to specific professional background at times I have chosen the term ‘clinician’ to maintain focus on clinical care rather than profession-specific tasks.

Recovery

For this thesis ‘recovery’ refers to regaining emotional and functional equilibrium. It is intended to signify a state opposite to that of being mentally unwell or in distress. It refers to living well in the presence or absence of illness and living a meaningful life which brings fulfilment.

An overview of the chapters

Chapter 2 establishes an historical context for the past and current state of Māori mental health and service provision. The efforts of government and health care providers to reduce disparity by legislation and strategies are summarised leading to a discussion about the development of ‘by Māori, for Māori’ services in Hawkes Bay. There is an overview of the drive towards culturally safety and culturally competent health care practice, then a selection of the literature about recovery and Māori experiences of mental health care is discussed. The research gap is identified and the research question is justified.

Chapter 3 sets out the methodology of the research, the philosophical underpinnings of two modes of enquiry; Gadamerian hermeneutics and Appreciative Inquiry (AI) are discussed. An overview of each methodology is presented showing how each contributes to the understandings gained in this research. Of particular significance is my belief that the underpinnings of AI, ‘truth, meaning and the future possibility’, are supported by the Gadamerian hermeneutic notions of ‘prejudice, horizons and dialogue’ – both are generative philosophies which may allow us to notice,

acknowledge and welcome the other into our lives. There is also a discussion of how these methodologies value Māori insights of divergent worldviews, multiple realities and mātauranga Māori understanding of phenomena with its need to contribute to future knowledge and development.

Chapter 4 outlines how the research was undertaken. I will describe the process for the selection of participants and gathering stories to the process of analysis and write-up. The analysis using Gadamer's hermeneutics, with its assumptions of multiple understandings which merge to create unique personal understandings will be enlarged upon. The chapter includes word portraits of the participants, to enfold them within the entity of this thesis.

In Chapters 5, 6 and 7 the findings are presented. The chapters follow the natural progression of the recovery journey from meeting the other, to being together and going on to creating new understandings. The chapters conclude with a summary of the findings and relates them back to the philosophical underpinnings.

The final chapter brings together the findings into 'the thesis of the thesis' drawing out the most significant notions from the stories. These notions then facilitate discussion about the way forward for teaching, researching and practicing mental health care.

Summary

This chapter has outlined the context for the study, including the researcher's experience and assumptions, the practice context and the chosen methodological approaches. The need to maximise the benefits for Maori whaiora who access mainstream services and the study aim of learning from stories of success have been highlighted. Therefore, this study asks the question "How is mental health recovery positively supported for Māori whaiora by non-Māori clinicians?"

The following chapter builds on this introduction by reviewing relevant literature and unpacking the study context further.

Chapter Two

Māori Mental Health – Research and Recovery

Introduction

This chapter provides an overview of Māori mental health, systems and modalities of care, and research into that care. It begins with an acknowledgement of the Treaty of Waitangi, the founding document of Aotearoa/New Zealand, traces the recognition of health inequality for Māori compared with other New Zealanders, and the major policies and strategies which have sought to increase positive engagement in healthcare for Māori. The chapter then provides an overview of the notions of mental health recovery, cultural competence and cultural safety, and reviews national and local efforts to provide culturally safe services for Māori in health care. It then reviews some of the literature about recovery from both Māori and non-Māori perspectives. A selection of previous research into Māori experiences of mental health care and non-Māori efforts to reconcile the disparity, shows how the focus has begun to shift from problem-solving to the identification of strengths and optimism. The research gap is then identified and the relevance of the research question is restated.

The scope of the literature review

In order to situate this research amongst previous explorations of Māori mental health recovery I undertook a search of the professional literature using the CINAHL, Google Scholar and PsycINFO databases. The broad search terms Māori, mental health, recovery and bicultural practice were then narrowed down to refine the search for aspects such as access to healthcare and cultural competence. In addition I reviewed significant seminal articles and older texts, and my supervisors guided me to related resources that contributed to the understanding of philosophical notions. It was difficult to locate a large amount of literature related to the day-to-day practice of cultural safety in therapeutic settings, or successful practice between

Māori and non-Māori people. The literature review highlighted a need for successful bicultural practice, and the meaning of that practice to be brought into focus.

The socio-political and cultural context for Māori mental health

One way of understanding the socio-political and cultural context of Māori mental health is by looking through the lens of whakapapa. Whakapapa or a genealogical framework is utilised in mātauranga Māori as a tool of analysis and taxonomy, a method of understanding the previously unencountered phenomenon. Sadler (2007) explains that the premise of mātauranga Māori is that all phenomena are inter-related and therefore to explain a new phenomenon the required approach is to search for connectiveness. Royal (1999, in Sadler 2007) uses the analogy of two (parent) phenomena coming together to create a third (child) phenomenon. When the parents are known the child can be identified. In order to understand the 'by Māori for Māori' mental health movement one needs to understand the events that led to it. This leads to further understanding of the space that still remains in the health service when Māori whaiora receive therapy from non-Māori clinicians.

Te Tiriti o Waitangi and The Treaty of Waitangi

To understand Māori mental health within the broader health system one must turn to the founding document of Aotearoa/New Zealand, the Treaty of Waitangi, which has no status in law itself, but is incorporated into related legislation that affects Māori in particular. The Treaty is also an acknowledgment that Māori are the only indigenous peoples who were not defeated militarily and that assurances for equality would be incorporated into New Zealand law (Durie, 1994). The Treaty of Waitangi, signed in 1840, has two texts; in English and in Māori. The Māori version is not an exact translation of the English and the differences and ambiguities between the texts has generated much debate over meaning and intent.

Te Tiriti is the Māori version of the agreement between Māori and the British Crown. The crucial differences between te Tiriti and the Treaty is the question of sovereignty. The English version states British intentions were to protect Māori interests, provide for British settlement and establish a government to maintain peace and order. The English version also states that Māori would cede sovereignty to the Crown. The Māori version, however, suggests that the Queen promises to provide a

government whilst acknowledging rangatiratanga, full control and authority over their lands villages and treasures, to Māori. Despite the differences between the two texts, there is legally one Treaty (Ministry for Culture and Heritage, 2012).

The Treaty of Waitangi provides a framework for the Crown's objectives for Māori health rights. Not only do the Principles of the Treaty: Partnership, Active Protection and Participation apply, the Treaty articles provides a framework as each article contains a significant provision that relates to health. Article 1 contains the principle of government and the right to govern, and with this privilege the responsibility to protect Māori interests. Article 2 upholds the principle of self-management with provision for iwi to exercise authority over their own affairs. This in fact establishes each tribe's prerogative to control the affairs of their people as they relate to physical, cultural and social resources, including health management. Finally, Article 3 contains the principle of equality, which guarantees the same legal rights for Māori as for other New Zealanders. The implicit assurance is that social equality can be achieved (Waitangi Tribunal, 1997).

The Treaty of Waitangi Act 1975 formally recognised the Treaty by establishing the Waitangi Tribunal. The Tribunal is instructed to have regard to both texts, and where there is ambiguity the international law principles of *contra preferentum* applies. This principle according to the Practical Law Dictionary (2010) means that when ambiguities arise "the doubt or ambiguity should be resolved against the party who drafted it". In this case the text drafted in the language of the indigenous signatories takes precedence. The Tribunal was set up primarily to investigate whether any New Zealand legislation contravenes the Treaty.

The second legislation to incorporate the Treaty Principles was the State Owned Enterprises Act 1986 and thereafter followed other legislation of social policy and health policy e.g. The Education Act 1989, The Children, Young Persons and their Families Act 1989, and the Health and Disability Services Act 1993. As this renewed focus on upholding the Principles within the Treaty of Waitangi was happening the Regional Health Authorities were established, which were responsible for deciding which health services to fund. The RHA enabled the funding of Non-

Government Organisations (NGOs) including Kaupapa Māori, or ‘by Māori for Māori’ health services.

In *Moving Forward: the National Mental Health Plan for More and Better Services* (Ministry of Health, 1997) one of the national objectives was:

To continue to increase responsiveness to the special needs of Māori, by providing access to both Kaupapa Māori and mainstream services. Currently, not all regions provide services at a level that would give Māori an adequate choice between mainstream or Kaupapa Māori community mental health services. There is a need for significantly increased purchasing of community mental health services from Māori providers (p.40).

The Treaty and Maori mental health

The Treaty is about the relationship between the government and Māori individuals and communities. There is recognition of the need for balance between state control and governance, and co-operative, collaborative relationships with Māori. In 2002 the Ministry of Health published *Building on Strengths* (2002b), which had three goals; to reduce inequalities relating to mental health, to create environments that are supportive of mental health, and to improve individual and community resilience skills. *Building on Strengths* restated that the principles of the Treaty – partnership, participation and active protection were at the heart of the New Zealand health strategy. Partnership refers to iwi and the Crown working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate services. Participation emphasises Māori involvement at all levels of the sector in planning, developing and implementing services for Māori. Protection recognises that the Crown needs to be proactive to ensure Māori enjoy the same levels of health as non-Māori New Zealanders whilst safeguarding Māori concepts, values and practices (Ministry of Health, 2002b). There is an expectation that mental health clinicians uphold these principles in their practice with Māori whaiora through culturally responsive service delivery.

Māori mental health disparity and the National response

Māori are over-represented in negative domains of Aotearoa/New Zealand's health statistics, including mental illness statistics (Oakley Browne, Wells, & Scott, 2006). The New Zealand Health Survey for 2014/2015 showed that one in ten Māori adults experienced psychological distress in the past four weeks, scoring 12 or above on the K10 scale, where >12 means high or very high distress and a high probability of having an anxiety or depressive disorder. Furthermore, Māori males were 1.6 times as likely to have experienced psychological distress as non-Pacific, non-Māori males (Ministry of Health, 2015).

The suggested reasons for Maori health disparity tend to fall into three main pathways: lifestyle factors, access to healthcare and differences in the quality of healthcare received. Māori and Pacific peoples are more likely to live in the most deprived areas, and as such are twice as likely to be hospitalised for an avoidable cause as people living in the least deprived areas (Hefford, Crampton & Foley, 2005). Furthermore those areas of high deprivation tend to be associated with other determinants of health such as poorer educational achievement, substandard and overcrowded housing, lower income, poor health literacy and involvement with the criminal justice system. These determinants therefore lead to Māori having higher risks to health such as tobacco smoking, Alcohol and other drug use and addiction, poor nutrition, problem gambling and unsafe employment conditions (Reid & Robson, 2006; Russell, Smiler & Stace, 2013). Of note however is the observation that even when in comparable income groups to non-Māori, health disparities for Māori persist (Alcorn, 2011).

Cost is a significant barrier to Māori accessing healthcare (Ellison-Loschmann & Pearce, 2006; Hefford et al., 2006) and when engaged in healthcare Māori experience slower pathways through the healthcare system (Read & Robson, 2006; Russell et al., 2013), and are less likely to be referred for specialist services (Ellison-Loschmann & Pearce, 2006). Access to public health interventions has also been criticised as being designed for the general population and delivered through the mainstream service, failing to acknowledge the barriers that might prevent Māori from accessing them, such as smoking cessation programmes that fail to take cultural factors into consideration.

The third suggested reason for Māori health disparity is the difference in the quality of care received by Māori. Reid and Robson (2006) state that racism is a major driver of ethnic inequalities in healthcare. Ellison-Loschmann & Pearce (2006) agree, highlighting how “the conscious or unconscious discriminatory attitudes” (p.614) of healthworkers, unsatisfactory previous contact with healthcare workers, and experiences of disempowerment contribute to a reluctance by Māori to seek medical care.

Despite Māori being the indigenous population and the existing principles of the Treaty of Waitangi, health policy and services for Māori have not developed quickly. The New Zealand Board of Health recognised two approaches to Māori health as early as 1987, namely, Māori service delivery and cultural appropriateness, but very little social policy was actually enacted in this era (Durie, 2001). Previous policy recognised health disparities but it took the deinstitutionalisation of the mental health hospitals of the 1980s to generate serious discussion about the appropriate care of Māori psychiatric service users. The first vigorous efforts to address Māori health disparity was the 1997 Coalition Agreement on Health (Dyall, 1997) with the introduction of the notion of ‘by Māori for Māori’ services. The privatisation of state-owned assets such as Telecom led to funds being ear-marked for deinstitutionalisation programmes and the closure of the large psychiatric facilities (e.g. Lake Alice and Sunnyside Hospitals). In other words, the patients were being sent back to their hometowns and families for community-based care (Gauld, 2001). The policies and strategies for Māori mental health which followed deinstitutionalisation can be viewed via a critical lens as being reactive and ad hoc rather than well planned forward thinking.

The Mental Health Commission

The 1996 Mason Report, an inquiry into mental health services in New Zealand, resulted in the establishment of the Mental Health Commission. The Commission was established to advise the government on the needs of people requiring mental health care, encourage research and advocate for improvements. The improvements mooted included appropriate services for Māori, integrating drug and alcohol services with those for mental health, better promotion of mental health and the prevention of mental illness (Mental Health Commission, 2007). The Commission

developed the Blueprint for Mental Health Services (1998) which highlighted the importance of cultural responsiveness in the recovery process and led to ring-fenced funding for innovation in service delivery and Non-Government Organisations, including Maori services.

New Zealand Health Strategy (2000) and New Zealand Public Health and Disability Act 2000

In the year 2000, the health system was restructured, however Māori mental health services were not referred to specifically for improvement. The Health Funding Authority (HFA) was abolished and restructured into the Ministry of Health (MoH) which established 21 District Health Boards (DHBs), (since reduced to 20 in 2015). DHBs are non-profit providers who receive public funding from the MoH on behalf of the Crown. They were made responsible for the purchase and provision of health services in their catchment areas. Despite the DHBs having regional responsibility and oversight, the MoH set the national health goals and targets which mostly emphasised preventative services such as increased immunisation rates, smoking cessation programmes, reduced waiting times in emergency departments and better diabetes management. Targets for Māori mental health were not prioritised.

The DHBs therefore became responsible for planning, funding and facilitating the provision of all health and disability services to achieve the government imposed health targets, and with the funder/provider split removed the DHBs' focus shifted from providing health care and *services* to ensuring health *outcomes* including Māori mental health outcomes. *Services* and *outcomes* are not the same thing (Durie, 2005). The DHBs were likely to be quite receptive to health providers which promised to deliver health targets, i.e. services in areas such as Māori health, upon which there was placed specific MoH emphasis.

These changes acknowledged that to reduce Māori/Non-Māori inequalities it would be necessary to improve mental health services to Māori, such as enhancing mainstream mental health providers and increasing the number of Māori in the mental health workforce (Durie, 2005).

The New Zealand Public Health and Disability Act (2000) required DHBs to be compliant to the Treaty of Waitangi principles to improve health outcomes for Māori. Section 4 of the Act refers to “mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services”. In response the MoH and DHBs gave priority to programmes designed to reduce the disparity in health, social and economic outcomes, which included supporting ‘by Māori for Māori’ services (Te Puni Kokiri, 2002).

Māori Health Strategy and Mental Health Service Development

In 2002 the He Korowai Oranga Māori Health Strategy (Ministry of Health, 2002) was released in response to the acknowledged disparity between the health status of Māori and non-Māori. This strategy, which was established by the New Zealand Public Health and Disability Act of 2000, identified four pathways to redress this status.

- Development of whānau, hapū, iwi and Māori community
- Māori participation in the health and disability sector
- Effective health and disability services, and
- Working across sectors

DHBs had a statutory obligation to foster Māori participation and the ability to provide for their own health needs. The strategy did not provide enough clear guidance about appropriate models of care, and because Māori are a diverse population with urban/rural and age differences and regional iwi variation in tikanga practices this strategy may be seen as an ambiguous document for planning service provision. *Whakatātaka: Maori Health Action Plan* (Ministry of Health, 2002) was subsequently released to guide the DHBs to implement *He Korowai Oranga*. It outlined the roles, responsibilities, performance expectations, measures and initiatives to achieve the strategy. The priority was the “ongoing focus on DHBs and mainstream providers to ensure greater effectiveness of the resources and initiatives aimed at improving Māori health outcomes” (p.5).

In 2014, the Māori Health Strategy (Ministry of Health, 2014) was updated and future-proofed following cross sector input. The foundations of the initial

framework; whānau ora (healthy families), mauri ora (healthy individuals) and wai ora (healthy environments) were strengthened and given relevance for the future by being woven together into pae ora (healthy futures). The strategy encourages those in the health and disability sectors to plan holistic pathways for reducing disparities between population groups, improving Māori health and ensuring Māori are involved in decision making and service delivery.

The current Mental Health and Addiction Service Development Plan: Rising to The Challenge 2012-2017, (Ministry of Health, 2012) aligns with the Maori Health Strategy in its focus on improvements to models of care and the resources in place for Māori. Priority actions include evaluating pilot kaupapa Māori programmes for substance use prevention, funding programmes and raising awareness of mental illness, actively involving Māori in the identification of disparities for Māori and in service planning, and contributing to Whānau Ora initiatives. The plan sets out work schedules for the Ministry and both the DHBs and NGOs.

The local response to the Māori health strategy - Hawkes Bay DHB

The development of Māori mental health services in Hawkes Bay is only accessible as an oral history and it has not been possible to ascertain if documentation exists that charts the journey that took place before the DHB response '*Agenda for Action*' was released in 2005. However, Hawkes Bay Māori Health Unit (MHU) staff remember the events during the time of deinstitutionalisation in the late 1980s and through the 1990s. Conversations with Dianne Wepa, a social worker and Te Ata Munro, a nurse who have worked for many years at the Māori Health Unit, told of the process and effects on the whānau of Hawkes Bay and the mental health service delivery:

“Whānau had to prepare to receive tangata whaiora home from 1993 when the (psychiatric) institutions closed. The whānau realised they did not have the resources or health care expertise to care for their tangata whaiora at home and so they met and formed Trusts” (Personal communication).

These Trusts were seen as an innovative solution for mental health but they were not necessarily innovative from a cultural viewpoint as they were collections of whānau,

very like the classical hapū (extended family) and part of the larger iwi (tribe). This was the beginning of iwi taking on the formal role of (mental health) service providers.

The Trusts, with funding from the Crown Health Enterprise (CHE) purchased two houses for tangata whaiora – one in Hastings and one in Napier. Directors and Boards of Trustees were established and had a Māori Community Mental Health Social Worker (CMHSW) and a Māori Enrolled Nurse to liaise with Community Mental Health (CMH) services. At this time another local innovation occurred, in that the CMHSW and nurse were referred to as Kaimanāki, (those supporting, or looking after). With Te Reo names for the staff and Trusts operating under the CHE umbrella, Māori providers began to be more prolific and more assertive throughout the country. Gauld (2001), enumerates Māori providers in 1993 as 23, and circa 1999/2000 as over 200. This suggests that the deinstitutionalisation programmes prompted the proliferation of Māori provider services, and highlighted the cultural safety requirements for mainstream providers. Cultural safety will be discussed later in this chapter.

Following trial and error, the Trust houses were successfully implemented in Hawkes Bay and other areas of New Zealand followed similar plans – for example Porirua also set up a Māori Health Service staffed by Kaimanāki. When CHEs were reformed as District Health Boards (DHBs) in 2001 via the New Zealand Public Health and Disability Act (2000), the funding arrangement changed and the national health targets were set. The DHB's responsibility was for planning, funding and ensuring the delivery of health and disability services in their area (MoH, 2006) therefore the tangata whaiora houses (and two others established meanwhile) were “not core business” and were closed by the DHB. A mainstream respite facility was opened to replace them. The DHB effectively put the responsibility for community care of Māori mental health service users entirely with the iwi.

Hawkes Bay had already in existence an iwi driven Māori health provider Te Taiwhenua o Heretaunga (TToH), which had in place medical, dental and midwifery services. Mental health care was not offered by TToH at that time, however the two Trust whānau houses disposed of by the DHB were taken over by TToH and the

whānau Trusts stepped away. Now there was the understanding that Māori had a choice of having their mental health needs met by Māori at TToH, with the oversight of the DHB, or by mainstream services.

Mental health service utilisation by Māori

The most recent Ministry of Health data on mental health service use in New Zealand 2011/2012, (Ministry of Health, 2014) showed DHB mental health teams of all types saw 147,972 clients, of which 37,321 were Māori. The services most commonly accessed for help were DHB Community Mental Health Teams (CMHTs), by 64% of people. The prevalence rates of serious mental disorder indicates Māori continue to have higher rates compared with the rest of the New Zealand population; for Māori males 5041 per 100,000 (non-Māori/non-Pacific males 2856) and Māori females 3676 per 100,000 (non-Māori/non-Pacific females 2464). The total prevalence rates for Māori compared to non-Māori per 100,000 are 4338 compared with 2660, an increase of 54.6% for Māori and 25.8% for non-Māori since 2001/02. Māori were 68% more likely than non-Māori to be admitted to hospital for a mental disorder during 2011-2013. Schizophrenia related disorders were the most common, followed by mood disorders then substance abuse, and lastly anxiety disorders (Robson et al., 2015).

The Hawkes Bay District Health Board Māori Health Profile (Robson et al., 2015) states the Māori population within the Hawkes Bay District Health Board (HBDHB) region in 2013 to be 39,500, up from 33,903 in 2011. This figure shows that Hawkes Bay has a higher proportion of Māori living there compared to the national average. Ministry of Health (2010) data, shows that Hawkes Bay DHB adult mental health teams saw 2190 people aged 20 to 65 in 2007/08; 36.39% of whom identified as Māori, compared with the total New Zealand figure of 20.6%. This figure of 36.39% is a high proportion of Māori presenting at 'mainstream' mental health services considering that Māori make up 25.3% of the Hawkes Bay population. Kaupapa Māori mental health services New Zealand-wide saw a total of 2990 adult clients, with the make-up approximately 83% Māori. The number of clients seen at Kaupapa Māori mental health services in Hawkes Bay is not yet available, however the suggestion is that if the trend of 2007/08 has continued, Kaupapa teams will see a

larger proportion of the total Māori population in Hawkes Bay, which will reduce the percentage of clients seen by mainstream mental health.

In fact, the HBDHB adult CMHTs, as at August 2015, had seen 2549 people of which approximately 33.6% identify as Māori (HBDHB Patient Administration System accessed 3.8.15). Of the 28 mental health clinicians employed by the CMHTs, four are Māori (one nurse, one psychologist, one community support worker, one dietitian). The non-Māori clinicians are predominantly from the United Kingdom but also South Africa, USA, India and European Union.

It is from this Community Mental Health Team region that participants have been recruited for this study on the basis that this is the ‘normal’ care many Māori whaiora receive. It has not always been well documented what models of care have been in place at the HBDHB, however it is accepted now that normal care is guided by the Recovery-oriented approach. Therefore it is important to gain insights into the nature of such a model of care.

Recovery and Recovery-oriented Care

Recovery as a construct is widely used in mental health discourse, but what does ‘recovery’ mean in practice? Is recovery something individuals experience, services promote or systems facilitate? Recovery is a broad multi-dimensional process which has been interpreted in a number of ways. William Anthony (1993) described recovery from mental illness as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles...a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness” (p.15).

Jacobson and Greenley (2001) proposed a model of recovery identifying “internal and external conditions” which when combined were responsible for the process of recovery (p.482). The internal conditions are the attitudes, experiences and processes of change of the recovering individual such as a belief in recovery, active participation in self-help, accepting responsibility for self-care and achieving goals, and finding roles to play in the world. External conditions for facilitating recovery include the providers having regard to the human rights of the client, and providing an environment characterised by tolerance, listening, empathy, compassion, respect,

safety, trust, diversity, and cultural competence. They argued that one of the key components to building a bridge between the internal and external conditions is the development of collaborative relationships between consumers and providers which is “one in which both consumer and provider come to see each other as human beings” (p.484).

There are also experientially-based understandings of recovery such as those from a Delphi survey by Richard Lakeman in 2010. The 31 respondents, who were all ‘experts by experience’ of recovering from mental illness, offered their definitions of recovery with the most dominant themes being: transcending the need for psychiatric services, living with one’s-self and finding personal meaning. It is noted that Lakeman’s study was based on a Western perspective of recovery, which tends to focus on an individual process rather than a collective and interpersonal one. Ida (2007, p.52) poetically defines recovery from a cultural perspective thus:

Recovery for diverse populations must
respect the importance of culture

Must heal the wounds brought on by
discrimination

Must provide the skills to make a
person feel whole, competent and
worthwhile

And recovery means making the
environment safe...to just be.

In Aotearoa/New Zealand the Mental Health Commission Blueprint (1998) simply defined recovery as “living well in the presence or absence of illness” (p.1) and in 2001 the Commission developed recovery competencies for New Zealand mental health workers which identified that a competent mental health worker:

- understands recovery principles and experiences in the Aotearoa/NZ and international contexts
- recognises and supports the personal resourcefulness of people with mental illness

- understands and accommodates the diverse views on mental illness, treatments, services and recovery
- has the self-awareness and skills to communicate respectfully and develop good relationships with service users
- understands and actively protects service users rights
- understands discrimination and social exclusion, its impact on service users and how to reduce it
- acknowledges the different cultures of Aotearoa/NZ and knows how to provide a service in partnership with them
- has comprehensive knowledge of community services and resources and actively supports service users to use them
- has knowledge of the service user movement and is able to support their participation in services
- has knowledge of family/ whānau perspectives and is able to support their participation in services (p.7)

Recovery approaches according to Lapsley, Nikora and Black (2002) are also congruent with Māori models of wellbeing in that “a balance is sought between the body, person, whānau, and the environment and ecologies within which they exist” (p.2). Recovery therefore seems to mean the personal process one goes through from being unwell to living a life which brings fulfilment, being more autonomous and having choices about the psychiatric services they access, accepting oneself unconditionally and being accepted by others for being oneself. Recovery in a Māori cultural context also has regard for the wellbeing of the whānau/family. It would appear recovery is the journey as well as the destination.

The research of Ianovski (2009) questioned whether recovery practices within New Zealand mental health services should be monitored and if so, how should each organisation’s recovery orientation be measured. A qualitative inquiry, within a critical realism framework, allowed her to hold focus groups with mental health consumer advocates (many of whom were former service users) and those with direct policy-making input (such as managers) for their views on recovery and the appropriate tools for measuring organisational application and outcomes of recovery

promotion. The findings suggested that recovery-orientation was seen to be achieved when “positive aspects of the service user and their reality were emphasised rather than their problems” (p.71).

Competencies for recovery-oriented practice have also been described in the international literature. Lakeman’s survey (2010) ranked recovery ‘competency statements’ from around the world according to the respondent’s view of its importance. In this project 31 respondents, 13 males and 18 females, with ‘expertise by experience’ of recovery were recruited using a ‘snowballing’ method. They were invited to visit the project website by members of the Irish Institute for Mental Health Recovery. Twenty-five were from the United Kingdom, two each from Australia and the United States, and one each from New Zealand and Germany. Twenty-three of the respondents reported having being diagnosed with a mental illness, and hospitalisation had been experienced by 12 people. Lakeman noted that there was near consensus on those ‘recovery competency statements’ rated most important. The top six were:

- A competent mental health worker recognises and supports the personal resourcefulness of people with mental illness (Mental Health Commission, 2001)
- To work in a recovery focused way mental health workers need to reflect a belief that recovery is possible (NHS Education for Scotland and Scottish Recovery Network, 2007)
- To work in a recovery focused way mental health workers need to
 - be able to listen to what service users are actually saying and respect their views (NHS Education for Scotland and Scottish Recovery Network, 2007)
 - reflect respect for the expertise and unique knowledge gained as a result of having experienced mental health problems (NHS Education for Scotland and Scottish Recovery Network, 2007)
- A competent mental health worker
 - helps the person develop self-belief, therefore promoting their ability to help themselves (Barker & Buchanan-Barker, 2008)

- has the self-awareness and skills to communicate respectfully and develop good relationships with service users (Mental Health Commission, 2001).

These recovery competencies resonate within the words of the storytellers in this research and also of relevance to this thesis is the emphasis on cross-cultural practice within New Zealand's recovery competencies (Mental Health Commission, 2001), presented earlier in this chapter. The competency states; "A competent health worker acknowledges the different cultures of Aotearoa/NZ and knows how to provide a service in partnership with them" (p.59). The dynamics of cross-cultural practice also feature in the accounts from the participants in this study.

There is argument of the need to "acknowledge cultural diversity and a connection to one's own culture as a key to recovery" (O'Hagan, 2004, p.2). Recovery, discussed so far in this chapter has been viewed from a Western viewpoint with its focus on an individualistic personal recovery rather than collectivist, interdependent recovery. When viewed through a cultural lens such as that of Māori, recovery must have a focus "on recovery being whole-family led rather than individually focussed" (O'Hagan, Reynolds & Smith, 2012, p.61) and a recognition that healing does not only refer to the individual's lessening of distress but to the extended family moving towards better health and functioning (Jacobson & Farah, 2012). This strengthens the requirement that all clinicians working with whaiora "have knowledge of family/whanau perspectives and [be] able to support their participation in services" (Mental Health Commission, 2001, p.7). This competence is further enhanced in The Code of Rights and Māori Concepts of Health (Health & Disability Commissioner) which states "The wellbeing of the individual cannot be enhanced without recognition of the importance of whanau wellbeing to that individual. Similarly, whanau wellbeing is enhanced by the individual wellness of its members".

Of further relevance to recovery for Māori is the need to acknowledge the broader political and historical legacies such as colonisation and "current experiences of violence, deprivation and discrimination" (Jacobson & Farah, 2012, p.335) in the wider Māori community. How these issues, which have been implicated as causes of Māori health disparity (Hefford, Crampton & Foley, 2005; Ellison-Loschmann &

Pearce, 2006), are acknowledged and addressed by legislation, health providers and individual practitioners within recovery-focussed practice, may indeed improve treatment outcomes for Māori. These ideas suggest that recovery-oriented practice needs to be political as it involves redressing injustices and social inequalities as well as psychological and social processes.

Bicultural competence in Aotearoa/New Zealand

The Treaty of Waitangi and the social policy principle of biculturalism have become an explicit template for relationships between indigenous Māori and subsequent migrants (De Souza, 2006, para.4). Biculturalism, therefore, refers to the two cultures of Aotearoa/New Zealand; Māori, and the non-Māori multicultural of the subsequent settlers. Bicultural competence requires that one know oneself and one's own culture, develop a deeper understanding of the perspective of the tangata whenua treaty partner, and learn how to interact appropriately and respectfully on Māori terms (University of Canterbury, n.d.).

The notions of bicultural competence and cultural safety in Aotearoa/New Zealand draws on the work of Irihapiti Ramsden (1990) who linked the poor health outcome of Māori to culturally inappropriate or insensitive health services. Cultural safety, or kawa whakaruruhau, was developed as a critical lens through which to view those health interactions which drew attention to the power imbalances thought to exist between Māori whaiora and the dominant health care system:

Cultural Safety began with the Māori response to difficulties experienced in interaction with the western based nursing service. ... [It] gives the power to the patient or families to define the quality of service on subjective as well as clinical levels. (Ramsden 2003, p. 110)

The Nursing Council of New Zealand introduced cultural safety into nursing and midwifery curricula and examinations in 1992 (Nursing Council of New Zealand, 2005) and it has continued to be of central importance to any discussion of health education, planning and delivery in healthcare settings and across disciplines.

Guidelines for developing cultural competence and ensuring cultural safety have been articulated within wider health care (eg. Durie, 2001; Hera, 2013). Durie clarified the difference between cultural safety and cultural competence thus - “Cultural safety centres on the experiences of the patient, while cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context” (Durie, 2001, p.2). Hera agrees with Durie’s definition and draws the notion even closer to the practice of health care, saying “Cultural safety fits better [than cultural competence] with a patient centred stance. The patient can and should determine what is culturally important to his or her needs” (Hera, 2013, p.49).

New Zealand’s ‘Health Practitioners Competence Assurance Act 2003’ (the HPCA Act) requires each health profession’s regulatory authority to set standards of clinical and cultural competence. Cultural competence standards are integrated within the Core Competencies of regulatory authorities such as the Psychotherapists Board of Aotearoa New Zealand (2015-), which requires that:

All psychotherapists will be knowledgeable of culturally safe practices, and familiar with the Treaty of Waitangi and be able to integrate these into their practice in ways that ensure that issues of diversity and equality are valued, upheld and promoted (p.1).

And the New Zealand Psychologists Board (2011) cultural competence guidelines that require psychologists to possess:

The awareness, knowledge, and skill, necessary to perform a myriad of psychological tasks that recognises the diverse worldviews and practices of oneself and of clients from different ethnic/cultural backgrounds (p.4).

It is acknowledged in both these authority’s competence documents that acquiring cultural competence is an accumulative process and practitioners should take all reasonable steps to develop, maintain and improve their practice with diverse populations.

The seminal article on Māori health and views of wellness is that of Professor Sir Mason Durie (1985) who in 1982 introduced the model ‘Te Whare Tapa Wha’ at a meeting of the Māori Women’s Welfare League. Many approaches and guidelines draw on this model. This is an holistic framework illustrated as a four-sided house

which represents “the four basic tenets of life” (Durie, 1985, p.483) and highlights the necessity for Māori wellbeing to have harmony and balance amongst the four elements: te taha wairua (spiritual wellbeing), te taha hinengaro (mental wellbeing), te taha tinana (physical wellbeing) and te taha whānau (family wellbeing). The model, along with other subsequent variations (eg. Pitama et al., 2007) have formed an integral part of cultural competence training and practice with Māori whāiaora.

Te Pou (2010), providing guidance for working in a culturally competent way with Māori whāiaora, highlight the importance of engagement, saying, “Engagement and the quality of the therapeutic relationship consistently emerge as the most important aspect in creating and sustaining interventions for change” (p.21). The document goes on to advise that the steps needed to improve the responsiveness of mental health services are to develop more kaupapa Māori services, train more Māori health professionals, use more Māori models in mainstream services and train non-Māori clinicians in culturally competent practice. They do acknowledge that non-Māori who have bicultural training will still not be able to operate from a Māori base. This suggests that there remains an underlying lack of confidence in non-Māori being able to effectively engage with Māori.

The most recent survey of the Māori adult mental health and addiction workforce (Te Pou, 2014), found that of the 189 health organisations that responded, 51 reported delivering kaupapa Māori adult mental health and addiction services. Those included 11 DHBs and 40 NGOs (Non-government organisations), and of those 40 NGOs, 34 reported delivering kaupapa Māori services only. The workforce across all 51 services delivering kaupapa Māori services totalled 911 FTE (full-time equivalent) positions; with an average of 18 FTEs perservice. The services surveyed:

- felt that they needed to increase cultural competence for working in te reo Māori me ona tikanga,
- were concerned about future shortages of staff to fill registered nurse and addiction practitioner roles, and Māori staff to fill clinical roles,
- noted that recruiting qualified and experienced staff was one of their workforce development challenges,
- stated that relationships were working well with primary health practices,

Māori continue to be under-represented in the frontline health professional roles. Explanations for the challenge of growing the Māori workforce include historical, political, demographic, cultural, academic and financial factors (Curtis, Wikaire, Stokes & Reid, 2012). These factors include a lack of marketing of health careers, few Māori students leaving school with science and maths qualifications (which hamper entry into tertiary health courses), the inability of Crown outcomes to incorporate both Māori and non-Māori worldviews, lack of suitable supervisors, negative placement experiences, lack of acknowledgement of Māori worldview in courses and organisations, institutional racism, lack of cultural safety of organisations and a lack of available career paths (Auckland Regional Public Health Service, 2004). Problems have also been identified within the current Māori non-regulated health workers training including very basic training, limited career structures and lack of clarity about the qualifications the sector accepts as the minimum standard for Kaimahi/Māori Community Health Workers (NZQA, 2013).

The report discussed above by Auckland Regional Public Health Service was the driver for the Ministry of Health's *Te Uru Kahikatea: The Public Health Workforce Development Plan 2007-2016* (2007), with its objectives to:

- encourage Māori recruitment and retention in public health careers where Māori are under-represented
- enhance training and development opportunities for Māori in public health
- reduce training and development barriers for the Māori public health workforce
- increase cultural support in the workplace for Māori
- improve the responsiveness of the overall workforce to Māori health needs
- implement strategies to advance careers and leadership opportunities for Māori working in public health.

To summarise, the key principles of cultural competence put forward for non-Māori working with Māori by Ramsden (1990), Te Pou (2010), and Hera (2013) can therefore be articulated as the need for awareness of power differentials and making attempts to reduce this imbalance. Culturally safe practice, therefore, enhances the whaiora's experience of the care they receive and respects the unique cultural identity of the individual whaiora within the broader Māori culture. It also requires

the non-Māori clinician to develop the skills to incorporate culturally relevant models (eg. Te Whare Tapa Wha), and practices (eg. karakia, waiata, mihi) for the comfort and recovery of the whaiora. There is noted also the need for non-Māori to be mindful that bicultural training is helpful but not sufficient to fully understand the Māori worldview. This research acknowledges these key points whilst suggesting that despite cultural distance and difference, through an openness to engage and respectful dialogue, positive and affirming human-to-human relationships which support recovery may be possible.

Cross-cultural competence

Cultural competence has traditionally been based on the assumption that therapists “should possess cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture” (Sue, 2006, p.237). This assumption led to the development of conceptual frameworks, such as the following developed by Sue, Ivey and Pedersen (as cited in Sue, 2006) which was adopted by the American Psychological Association in its *Multicultural Guidelines* (2003) which reads:

- Cultural awareness and beliefs: Provider’s sensitivity to her or his personal values and biases and how these may influence perceptions of the client, client’s problem, and the counseling (sic) relationship.
- Cultural knowledge: Counselor’s knowledge of the client’s culture, worldview, and expectations for the counseling relationship.
- Cultural skills: Counselor’s ability to intervene in a manner that is culturally sensitive and relevant.

However, Sue (2006) questions the practical application of such guidelines, asking if it is possible to ‘know’ all cultures, how much knowledge is enough, and if it is possible or desirable to manualise cultural competence skills. In other words, as Le Baron (2003) explains, culture is multi-layered and therefore, generalisations which you see on the surface are not the whole story. Le Baron also points out that culture is dynamic; it changes and adapts as conditions change, therefore understanding a culture must take into account the dimensions of time, context and individual differences. Knowing the cultural norms of a group does not take into account the

individuals who may not conform to the group norms for personal or contextual reasons. Le Baron also reminds us that culture operates below the surface – influencing identity and value systems which are outside the awareness of the outsider.

Sue (2006) therefore presents cultural competence in terms of ‘process’ and ‘content’. Process refers to the skills of therapists who do *not* prematurely draw conclusions about the culture of others, and who do develop creative ways to test alternative explanations for client presentations. Content refers to the strategies and tools culturally competent therapists access to improve self-awareness, such as one’s own feelings of discomfort working with culturally different people and having full awareness of the client’s history, cultural values, perspectives and level of acculturation.

Singer and Tummala-Narra (2013) also emphasised the importance of collaborative, empathic relationships, and the potentially negative consequences of ignoring underlying tensions when working with a culturally different client. They stressed the need for therapists to understand their own socio-cultural identities and how they may impact on cross-cultural work.

The complexities of working with culturally different people, in this case Australian Aboriginals, were raised by Bennett, Zubrzycki and Bacon (2011) who highlighted the importance of critical self-awareness and found that the introduction phase of a relationship was the most significant part of creating links. The Aboriginal people they spoke with valued deep respectful listening, having space and time, and the therapist’s tolerance for silences and pauses for them to tell their story. This focus on respect and space and time for listening has also been articulated in research related to cross-cultural practice with Pacific Island people in Aotearoa/New Zealand. (Tiatia-Seath, 2014).

Previous research into supporting mental health and recovery for Māori

Much of the research undertaken in the area of Māori and Mental Health care is concerned with the needs of the organisation, such as setting health targets, and developing programmes to reduce health care inequity. A review of the literature was

undertaken and searches related to Māori mental health revealed reports focused on *outcome* (Durie & Kingi, 1997), *expectations* (Huata, 1999), *experience* (Fenton, 2000; Moeke-Maxwell, Wells & Mellsop, 2008), *discourse* (Cram, Smith & Johnstone, 2003; Crocket, 2010), and *recovery* (Wirihana, 2008; Abel & Marshall, 2009).

In 1997 Durie and Kingi developed and evaluated a Māori measure of mental health outcome, 'Hua Oranga'. It was developed in response to the perceived need for the effectiveness of mental health care for Māori to be assessed in a more culturally appropriate way. The tool is based on the holistic framework of Te Whare Tapa Wha, using three schedules and three perspectives of outcome (tangata whaiora, clinician and family/whānau). The tool is intended to provide a multi-dimensional assessment of recovery, however it does not take into account *how* the tangata whaiora achieved recovery, only how well they recovered.

Another lens for research into recovery has seen a focus on the expectations tangata whaiora may have for the outcomes mental health services should achieve. Huata (1999) used focus groups to explore the views of tangata whaiora, whānau and Māori mental health workers. The emergent themes were Control, Recovery, Māori Participation and Outcomes. Initially maintaining control throughout the period of contact with mental health services was important, participating in policy-making, choice in accessing services, and the opportunity to be working and living independently. Recovery as an active process of involvement in Māori activities was seen as important with participation in all stages of the planning, implementation and monitoring of service delivery and finally the development of outcomes appropriate for Māori. These issues raise further questions such as how 'control' and 'recovery' are interpreted by tangata whaiora and clinicians and how a common understanding is achieved.

Wirihana (2008) published a monograph about the effectiveness of including kapa haka as part of the recovery model in the community-based *Kapua Awatea Māori Mental Health Service, Auckland* as a mental health outcome measure. It was anticipated that including kapa haka, Māori knowledge, language and culture in their recovery plan would enhance the recovery of Māori whaiora. The outcome was seen

as very positive based on tangata whaiora feedback and it was envisioned that administration of the Hua Oranga outcome measurement tool in future would aid evaluation.

Abel and Marshall (2009) carried out an evaluation of the Wairua Tangata Project, a Hawkes Bay primary mental health initiative for Māori mental health. Levels of distress were recorded using the Kessler-10 (K-10) which assesses ten symptoms indicative of psychological distress. The primary indicators of tangata whaiora recovery were the reduction in K-10 scores, higher attendance rates and self-reported client progress and gratitude. Although this research provided a view of outcome and satisfaction related to a Māori mental health initiative, it does not illuminate the processes that enabled positive recovery.

Further understanding of Māori mental health experience is presented in Fenton's (2000) collection of stories *Four Māori korero about their experience of mental illness*. The research fits into both Kaupapa Māori and critical/post-structuralist milieu and consists of the telling of stories of recovery from mental health problems by tangata whaiora. It was developed in response to the outcome of a hui which emphasised Te Whare Tapa Wha (Durie, 1994) as the philosophical framework for Māori health and wellbeing. This holistic philosophy and the Māori ways of communicating oral history (kōrero paki and kupu tuku iho) anchor the work within a Kaupapa Māori framework. The sharing of tangata whaiora's stories were an opportunity for them to articulate what helped (e.g. "My extended family was also informed about what was going on for me through conference calls" p.26) and what hindered their recovery (e.g. "I wasn't fully informed or a part of decision-making" p.14). Whilst the stories shared important insights and provided a general overview there was no further interpretation of those experiences in relation to what led to successful outcomes..

Another example of outcome expressed as experience is the research of Moeke-Maxwell, Wells and Mellsop (2008). Focus groups of whaiora from seven regions of New Zealand were thematically coded to analyse the experience of being diagnosed with a psychiatric illness. Computer software (NVIVO) was used to categorise the data which enabled conclusions to be drawn. The results suggested that overall

tangata whaiora made meaning out of what they were experiencing, felt that diagnosis helped them to make sense of their distress, and wanted to participate in their own recovery.

Cram, Smith and Johnstone (2003) conducted research using discourse analysis within a Kaupapa Māori framework. Semi-structured interviews were conducted with a purposive sample of tangata whaiora utilising marae-based physical health programmes. The interview questions and analysis were structured in such a way as to fit Kaupapa Māori ontology. A critical lens was used with the associated assumption that discourses are maintained by such issues as knowledge claims, power imbalance and oppression of one culture by another. The authors noted that in mainstream health services the Western or medical discourse is dominant and Māori discourse is marginalised. The researchers acknowledged their own world-view as Māori-centric, and that the research is viewed through their pro-Kaupapa Māori lens. The participants however acknowledged that when they were respected and rapport was established, they were better able to relate to and make sense of their treatment regardless of being in mainstream or Kaupapa services.

Culturally competent practice also continues to be of relevance in healthcare research. Within Aotearoa/New Zealand, PhD research into the cultural competency in a medical school curriculum (Pitama, 2012) and in the practice of experienced psychologists (Waitoki, 2012) both turned up unexpected results which suggested there is currently effective naturally occurring bicultural engagement and practice, upon which to build further skills.

Suzanne Pitama (2012) qualitatively investigated indigenous health curriculum at the University of Otago Christchurch medical school. She found that although there was at times a lack of cohesion between the university and the wider health system's view of indigenous health competencies, there were positive impacts on the relationship between the students and Māori patients, whānau and community. Engagement was seen to be positive in terms of feeling that a positive relationship was developed, power and expertise were shared, trust was identified, and there was a better understanding of how the other interpreted the interaction.

Moana Waitoki (2012) conducted a training needs analysis to identify the Awareness, Knowledge and Skills (AKS) that 30 experienced psychologists used in their practice with Māori whaiora and their whānau. She unexpectedly found that the psychologists used distinctly Māori cultural practices, Māori tikanga and Māori knowledge with their clients despite having had little or no bicultural training. The psychologists used Māori cultural practices in an every-day fashion, regardless of whether or not they were clinical practices. An example from her study is a vignette illustrating the use of te reo (Māori language) to assist engagement: Jean, a non-Māori psychologist was at a meeting of whaiora, whānau and three other health professionals. She recognised that the father of the whaiora was uncomfortable and not participating in the discussion. Jean went to sit next to him and called him by his full Māori name, ensuring she pronounced it correctly. The father responded to this by looking at her, speaking with her and then participating in the discussion.

A project with a positive focus on discourse is that of Crocket (2010) who considers that the “conceptualisations of appropriate practice have been built upon a Māori-Pākehā binary that increasingly excluded many clients and (counselling) students” (p.3). His project examined the practice of a female non-Māori counsellor with a young Māori male. As the counsellor reflected on her Pākehā and gender identity she was able to challenge the discursive restraint which had produced for her an ambivalence about working with young Māori males. Reflectively exploring her identity, cultural competence and the culturally appropriate discourse ‘like work with like’ caused a shift in her thinking and practice with positive effect for her client. The counsellor, reflecting on her tentativeness with the Māori client and her awareness of the restraints of cultural safety, found a way to increase dialogue in her workplace around difficult cultural issues.

There has been one research project (Cram, 2010) investigating the potential of using Appreciative Inquiry within whānau research. The principles of AI including its assumptions of multiple realities, positive focus and welfare for all, were consistent with the principles of structural collaborative change underpinning Kaupapa Māori research (Smith, 1997). Cram concluded that AI was compatible with Kaupapa Māori research and has potential as a research method with Māori whānau.

The previous research sampled in this chapter has focused on the experiences, expectations and recovery journeys of whaiora in mainstream settings. When there was a perceived lack of consideration for their comfort, participation and holistic wellness the experience was described in negative terms. However, when there had been attention given to recovery-focused practices such as respectful relationships, and room given for Māori concepts, whaiora tended to feel more involved and supported in their recovery. How these respectful relationships and awareness of the need for tikanga Māori developed is an important focus of the present research. A small number of studies have begun to explore practice with Maori whaiora using a positive lens, and the findings indicate that this could be a fruitful approach to explore what works well in cross-cultural exchanges.

This research gap this study addresses is how Māori whaiora and non-Māori clinicians in a mainstream community mental health team achieved positive outcomes despite having few Māori resources.

Conclusion

This chapter has discussed disparity in the health status of Māori people compared with other people in Aotearoa/New Zealand and how Māori people are accessing mental health services, and introduced the concepts of recovery, cultural competence and cultural safety. I have discussed how legislation, policy and health care decisions have at times aided and at other times disadvantaged Māori. National events such as the closure of the large mental health hospitals prompted the development of local solutions for whaiora and led to efforts at collaboration, pooling the resources of whānau, hapū, iwi and the wider community. Research into Māori mental health experience has often found that Māori solutions have much to offer Māori recovery needs, nevertheless as Māori continue to access mainstream services there is need for ongoing reflection on what seems to be helpful and encouraging in these services.

The literature review also highlighted significant interest in the mechanisms of recovery for Māori and the process of bicultural working with non-Māori health providers. Whilst there has been historic criticism of non-Māori ways of working with Māori - much of it validated in the stories of whaiora in previous research -

there are also glimmers within the research of the possibility that non-Māori clinicians can work in a culturally safe manner and achieve positive outcomes for Māori whaiora. This is significant due to the large numbers of Māori still accessing mainstream services, either by choice or necessity. This research, *Supporting mental health recovery for Māori whaiora: The success stories of Māori whaiora and non-Māori clinicians*, will further investigate the possibility of effective cross-cultural mental health engagement. Bringing the lens of hermeneutics to explore meaning in cross-cultural practice intends to bridge the gap in understanding what works well. The next chapter discusses the strengths-based methodologies selected for this research and how they are intended to shed light on this phenomenon.

Chapter Three

Methodology

This research was underpinned by the methodology of Gadamerian Hermeneutics, with a focus on the interpretation of meaning within the participant accounts. It was further informed by bringing the lens of Appreciative Inquiry to frame the research in terms of what worked well. I will now explore the rationale for the choice of methodologies, the philosophical underpinnings of each approach, and the contributions of each within the journey to this research and the ongoing conduct of the study.

Methodological influences

This hermeneutic research is framed within an appreciative approach, drawn from Appreciative Inquiry (AI), seeking to explore how non-Māori clinicians and Māori former tangata whaiora/mental health service users described the peak experiences working together. The interest for this research began with the desire to understand how non-Māori and Māori can work together effectively, including their views on their perceived effectiveness, hence the positive focus of the research question. It was important for me as researcher, and for the participants involved, that this was a study that affirmed and celebrated care that was experienced as helpful. It was my early reading of the principles of AI that showed me the respectful path into this project. Nevertheless, I recognised it would be difficult to bring together a group of participants to work collaboratively on the steps towards change that AI proposes. It was at that stage that I decided to add a hermeneutic approach to a research process where I was the main interpreter of data. I was confident that the AI approach to questioning was very congruent with how questions would be framed from a hermeneutic perspective.

The method of analysis was guided by the hermeneutics of Hans-Georg Gadamer. The aim was to understand more about the practice of non-Māori clinicians with Māori tangata whaiora and the tangata whaiora perceptions of the interactions, to gain a deeper understanding of effective cross-cultural practices. Using hermeneutic analysis the research sought to uncover what understandings each participant brought to the mental health treatment relationship and how the subsequent new understanding between them led to a positive mental health outcome. The paradigm of interpretivism has the assumption that to understand how non-Māori clinicians and Māori service users work successfully together part of the truth is to be found in the self-understandings of each party.

Māori understandings from my own background, and that of my participants and cultural supervisor, provided a vital and dynamic worldview context within which to situate Māori voices in the research, to ensure they were heard and not distorted in the analysis process. I myself became more and more drawn back into my own heritage of being Māori as the research progressed. This has been a personal gift from the research.

The philosophical underpinnings of Appreciative Inquiry

Appreciative Inquiry provided the initial method of engagement with participants and lead to the stories-as-data, with the focus firmly on successful practice in mental health care interventions. This integrates with research involving Māori as it is considered to be a culturally congruent manner of conducting research which is respectful of participants (Cram, 2001).

Appreciative Inquiry (AI) requires data to be ‘collected’ by asking participants for their stories about the best or most positive experiences of cross-cultural working from their perspective. This is termed the *Discovery* step and it is the participants experience which is valued. When AI is used as a development tool there are three further steps which are collaboratively worked on by the participant/s and researcher and are amenable to creative adaptation. Usually the second phase is *Dream* when the themes are drawn from the stories about how things could be even better, followed by *Design* when the possibilities or propositions are made. Finally there is

the *Destiny* step which is an action plan, a generative phase when the best of the past can be projected into the future (Cooperrider, Whitney & Stavros, 2008).

This research draws on the *Discovery* step, taking the intention to focus on the positive aspects of patient and clinician experience. It is not within the scope of this research to pursue the programme development steps of *Dream*, *Design* and *Destiny*, however as researcher I offer my own sense of dreaming, designing and destiny in offering recommendations that arise from the findings.

AI, although originally aimed at the consultant seeking organisational change, is well demonstrated as a tool of community development and as a qualitative tool it captures the narrative and the future-focus of the community. I refer to Elliott (1999), who in his book cautions against using AI in a mechanical way, instead urging the researcher to use “art as much as science, poetry as much as prose...a spark of creativity, of humour and humanity (and) the capacity to surprise and be surprised” (p. 57).

AI started with the doctoral work of David Cooperrider (1986) in which the positive historical elements of an organisation was the source for discovering possibilities for a better future. The first AI article was published by Cooperrider and Srivastva in 1987 in which the philosophical underpinnings that the framework builds on were articulated. Very few articles were published between then and 1999 (e.g., Jones, 1998; Whitney & Cooperrider, 1998), when Cooperrider and Whitney (1999) published the first book on how to do AI; since then the number of articles, books and dissertations using AI has burgeoned. The Appreciative Inquiry Commons website alone has over one hundred references and entire community projects such as those run by the International Institute for Sustainable Development (IISD), a Canada-based public policy research institute who are using the AI principles and methodology. Two examples are the Skownan First Nation Community Values Project (Ashford & Parry, 2001) in Northern Canada, which is looking at how to integrate Aboriginal values into land use and resource management, and MYRADA Appreciative Inquiry project in Southern India (Ashford & Patkar, 2001) to provide government and non-government organisations with a method of designing and delivering programmes based on the strengths of the community.

AI is premised on there being something good in every organisation which can be discovered, used and exploited to enhance the organisation. It is a strengths-based model which suggests that an organisation shifts its focus to its strengths to get more of what is best rather than a problem-solving approach which attempts to eliminate what does not work. It is hoped the proposed research will assist in furthering the understanding that non-Māori clinicians can and do achieve positive outcomes for Māori in mental health settings despite the long-held belief that the cultural distance generates only misunderstanding and negative outcome for Māori.

Appreciative Inquiry Principles and Assumptions

David Cooperrider (1986), the creator of AI, purposefully avoided a specific method for doing AI but highlighted four *guiding principles* and five *core principles* to bridge the philosophy and application of AI (Hammond, 1998).

The guiding principles are:

1. The inquiry begins with appreciation.
2. The inquiry is applicable.
3. The inquiry is provocative.
4. The inquiry is collaborative.

The core principles are:

1. The constructionist principle - Reality is socially constructed through language.
2. The principle of simultaneity - Change begins from the moment a question is asked.
3. The poetic principle - What we study determines what we discover
4. The anticipatory principle - Our image of the future shapes the present.
5. The positive principle - Positive questioning leads to positive change.

The philosophical assumptions of AI have their foundation in the social constructionism paradigm, as articulated by Kenneth Gergen (2004, cited in Dinesen 2009) who suggests that the world, including identity, is entirely socially constructed and is created in relation to others. Kenneth and Mary Gergen (2005), translated from Danish and quoted in Dinesen (2009), go onto explain that meaning emerges in relationships and not in isolation: “The basic idea of social constructionism is quite

simple but also quite deep. Everything that we perceive as real is socially constructed, nothing is real before people agree that it is” (p.9).

The first assumption is that truth and meaning emerge in dialogue and relationships; not in themselves. In other words there are multiple realities and truths, and according to Gergen (1982) it is because of social impermanence and the instability of the social order that new meanings emerge. Social reality is therefore at any given moment the product of social agreement or shared meanings. The perceptual possibilities are unlimited because people do not respond to the world in a reflex-like fashion but their pre-existing experiences transform their perception and alters their range of potential reactions. Cross-culturally this has implications because the diverse experiences, historically and symbolically, each party brings to a discussion leads to an outcome that cannot be predicted and is different to that which each party initially held.

The second assumption is that the meanings and beliefs individuals hold have an impact on or create future reality. What we focus on becomes our reality, therefore if we focus on what is wrong we tend to see things through that frame only – and yet we also fail to see the frame (Hammond, 1998). If, however, we focus outside our frame we may be able to see data that conflict with our prejudgments and assumptions and a new reality comes into view. When one conducts research using AI, the frame is intentionally positive and challenges the prejudgments held by both the researcher and the participants to purposefully generate the possibility for future improvement.

These assumptions of AI therefore echo Gadamer’s hermeneutics which I will discuss next, which refer to the perception and reality (prejudgment) each person brings to a dialogue and the emergent understanding of both people thus generated.

Appreciative Inquiry as a method for gathering the stories of successful understanding between non-Māori clinicians and tangata whaiora encourages the uncovering of this mutual understanding, previously underestimated in the clinical relationship and undervalued in the research to date. The method of seeking strengths rather than problems is consistent with current models of care in mental health. It

encouraged the participants to reflect on best practice towards enhancing future practice.

Gadamer's Philosophical Hermeneutics

Hermeneutic association with the interpretation of texts was founded by Schleiermacher (1838) and was further developed by Heidegger (1962), Gadamer (1975), Ricoeur (1976) and Dilthey (1988). Schleiermacher (1838) took hermeneutics along from the study of texts to the understanding of human engagement, and Dilthey (1988) broadened this out to cultural systems and organisations.

This research focuses on the main conceptual ideas of Hans-Georg Gadamer's (1979) philosophical hermeneutics: self-knowledge, traditions, I and Thou, the hermeneutic circle, his metaphor of 'horizons' and dialogue as the means of understanding the other. This philosophy was chosen as it underpins the understandings sought in this research, 'restoring' the meanings in therapeutic engagement in mental health settings. Gadamer described 'restoring' the meaning of what we wish to understand thus:

To let what seems to be far and alienated speak again. But in all the effort to bring the far near ... we should never forget that the ultimate justification is to bring it near so that it speaks in a new voice. Moreover, it should speak not only in a new voice but in a clearer voice. (p. 83)

Self-knowledge and Prejudice

Gadamer developed his view of self-knowledge as a necessary starting place for understanding the other from his study of Aristotle's 'phronesis', and went on to illuminate this by stating that we cannot come to an understanding of the other's point of view unless we come with our prejudices (or pre-judgments) self-understood. "Prejudices are not necessarily unjustified and erroneous, so that they inevitably distort the truth... They are simply the conditions whereby we experience something – whereby what we encounter says something to us" (1979, p.9). Prejudices, therefore, are not necessarily negative, limiting and unalterable. As one encounters the other (who has their prejudices intact), what one expects to find (one's own prejudices) becomes clear and open to being questioned. This is the first

of Gadamer's constructs. The mental health clinician and the service user each bring with them their knowledge, derived through history, culture and language-histories which will have differences such as the lived experience of being mentally unwell or the experience of studying psychiatry, and there will be similarities perhaps in values or experiences of colonisation.

Traditions

Gadamer (1989) refers to the historical element, reminding us that we are connected to our past, our traditions saying "...history does not belong to us, we belong to it" (p.276). And furthermore that we are historically shaped beings, which has influence on us beyond our conscious awareness, "...the authority of what has been handed down to us – and not just what is clearly grounded – always has power over our attitudes and behaviour." (p.281).

I and Thou

The original I and Thou has come from the work of Martin Buber (1923), in which he established that man has two distinct attitudes towards the world: I-It and I-Thou. In the I-It mode man collects data, analyses it and theorizes about it. The It is experienced by the I as an object – a thing to be known or put to some purpose. There is a distance between the It and the I which allows for the I to be an objective observer rather than an active participant in engaging with the world. The second mode is the I-Thou, when man chooses or is chosen to enter a mutual and reciprocal relationship with the object encountered. The object thus encountered becomes a subject, a Thou, and is affirmed as a whole being, truly human.

Gadamer thereafter developed his three modes of experiencing the Thou. The first mode is treating the other as an object and modifying our behaviour based on how we interpret this object, because as Gadamer (1989) says "We understand the other person in the same way that we can understand any other typical event...he is predictable" (p.322). The second mode of Thou is more self-regarding because although the Thou is acknowledged as a subject (a person) rather than an object, one presumes to understand them "better than he or she understands him or herself" (p.322). Finally, the third mode of the Thou, is when we neither objectify nor claim to speak for him or her, but listen to what he or she has to say. Gadamer says:

“Without this kind of openness to one another there is no genuine human relationship. Belonging together always also means being able to listen to one another.” (p.324).

This fourth mode, therefore, requires us to open up our prejudices, which may allow possible modification by the Thou. Accordingly by not objectifying the Thou or subsuming them into ourself we can be free to be open whereby a unique encounter may take place.

Hermeneutic Circle

The ‘hermeneutic circle’ is the moving to and fro between the parts and the whole of a dialogue (text) in a circular process to arrive at understanding (Gadamer, 1979).

The communication patterns and oratory of Māori have been described as ‘circular’, ‘not getting to the point’ – talking about the issue at hand by references to issues from history, from mythology, or other seemingly unrelated and extraneous experience. Storytelling is therefore often seen as the preference among Māori according to Bishop (1996): “While the storyteller makes every endeavour to ensure understanding on the part of the listener, there is a real sense that it is for the other to bring their own understandings to the interpretations” (p.25). The ‘coming to the point’ cannot be taken for granted in Māori speech and each foray from the point and back again enriches the story. Listening respectfully is therefore essential to communicate effectively with tangata whaiora, particularly if the research can illuminate this hermeneutic circle in action in the dialogue between clinician and tangata whaiora. Schuster (2013) beautifully captures the hermeneutic interpretive process as having three ways of moving, “...between sameness and otherness, between past, present and future [and] between proximity and distance” (p.198).

Horizons

Gadamer’s horizon refers to “the range of vision that can be seen from a particular vantage point” (1979, p.269). Lampert (1997) describes Gadamer’s notion of horizons as not merely useful for understanding a text (or dialogue) *within* a culture but also *across* cultures. He proposed that the concepts which make this possible are horizon, culture, translation and conflict. Horizon, he argued means that each person shares their unique interpretation of the world when dialogue occurs. Cultures are,

therefore, identified and differentiated in the fusion of horizons, and there is recognition of the distance between cultures at the same time translation or contact occurs between them. Finally, he posits that ‘culture conflict’ and dispute over the meaning of a history is essential to cross-cultural interpretation.

Fusion of Horizons

If the horizon is the viewpoint each person brings to a dialogue, and assuming there is openness to difference or ‘culture conflict’ (Lampert, 1997), acknowledgement of the prejudices one brings from their cultural history makes it possible for those horizons to intersect, to achieve fusion. Fusion of horizons is thus a unique and co-created understanding that occurs when a dialogue has been successful.

Gadamer (1979) is speaking about hearing the other’s voice with our own preconceived ideas intact, creating new understandings or ‘a fusion of horizons’. The phenomenological concept of ‘horizon’ is that understanding and interpretation always occurs from within a particular worldview that is determined by our historically-determined situatedness (Malpas, 2009). The implication of this assumption for the research is that both participants’ worldviews are the ‘right’ worldview to bring to a dialogue with tangata whaiora. The importance of the fusion between doctor and patient is stated by Gadamer:

...(the patient) must be treated with care because of their neediness ... and extreme vulnerability. In order to preserve this important recognition of distance, doctor and patient must gain some common ground where they can come to mutual understanding. Such common ground can only be provided by the dialogue they sustain between themselves. (Gadamer, 1996, p.127)

Dialogue

Gadamer was also explicit about the importance of dialogue. He says that when engaged in dialogue, two parties bring their already existing prejudices, which have been passed to them from their language and socialisation to the issue at hand. The two parties do not surrender their understanding to the other’s understanding but a new understanding emerges – the ‘fusion of horizons’. In the present research the initial fusion of horizons is that of the clinician and the tangata whaiora – the clinician forms an understanding which guides their treatment of the tangata whaiora,

who also forms a new understanding, about recovery, for example. For the dialogue, and therefore, the recovery to be successful it is assumed there has occurred a fusion of horizons. The second layer of fusion is between the researcher and the storytellers when the analysis of the stories develop further understandings for the research. The third layer of fusion will hopefully be between ‘me’ the researcher and ‘you’ the reader.

Hermeneutic Assumptions

The goals of hermeneutics are:

- to seek understanding, not to provide the authoritative explanation of a text or dialogue.
- to acknowledge the individual insights brought to a situation.
- to recognise the influence of prejudice on interpretation.
- to seek a common language in order to allow a dialogue to happen.
- to be interested in questions, not absolute answers.

(Kinsella, 2006).

Gadamer’s philosophical hermeneutics, therefore, assumes that it is the differences and prejudgments held by the individuals engaging in dialogue that permits understanding to happen in the to and fro of the hermeneutic circle. Furthermore, analysis of the prejudgments held within the success stories will highlight the points at which any ‘fusion of horizons’ and new knowledge happen for the clinician and whaiora. By gathering stories using the assumptions of Appreciative Inquiry; that improvements are possible when built upon successes, and when viewed through a hermeneutic lens, the research is likely to present a positive appreciation of how non-Māori clinicians and Māori whaiora can work together successfully.

Māori methodologies and understandings

This research needed to be cognisant of the population it is intended to benefit, in this case Māori mental health service users. An understanding of Māori research frameworks needs to begin with an understanding of the differences between Western Inquiry paradigms and Māori Inquiry paradigms. Durie (1996) suggests three developments as the catalysts for Māori methodology development: the

international indigenous push towards autonomy; government emphasis on Treaty of Waitangi issues and the emergence of Māori frameworks of inquiry. It is also apparent that the discourse “by Māori, for Māori, about Māori” (Bevan-Brown, 1998, p. 231) which relates to research, service provision and economic and social development, has gained momentum over recent years.

Western ‘positivism’ asserts there is one reality which can be objectively investigated by a researcher. Māori ontology is about multiple realities, shaped by historical and social backgrounds. The methodologies to investigate these unique Māori views of reality are only beginning to be adapted. Constructivism, at the opposite end of the research paradigm from positivism, offers opportunity for the acceptance of multiple realities, subjective knowledge and the researcher to be situated within the research relationship (Ratima, 2003). Te Awekotuku (1991) suggests a methodology “needs to be responsive to expressed Māori needs, needs expressed from within the community and not needs perceived by those outside it” (p.67). Clearly research that aims to understand how Māori needs are being met by mental health services must have input from Māori to determine the terms of the research, method and means of analysis.

An inquiry into ‘stories’, the collaborative study of ‘themes’ and the development of directions “by Māori, for Māori, about Māori” (Bevan-Brown, 1998) is also applicable to this research even though Māori are only telling half the stories. They are therefore the ‘unwitting participants’ some of the time. Unwitting participants are those whose life-stories have intersected with the life-stories of the other participants. In this research the clinician’s stories are about Māori service users (and the Māori service users’ stories are about clinicians). The research design, therefore, needed to address the unwitting participant’s needs and rights.

Situating the research on a Māori research taxonomy

As Māori research suggests there is no one-size-fits-all methodology. In fact the diverse definitions of Māori research are more usefully arranged in a hierarchy from no Māori involvement to exclusive Māori control. Cunningham (2000) provides a taxonomy represented in Table 1. This taxonomy is often cited as a framework for

researchers, for example O'Neill, Bryson, Cutforth and Minogue (2008) and Health Research Council (2010).

Table 1. Characteristics of four identified types of research, science and technology. (Source: Cunningham, 2000)

Characteristics	Research not involving Māori	Research involving Māori	Māori-centred research	Kaupapa Māori research
Description	No Māori participation or data sought, results are thought to have no impact on Māori	Māori participants or junior researcher; Māori data sought	Māori significant participants or senior researcher; Māori analysis produces Māori knowledge measured against mainstream research standards	Māori significant participants; All Māori research team; Māori analysis; Māori knowledge produced; Standards set by Māori
Example of study	Quantum chemistry	Genetic study of illness	Longitudinal study of Māori households	Cultural determinants of health
Control	Mainstream	Mainstream	Mainstream	Māori
Māori participation	Nil	Minor	Major	Major; exclusive
Method	Mainstream	Mainstream	Mainstream and Māori	Māori and mainstream
Analysis	Mainstream	Mainstream	Māori	Māori

This research sits at 'Research involving Māori' within Cunningham's taxonomy as it includes Māori participants. The design involved interviewing both Māori and non-Māori participants directly, and the researcher is herself Māori. This research seeks Māori data and its intention is to have a positive impact on outcomes for Māori.

Being someone positioned in-between the worlds of Māori and non-Māori it felt appropriate that my own study found its genesis from that same context. The appreciative inquiry lens holds the assurance that this study chooses to focus on what

works well. It is therefore not a study seeking to undermine Kaupapa Māori health services; rather it seeks to show how the many Māori clients who access care through mainstream services have some positive stories to tell. Building on insights from such stories has the potential to strengthen the cultural responsiveness of Western models of care.

Nevertheless, being Māori, I have a deep concern for the wellbeing of Māori mental health clients. I myself practice outside of the Kaupapa service, alongside Māori and non-Māori colleagues and I have high regard for the manner of their practice. Further, the experience of this research has drawn me much closer to my own Māori heritage.

The rationale for the proposed research is to support the ongoing development of mental health services for Māori tangata whaiora by gathering and analysing insights of what has worked well in the past. Māori knowledge also assumes there is communal ownership of the outcomes rather than individual ownership. To be an academic piece of research the process is necessarily 'owned' by the researcher. The outcome, and particularly the effects of the research, achieves a 'ripple effect' rendering moot the notion of ownership.

It is assumed there are multiple realities and therefore one's perception of an event or phenomenon is subjective. The researcher using a qualitative methodology such as hermeneutics, acknowledges the subjective nature of experience and divergent worldviews shaped by historical and social backgrounds.

This research specifically explores stories of perceived successful understanding between people from different cultures, one of which is Māori. Perhaps my own story of someone who was born Māori, who looks Māori, yet who has some hesitancy in affirming my understanding of what that means within the Māori community, is one shared by many others. I sit between two worlds. In this study I seek to build a bridge between those worlds.

Conclusion

This is a hermeneutic study informed by Appreciative Inquiry, mindful of Māori ontology. It seeks to explore multiple realities, shaped by historical and social backgrounds. It is hoped that stories of positive Māori outcomes in a mainstream mental health service will help shape the future of mental health care. It will be shown in the conduct of the research how the appreciative inquiry into ‘stories’ and the interpretive study of meaning, drawing on Māori notions weave together in a synergistic way to guide this research. The following chapter will describe the conduct of the research.

Chapter Four

Method

Introduction

The previous chapters have introduced the motivation for the research, its aims and philosophical underpinnings and briefly outlined the context of Māori mental health, and the national and local efforts to provide appropriate services for Māori whaiora. I have also introduced the methodologies used in this research :Hermeneutics informed by Appreciative Inquiry, with an interpretive lens mindful of Māori ontology. I have acknowledged my pre-understandings and my stance as a hermeneuticist immersed in the data rather than standing outside and I have justified and refined the research question. This chapter will describe the conduct of the research beginning with ethical considerations and traversing through the gathering and analysis of data and ending with a discussion of academic rigour. I have also included ‘word portraits’ of the participant storytellers to fully include them in this thesis. They and their stories are the central figures in this research.

Ethical considerations

This research received ethical approval as a doctoral study from AUT Auckland University of Technology in February 2012 (Appendix A). Feedback following presentation of the proposal included recognition of the need for further consultation with Māori and the Hawkes Bay District Health Board (HBDHB) about participants. It had proved to be difficult to enter the networks necessary to gain support from local iwi, Ngāti Kahungunu, because I am living outside my tribal area of Ngāti Porou. Other difficulties to be overcome were some resistance to the research, which was initially viewed as challenging Kaupapa Māori practice. I approached various Māori colleagues for guidance and was able to establish a whānaungatanga link with a Kaumātua who initially supported me in the study. When that Kaumātua became unwell I sought another support and fortunately linked up with an experienced Māori woman, Mrs Te Ata Munro, who has a deep knowledge of tikanga and nursing. In

all likelihood, she would not thank me for calling her kuia and I shall instead refer to her as a wahine mātauria (wise woman). We tended to meet ad hoc as the research progressed and cultural matters arose for me. The matter of HBDHB approval was also a complex route to navigate as it was dependent upon me having iwi support. Once a Kaumātua had agreed to support me the HBDHB granted Locality Approval (Appendix B).

A further point requiring clarification related to the terms ‘recovered’ and ‘discharged’ from mental health services. Discussion with my Kaumātua supervisor, mental health colleagues and the Ethics Committee required reflection about the meanings of these words we use so freely in clinical settings. ‘Recovered’ implies ‘cured’, ‘well’, ‘free of illness’, ‘restored’; whereas ‘discharged’ means ‘no longer receiving care’ from the mental health team. When a patient is discharged they are by implication ‘recovered’ or restored to a level of mental wellbeing that is acceptable to the ‘recovered’ person. There are many people still open to mental health teams who have achieved a level of mental wellbeing that is acceptable to them, but because of the need for long-term psychotropic medication, their ongoing institutionalised behaviour or the recurrent nature of their illness, they are not ‘discharged’. It was therefore decided that for the purpose of recruitment of participants, only whaiora who had been ‘discharged’ would be invited into the study.

Once the issues of iwi support and participant recruitment were settled final ethical approval was granted by the Central Region Ethics Committee in May 2012 (Appendix C). Ethical approval was given to interview up to 15 mental health clinicians in Hawkes Bay who do not identify as Māori, to talk about the most successful Māori tangata whaiora recovery experiences they have been involved with. The researcher also received approval to interview up to 15 discharged Māori whaiora or whānau for their stories of successful recovery experiences with non-Māori clinicians. Other ethical considerations related to recruitment, consent and protecting participants’ safety and privacy are discussed in the following sections.

Selection of participants

It was decided to use purposive sampling. Purposive or non-probabilistic sampling is used to identify cases that possess the relevant characteristics which may be most informative for the study question (Astin & Long, 2009; Nicholls, 2009). There were two groups of participants in this study: mental health clinicians and former mental health service clients who identify as Māori.

The mental health clinicians were recruited by the researcher directly who sought expressions of interest to participate. A powerpoint presentation about the proposed research was given to four groups of people at three locations within the Hawkes Bay community mental health region: the DHB psychology team, and clinicians at Hastings, Napier and Walnut Grove Recovery Centre (Hastings). The presentation was made at the conclusion of each team's clinical meeting to capture as many staff as possible. In total 42 staff members viewed the presentation and discussed the research and participation.

The powerpoint presentation outlined the background and aims of the study, the philosophical underpinnings, the methodology and method of data collection, and the expected time-frame. The powerpoint also outlined the difficulties the researcher had experienced gaining Māori cultural supervision. Comments during and after each presentation offered valuable points that helped shape the research project. All but one team leader gave enthusiastic support to the study. The one person, a manager, who was critical felt her team had mostly negative experiences with Māori clients. Despite the team leader's misgivings members of that team volunteered to be part of the research.

At each presentation I was asked whether there had to be matching of clinician and former whaiora to elicit the same story from each of them. They were advised that this was not intended. There would be no matching of what the clinician said about the whaiora with what the whaiora said about the clinician. Another question concerned the possibility of whaiora wanting to talk about experiences of poor care and how this would be managed. My response was that a discussion about this with the whaiora would be framed in terms of "how could your care have been better?" It turned out that there were no stories of poor care from the mainstream services, but

some stories of dissatisfaction with previous Kaupapa services, leading them to change to mainstream. Someone asked if as a non-Māori clinician married to a Māori person they could still participate. This led to vigorous discussion about learning about each other's cultures within the realms of close relationships. That particular person (a manager) felt his clinical experience was too long ago to be accurately recalled for my research and he did not participate. Some people said they did not think their stories would be interesting enough and some said they would feel embarrassed telling how well things had gone. Someone asked if the research would include the stories from patients on the methadone maintenance programme, who were deemed as recovered, but who would likely never be discharged. I advised these whaiora would not be eligible as they had not been discharged despite being well.

Almost all clinicians believed they had connected well with their Māori patients but could not pinpoint peak events. There was surprise expressed that cultural supervision for my research had been difficult to access, and consequently Māori staff, including a kuia, added their support to the research with offers of help in any way possible. Finally, the clinicians felt the findings from the research would empower them in their work and lead to improved bicultural understanding.

Recruiting clinicians

The inclusion criteria for clinicians were that they did not identify as Māori, they are a current or recent mental health practitioner in Hawkes Bay mainstream (not Kaupapa) services and they are willing and able to share stories of the best, or peak experiences, of their direct work with whaiora. Clinicians approached the researcher to offer their stories for the research. Although my open invitation was made directly to groups of potential participants, it was left to individuals to approach me with an offer to be involved in the research. In this way there was no coercion.

The clinicians who became participants were from a variety of professional groups: psychiatry, social work, counselling, occupational therapy, community support and nursing. Some were born in New Zealand and others came from the United Kingdom and other European countries. They ranged in age from approximately 30 to 55 years. Mental health work experience ranged from 5 to 35 years. The details

of these participants has deliberately been generalised to protect their identities in what is a small community of practitioners. I stopped recruiting at six because by that stage it felt more important to hear the voices of the whaiora.

Recruiting whaiora

The second group of participants were discharged mental health service users who self-identify as Māori and were willing to participate. They were identified and initially approached by the clinician who had worked with them prior to discharge, and introduced to the researcher when they had agreed to that contact. The clinicians ensured that the whaiora understood participation was voluntary. It was a frustrating process locating former whaiora as they had often moved and changed telephone numbers and therefore could not be contacted. There were fifteen former whaiora whom clinicians felt would have stories for the research, however eight of those could not be located due to changed details. In total seven former whaiora were successfully recruited. When contact was made by the researcher, an appointment was made at a time and venue convenient to the participant.

All thirteen participants were given the same Information Sheet (Appendix D) about the research project, information pamphlets about their rights as research participants, and a different consent form for clinicians (Appendix E) and whaiora (Appendix F). All effort was taken to avoid any perceived coercion to participate.

Data collection

Almost all clinician participants chose to be interviewed at mental health team offices, citing work commitments. Other venues offered to participants were the Māori Health Unit marae, the team office (at Hawkes Bay Hospital, Hastings) or at the participant's or other's home. The options were left open to ensure the participant's comfort and safety. All former whaiora were well known to the clinician who referred them and therefore there was an assurance of no risk to the researcher seeing them at their home. The former whaiora chose a variety of places for their interview: a marae, the team office at the hospital, their home or a relative's home.

Whaiora were sometimes in employment and other times receiving government benefits. They had been seen by the referring clinician for between two months and one year approximately and had been discharged within the previous year. The strength of their identification as Māori was not explicitly enquired into but was often part of the whaiora's talk about themselves. Most felt they were close to but not fully immersed in tikanga Māori (Māori practices). One former whaiora is a leader in the local Māori community and one other participates in multi-cultural groups. Their ages were estimated as being between 30 and 60 years.

Prior to the interview the researcher checked that the Information Sheet had been understood and a Consent Form was offered for completion. There were six interviews with clinicians and seven with former whaiora. Interviews ranged in length from 45 minutes to 80 minutes and were recorded on a digital device with a back-up tape recorder in case the digital recorder failed. The interviews were initiated with a variation of the question "Please tell me about a time when you felt something good or positive happened when you worked with a clinician/Māori client at work". Prompts were occasionally used such as "Can you think of a particular example of when that happened?" or "What did you say to each other at that time?". The experience of being invited to share stories was reported by some participants as being profoundly satisfying and by some as making them feel proud, humble or in the case of one clinician, embarrassed. For another clinician there were tears because of reliving such a special time with her patient. One former whaiora also had a tearful moment which he said was due to his relief at being free from depression and his gratitude for the help he had received. The stories were visceral and emotion-laden for both the teller and the listener.

Word portraits of the storytellers

It seemed to be extremely important to comment on the how and where and who of the interviews as much as the what. Every storyteller's choices, including the surroundings they chose to be interviewed seemed to 'speak' of who they were as much as their stories. My fieldnotes included observations of the environment in which the storyteller decided we would meet in, the interruptions, pauses, distractions and anything I had not expected during the interview. I also noted the emotional responses I had to the story and the person as I thought this may be

important in my later analysis. Each fieldnote commented on ‘who’ the storyteller seemed to be, how comfortable they seemed to be and my later reflections on the interviews. My impressions of the interview, and of the participant therefore began from the moment we met, before I switched on the recorder. My later reflections on ‘being there’ shaped my analysis, and understandings of that person. Most interviews left me with a deeper understanding of the person and how they had experienced their mental health worker (or client) and how they may have begun their relationship together.

Lyn chose to meet me at her workplace, a mental health team office, in an empty interview room. We sat there as clinician and patient so often do; me on a swivel chair and Lyn on a metal-framed chair of the sort seen in clinical rooms all over the world. On the desk by us was a computer and monitor, blank case-notes sheets, office paraphernalia, an abandoned coffee cup and my digital recorder. The windows with venetian blinds looked out at the wall of another building and the glass observation square in the door gave glimpses of people passing and glancing in to make safety checks. Lyn seemed very comfortable in that room and I thought this was the familiarity of the clinic and her role as mental health nurse. I did not feel comfortable in that room which seemed to me impersonal, public and clinical and wondered how Lyn came to seem so at home here. It seemed to me that Lyn chose a place within which she has become accustomed to talking about her role and mental health issues. Her stories, showing her confidence as a nurse confirmed this notion of her being most at ease and secure in her role and in this room.

Lewis. Before we sat on a pile of mattresses to talk, Lewis took me around the carved pou and tukutuku panels of the whare nui. He told me the stories, the cosmological explanations, the local meanings and the whakatauākii represented there. Sometimes he used gesture and mime, graceful turns of phrase, changed his tone of voice, laughing or growling, sometimes with misted-up eyes. One panel had been broken in the making and he spoke about the difficult decisions about its desanctification and disposal, to reconcile the mauri (life principle) of this wood and the artist working it. We sat and talked with the sound of the tapping of a chisel on wood, the radio and the chatter of the carvers on the paepae.

Lewis clearly felt comfortable here in this house of ancestors, stories, art and te reo. His belongingness was so evident and his efforts to make me welcome was humbling. It rained outside while we talked but we were warm and comfortable there. Sometimes during the telling of his stories Lewis laughed or wept, shouted or whispered. I believe he was telling the atua his stories as well as telling me; sometimes he seemed angry at them and wanted them to know precisely what he had to say and other times he did not want them to hear what he was saying. That this man had previously spoken of his mamae and pain at our hospital with a Pākehā clinician, without the atua (Gods) to look after him seemed to me to have been a huge and courageous thing for him to have done.

Jason chose to meet me at my office at the mental health team rooms. When I went to greet him he was sitting quite contentedly in the waiting room. He said he felt comfortable as there were good memories of the recovery journey and the counselling he had there. We sat in my little office and as he told me stories he often jerked his thumb or his head to indicate ‘down the hallway’ where he had often sat in counselling sessions with _____. It was apparent to me that this place held deep emotional meaning for him. His stories told of first arriving there frightened and desperate, and how with trust and feeling cared for he had progressed through and left at peace with himself. There were no demons for him here – perhaps that was why he wanted to come back, to check it out for himself.

Hollie invited me to her family’s home. We sat on her mum’s bed. “It will be a quieter place” Hollie said. Her mother greeted me at the door of their modest home and although she wasn’t expecting me, welcomed me into their house. In the bedroom there is a framed photo of an old man, Hollie’s dad, next to the television. He has passed away but is still at the centre of this family and I was aware of him watching over us as we talked. Hollie smoked her cigarette and reclined on a stack of pillows, sometimes relaxed and laughing and sometimes sitting up to wipe tears away. She had not been talking for long when her teenage son came in and stretched out next to her on the bed. Soon after that her friend arrived and she invited him to sit on a sofa by us and listen to her stories. Her mother came in to get something from her bedside table and Hollie kept talking to me “they know all this” she said to me. Then Hollie’s daughter came in to get her to the telephone. Hollie seemed so

comfortable talking about her recovery, with her family and friends around, I could see why she had chosen to be in her mum's room.

Rose is an occupational therapist. She took me into the client lounge. This room is filled with client's artwork and projects. There are musical instruments, recording gear and an overhead projector on a table. Songs in English and Te Reo are taped to the walls, and on the table are newspapers, timetables, a vase of flowering weeds and home baking. This is a fertile room of activity and interaction. Rose's stories turned out to be centred on this environment and I could sense that she used the room to aid her recollection of work she had done with her clients.

Rick was such a busy man he asked to see me at my office so I did not have to try to find him. He seemed to like being in a busy place, with clinical noise and bustle in the hallway outside. In my office he commented agreeably about the amount of work on my desk and how many people were coming and going about the place. His stories are filled with action, interaction, moving onwards and experiential learning. He stays for quite some time, enjoying talking about the counselling he had and letting me know how he has taken that learning out to share with his whānau. He is generous with his time and his words, preferring to give me the long version, with digressions and lessons along the way, so nothing important is left out. This man's prodigious memory for counselling terms and techniques would make him an excellent therapist – but I realised that within his own whānau that is exactly what he does. No wonder he chose to come to our office.

Anne. When Anne was referred she and I were not aware of a whānaunga connection, as we had not seen each other for 20-odd years and had changed our names some years ago. When we were introduced we recognised each other as relatives and I invited her to my home to catch up on family news. She asked if she could have her interview there. It also gave her an excuse to cycle the half hour ride each way. She is probably the fittest woman in her neighbourhood and it clearly gave her pleasure to show me that aspect of her health and wellbeing. Sitting at my dining table she spent some time telling me about health foods, fitness training programmes and the Iron Māori event (a local triathlon). It seemed fitting that she prefaced our interview with positive, health-related conversation as that was one of

the main themes of her stories – the notion of getting the best health care she could find. Anne also impressed me with her trust and willingness to tell me about her mental health care, as it became clear in her stories that she had not told the rest of her family and has always kept them away from her recovery.

Ngawai met me at her daughter's house. She said she was going later to pick up her mokopuna (grandchild) from school around the corner while his mother was at work. Ngawai told me about her mokopuna and what a good boy he was, in fact how all her kids and moko's were important to her. Her story for the research was about sessions of family therapy and how they had come to the first session unable to talk to each other, discovering each other again and the ability to be open during the work there. I felt her choice of talking to me at her daughter's home was a continuation of the new closeness they had developed from the therapy, being in each other's spaces as she happily waited to pick up her moko from school. The fact that her daughter did not mind a researcher from the mental health team in her home also lead me to feel that there was trust in me by my association with the team who had helped Ngawai and her family.

Anthony invited me to his home. The clinician who had referred him to me said "Ask him to play his _____ for you. It's an amazing talent. Tell him I said so". His two friendly, large dogs roamed around us as we sat chatting and drinking coffee. Before the interview Anthony and I exchanged whakapapa and he pointed to photographs of his grandparents, his parents and his sons. Each of these photos stirred memories for him and during his interview, whenever he mentioned any of those people we both looked up at the photos as if to bring the people into the room with us. While I fiddled with my digital recorder Anthony asked if I minded him playing his _____. He played beautiful classical music and he told me in his interview how playing music had been a part of his illness, his recovery and his relationship with his mental health keyworker. I was able to tell him his former keyworker had mentioned his playing. I realised he could not have brought his photos or played for me if we had met anywhere else but at his home. This sharing was important to him.

Dave plonked himself in one of the chairs in my tiny office as if he owned the room. He adjusted the angle of the recorder, explaining it would pick up better. He's worked here many years longer than I have and I did wonder if my office is more familiar to him than to me even. He has a direct and forthright manner, speaking to me very much as an equal, fixing me with a steady gaze and smiling throughout. He seemed so capable and confident (starting with setting up my recorder 'properly') that I didn't feel I could interrupt his storytelling. I sat back and let him get on with the telling. When he finished he checked if I was "happy with that" and rushed off to do something else. No nonsense, busy and efficient were my impressions of Dave.

Kelly wanted to meet me at my office because she was training nearby and had a lunch break. It seemed to me the training must be very interesting – she was animated and very chatty. She seemed full of excitement, explaining she did not have long but really wanted to share her stories. They were told in an engaging way, in a modulated English accent, leaning forward in her chair towards me. I think she really wanted me to hear her. I picked up a sense of pleasure at how well her work was going and how keen she was to learn more.

Jo and I sat with a cuppa and our lunches. She chose to sit in the large, sunny meeting room as that would be "a nice place to eat and talk". I noticed however that she was so deeply engrossed in telling me her stories she didn't eat her lunch. The setting seemed important to Jo and I sensed she wanted me to have a break in the sun, out of my office. She paused often in her storytelling, sitting and reflecting on how she would tell the next part, or checking with herself that she had the details right. It seemed important to her to be truthful. She was at times so engaged in her memory that she shed some tears. She told me they were "happy tears for a happy memory".

Elvis. Names are important he said after telling me his pseudonym was to be Elvis. I didn't ask but had the impression he was thinking of Elvis Costello, not Presley. Costello has a social conscience and a realistic way with song lyrics. The Elvis in front of me is a doctor who speaks quietly and rapidly so I had to move closer to hear him. He had chosen my living room for his interview; wearing t-shirt and jeans, sprawled casually in an armchair and looking anything but medical. As he tells his

story he reiterates parts of it but I am not sure if that's to make sure I understand or to reassure himself he has told it all. I had the sense he was more comfortable chatting with someone at home rather than at a clinic.

Transcription

The interviews were transcribed verbatim; by the researcher on one occasion, and by a professional transcriber for the others. Participants were invited to use a pseudonym, however many participants wanted to use their real name. All names of other people and places in the stories were changed or removed to preserve anonymity. As the intention of the data gathering was to have stories grounded in the actual experiences of each person, they were invited to present their stories wherever and in whatever way they felt most comfortable, for example a preference to write their own story rather than speak it.

The transcribed interview was offered to each participant to enable them to ask for any part of the data to be removed from the study, to correct any mis-hearings, and to validate that the story was still their story (Smythe, 2010). This step is fundamental to the trustworthiness or rigour of the study. All except five participants chose not to review their transcribed interviews, saying "I trust you" or "I'll see it when it's all finished". Of the five who did review them very few changes were made. One person did not contact me again but when I met her inadvertently when she was working she said she had not got around to reading it "but don't worry it will be all good". One person telephoned to say it was all fine. One man called to say he was surprised how long it was and I could remove the "um's and ah's" if I wanted. One man corrected two misheard Māori words, reworded something to better say what he meant, and asked that two lines about him as a youth were deleted. One woman asked that a reference she made about family history was deleted.

Analysis

Analysis and interpretation of the stories was guided by hermeneutics. Hermeneutic understanding requires that the text is reflected upon, read, re-read, written and re-written until the meaning emerges (Caelli, 2001; Smythe, 2011) and the interpretation captures the meaning that lies between the lines that points to the phenomenon (Giddings & Wood, 2001). The questions guiding the analysis

pondered the prejudices or pre-understandings the participant brought to the experience, how the participant experienced the other person in their dialogue and the new understandings (fusion of horizons) uncovered by the participant as a result of the experience. The analysis drew on philosophical notions to explain what was uncovered in the experience and how the participant understood what was uncovered.

The hermeneutic working with texts

The first task of crafting the transcripts into hermeneutic texts was to read each and listen to each taped interview to gather my overall impressions of the transcripts. For example Jo used words and phrases such as “I felt sorry for her...It was so sad...things I struggled with” which gave me a sense of her emotional investment in the experience. Rose on the other hand used phrases which suggested emotions which related more to her dilemma about being the appropriate person for a whaiora such as “I felt I was insufficient (in knowledge)...do you really want *me* to help...I was allowed (to enter)”. Whaiora stories too created impressions such as Ann’s “He greeted me with aroha...I could open up to him...made me feel relaxed”, which sounded like a sense of safety, whereas Jason “We clicked...he wants to know me...we worked as a team” spoke to me about shared responsibility. Van Manen (1990) suggests this wholistic reading approach identifies the themes or threads which allow us to proceed with phenomenological descriptions.

Once I had a sense of the overarching shape of the texts and formed phrases to orient myself to the phenomena I then set about re-reading the texts and forming clusters of sentences into stories which still retained the overall impression of the text.

Interpreting texts hermeneutically requires that one “keep one’s gaze fixed on the thing throughout the constant distractions that originate in the interpreter himself” (Gadamer, 1979, p.269), and I was careful to avoid forming *fait accompli* interpretations until I had crafted multiple stories from the texts. An example of working with the stories-as-data appears as Appendix G.

Van Manen (1990) describes phenomenological methodology as “more a carefully cultivated thoughtfulness than a technique” (p.131), which requires a dialectical going back and forward through various layers of questioning. Reading the stories

and rereading them in relation to the text I asked myself questions such as “what is really happening for this person? What meaning did this event have for this person? What historical learnings does this story illustrate?” By reading, questioning, writing, re-reading, re-questioning and re-writing, the deeper meaning of the experiences began to make themselves apparent. I was always careful to reflect on the meanings that emerged, checking that they were not merely what I wanted to see based on my pre-understood notions of bicultural relationships, for as Van Manen suggests it is difficult to ignore what we already know as assumptions kept creeping back. Discussion and challenge from all supervisors helped me to remain aware of my own historical horizon and to subject my own assumptions to scrutiny. Gadamer cautioned “To acquire a horizon means that one learns to look beyond what is close at hand – not in order to look away from it but to see it better, within a larger whole and in truer proportion” (p.305). The meaning I took from this was that I needed to be aware that my own horizon needed to be acknowledged and disregarded in order that I might truly see the horizon of the one telling the story. I began to notice that the stories when arranged thematically were describing the process of being-with someone: meeting, getting to know and being known and making a commitment to mutually guide the relationship.

Contribution of literature to the interpretation

In cultural supervision with Ata Munro in mid-2014 I was discussing the findings and how they seemed to fall into themes of meeting and progressing along a pathway. Ata likened this to arriving at and entering a marae (traditional Māori meeting facility). She used the term maraeātea and drew for me a whare (traditional house), a waharoa (gateway) where visitors assemble and wait to be welcomed on, and the maraeātea (the open area between the gate and the house) where the initial meeting happens and the agenda is set. The similarity with my initial imagery for the findings was satisfyingly apt. Ata suggested Professor Sir Mason Durie had drawn up a model of Māori psychology with which my findings seemed to concur.

The address by Professor Sir Mason at the Polynesian Society Annual General Meeting in 1999 entitled *Marae and Implications for a Modern Māori Psychology* questioned whether mainstream education, health, counselling and business were able to deliver effective services to Māori. He then outlined the encounters on Marae

in modern times and how these encounters demonstrated a distinctive Māori way of thinking and behaving, with the codicil that modern Māori may have a lack of opportunity to experience such encounters in a meaningful way. He described Marae encounters as having several dimensions spanning the spiritual, physical, and social domains and asserted that these domains had significance for Māori which were not represented in mainstream settings. He was concerned that as these were not present in mainstream services, and when mainstream thinking did not work for Māori, both styles of engagement tended to be abandoned with a resultant dissonance and ineffectiveness.

He revisited marae encounters again in 2007 as a basis for understanding “the ways in which relationships are negotiated and strengthened” (p.6). The domains he wrote about in 1999 and 2007 were further developed as a model of interaction relevant to Māori educational success: whakapiri (engagement), whakamārama (enlightenment) and whakamana (empowerment) (Durie, 2014).

The writing of Mason Durie became a dialogical partner (Smythe & Spence, 2012) to my thinking and writing. The phases of the growing relationship between whaiora and clinician mirrored the three stages he described in his model. It is no surprise that such congruence exists; the whaiora had simply been describing their experiences in terms of age old traditions of encountering other. The clinicians had been responsive to the unfolding play and without pre-determined thinking joined in this way of greeting, receiving-in and coming to know ‘other’.

Rigour

For research to be trustworthy and credible the process must be rigorous. It requires systematic methods of data collection and analysis, transparency in documenting these processes, and consistently operating within the philosophical assumptions of the paradigm (Lincoln & Guba, 2000). It is also central to rigour that the multiple stages of interpretation, of reading, writing, re-reading and re-writing, along with the discussion of how interpretation emerges from the data are articulated (Koch, 1995). The question for establishing rigour is how much is adequate to establish credibility and transparency. Hall and Stevens (1991) describe it is adequate when the whole process is reflected through the use of reflexivity, texts which are credible to the

experience and can be understood by those outside the experience as much as those inside, coherent interpretations which reflect the complexity of the phenomenon, and lack of deception. A further suggestion for establishing rigour is to use multiple methods and sources of data (Denzin & Lincoln, 2000).

In laying out the beginning stages of this research, acknowledging the pre-understandings I bring to the research, reflecting on the data and my interpretations with my supervisors and cultural advisor, I have shown transparency and rigour in the processes used. During the analysis phase there were points which required deep reflection by me, to challenge my professional assumptions. For example in Dave's story in Chapter six, he spoke about feeling puzzled by the whaiora's interpretation and emotional response to the word 'rights'. Initially I was puzzled about her response also, as I felt it was a caring and responsible act by the clinician. In supervision I came to see that some terms which are taken for granted by health professionals can have the opposite connotations for whaiora. Reflecting on such pre-understandings I held helped me to ensure that the experience and meaning I wrote about was that of the participants and not my own.

I have gathered stories-as-data from a range of health care professionals within mental health: medical, nursing and allied health, who vary in years of work experience, and the whaiora represent a heterogeneous group of people from different occupational groups, from professional to not working, male and female and across a range of ages. In this way I have gathered many different perspectives on the experience of bicultural working.

As I described earlier in this chapter, in order to be sure of the accuracy of my listening and recording, I invited the participants to review and correct their own transcript. Ultimately, the reader will need to decide based on the accounts presented and the subsequent analysis whether the findings 'ring true' and can be considered credible and trustworthy.

Conclusion

This chapter has laid out the process by which the research was conducted including ethical considerations, the discussions held as part of early consultation, the selection

of participants, the gathering and crafting of stories and the steps of the analysis. I have discussed issues of trustworthiness and rigour. The findings are now presented in chapters 5, 6 and 7.

Chapter Five

Meeting the Other

Mihi mai ra aku rangatira e	Greet us my esteemed hosts
Mihi mai ki runga ra	Greet us on this
I te harakoa o te kupapa e	happy occasion
He taonga na tatou katoa	A gift from us all
Meinga tenei hei tuhonohono e	May it unite us
He tikanga pain a te aroha e aue	for it is a good cause
Ka poua te Manawa	Touching the heart
Whiti rere tonu ake	Alighting directly
Na te rangimarie	from peace
Te rangimarie	comes harmony
Te rangimarie	From harmony
Na te rangimarie	comes peace
(Ngoi Pewhairangi)	

This chapter will speak about initial encounters between Māori whaiora and non-Māori clinicians: recognising the distance between ourselves and others, encountering difference and the similarity with them, and beginning to establish communication and understanding. Some stories are about the ‘walk-in’ meeting when there has been no time to prepare one’s mind, face and demeanour for a first meeting. Other stories are about the first meeting that has been scheduled, possibly dreaded, but certainly prepared for. The need for the initial space between the parties is well illustrated in these stories. In each case however communication starts to happen, and because of the experiences and worldview each person brings, the communication does not always start positively. What is demonstrated is that the opportunity for mutual understanding in each first meeting is present and how this is eventually captured by the parties.

Mason Durie (1999) in his analysis of encounters rehearsed on marae says that “the culture of the marae lies outside every day experience (and) may not be perceived as significantly relevant to the modern reality” (p. 352). His insights however highlight most dramatically how procedures similar to the rituals of the marae are enacted when two parties come together in clinical settings. In particular regard to first

meetings and setting up the kaupapa or reason for coming together that this chapter discusses, I will refer to Durie's notions of 'the domain of space' and 'the domain of the circle'. The stories from the Māori whaiora and the non-Māori clinicians echo these domains and show how these same notions can describe the mental health clinic encounters.

Meeting, first encounters, challenge, powhiri and communication. This happens at the clinic as it does at the marae. The clinicians could be described as the tangata kainga or tangata whenua (the local people) as they work there and have responsibility for the place, and the whaiora are the manuhiri as they are the people visiting. The first thing one notices is what Mason Durie calls the Domain of Space. The maraeātea is a formal space with an entry point at the gateway and gathering points for tangata kainga and manuhiri. The mental health clinic has this same sense of space and separation between the waiting room and the clinical areas.

In both maraeātea and waiting room the intention is the same; to create a place for arrival, establishment of the kaupapa or reason for meeting, and to create a distinction between the parties. Whilst the gap is intentional on the maraeātea it is utilitarian at the clinic yet it still serves to highlight the different circumstances of each party and to allow each to judge the intentions of the other. There is the sense of standing-off, awaiting and deciding.

The first meeting is always a time of anticipation, doubt, curiosity and expectation for both parties. Working in a mental health team and meeting a patient for the first time is different to first meetings with people in a social setting. The clinician has had a referral from the person's doctor with a name, a brief description of the problem and a request for specific assistance, but sometimes people walk in without a referral or introduction. Whichever the lead up to the meeting the clinician has very little background information to go on and certainly no sense of a real person up to that point. The whaiora also is likely to have doubts about the person they will meet and what welcome they will receive.

All judgment, including clinical assessment, begins from the first contact. The clinician, from my own experience, is observant. Has the person come alone or who

has accompanied them, are they dressed for the conditions, how well do they appear, what is their facial expression and eye contact, how do they move and walk, what mannerisms do they have, how do they appear in terms of their emotional expression, do they appear their stated age, what ethnicity do they appear to be. All this judgment is made without a word spoken between, across the space of the waiting room. This evaluation of the other most certainly occurs for the whaiora as well. Gadamer (1979) spoke about how one comes into a dialogue with the other bringing self-knowledge, awareness of one's own history and traditions, and prejudices or prejudgements about the other and the relationship.

New Zealand socialisation mores and our professional training tell us to greet people in a friendly, open and welcoming manner, but of course this is not always what you feel when you meet someone. Memories intrude of meeting similar people, for both the clinician and the patient. The clinician might have had a bad day and the person waiting to be seen almost certainly has done. Impressions, interpretations and instant judgments are made, back and forth between, which sets the scene for starting a relationship. The Māori whaiora and the non-Māori clinician look for points in common, while retaining the uniqueness of their own situation. The Māori whaiora does not expect or want the non-Māori clinician to be Māori and neither does the non-Māori clinician expect the whaiora to become Pākehā.

When we meet we enter the other's physical space by extending our hand to shake theirs or to press noses in a hongi. The original understanding of the handshake was to reveal an empty right hand to show that you are unarmed and not a threat. The Māori hongi, for those with cultural confidence is the pressing of noses whilst clasping right hands, with the left hand on the shoulder of the other. The meaning is the sharing of the breath, the hā (the life-force) of the other.

In the modern context the handshake and indeed the hongi have different but deeply meaningful purposes. Both types of embrace are an acknowledgment of the awareness of the physical distance between the parties. The parties must have an awareness of their apartness in order to engage in the pressing of flesh that closes the space momentarily. Because the handshake or hongi is brief, and we come apart again we must also have an awareness that the distance must be reasserted for

comfort. To linger too long in the clasp is alarming and unsettling, and rather than making us more comfortable and trusting of the other it raises questions of their motives (we have all had the experience of having our hand held too long for comfort).

The talk starts by naming ourselves and offering a handshake. Then come the questions: how are you? did you manage to find a parking space? isn't it cold today? The clinician is likely still evaluating mental state by the responses they get to their first tentative conversation but they are also hoping to create rapport and a relationship. Each observes the other. This is a ritualised meeting – it has to meet clinical requirements, social conventions and bridge cultural differences simultaneously. It has to create a safe and professional feeling, whilst maintaining the necessary boundaries. Most importantly, the distance it begins with remains to some extent throughout the professional relationship.

Making Space for Engagement

The stories from participants in this study reveal how they experience meeting, relating and recovery in a mental health clinic setting. Lyn, a mental health nurse describes a first meeting that started in a very unfriendly way, and how professional 'ritual' was required to simultaneously maintain a safe distance and empathetic closeness with an unexpected visitor. Lewis, Ann and Jason, three tangata whaiora, also describe their first contact with mental health services as an unsettling and uncomfortable new experience, with Ann telling of her distress when there was too much physical closeness and no space for new learning.

Being strangers was not always an uncomfortable feeling, as some of the stories illustrated. Rick felt freer to be himself and Kelly spoke of the need of the whaiora she worked with to have no past when they met.

Lyn, a non-Māori mental health nurse tells of her first meeting with a Māori whaiora who turned up at the door of her office:

So I was sitting in there and there was a very strong knock on my door 'bang, bang, bang', so I got up and opened the door and there was a

man there, who I went “ugggh”, because he was Māori, I had never seen him before, he looked quite scary, he was a bit ‘wild eyed’. He was really tense, I could see the muscles in his jaw going and he was standing there with his fists clenched, and I thought, he has come to beat me up or something, what have I done? (Lyn)

There was no time to prepare for meeting this man who ‘walked-in’ without warning. Lyn described initially experiencing fear and uncertainty when the knocking on the door was loud. She was startled before she got to meet this person knocking. On opening the door she was faced with a stranger, a Māori man, with a “scary, wild-eyed and tense” physical presence and emotional tension. Her fright and observations of his physicality initially led her into thinking she was about to be assaulted. She too experienced emotional tension and fright.

This story is about fear of the different and unknown seen across the space. Lyn was frightened and thought this man had come to beat her up because she was unused to being confronted by threatening-looking strangers in her work space. The normal human responses of ‘fight or flight’; to respond aggressively or to run away, were not available to Lyn in her professional setting and she had to rely on another human response of trying to connect with him. Her impression was that he was probably dangerous but she still tried to understand why he was being so aggressive:

So I said, “Hello, are you in the right place? I am Lyn the mental health nurse, can I help you?” He was just about talking through gritted teeth, he said “you’ve helped my brother, now I need some help!” I didn’t even know who he was so I said “would you like to come in and talk to me and tell me what’s happening?”(Lyn)

Although her initial interpretation was of danger she tried to view the situation from his perspective, as being fearful for *him* and therefore she chose to talk to him calmly to find out why he was afraid. She ‘called’ to him across the space with a kind of karanga. “I see you, can we meet and talk and make peace?”

Lyn responded to his ‘scary’ presentation with a rather formal introduction and a polite manner. This is a part of her professional training – calming and reassuring people who appear dangerous instead of responding to him with aggression. Her professional demeanour seemed to act as a shield, to keep the distance between them

until she could decide what his intentions were. Despite him continuing to appear menacing he was able to make his intention clear – he asked for help. Lyn’s training, compassion and humanity immediately replaced her fear as she invited him into her office. By asking a seemingly innocuous question “can I help you?” she invited talk and an opening for him.

Tauroa and Tauroa (1998) explain that the wero, or challenge issued by a warrior on the maraeātea is to determine the intention of the visitor and is not done with physical contact but “done through a spiritual awareness of the actions of people and the responses between people” (p.47). They also explain that if the visitor has not come in peace, “...on the maraeātea a way can always be found whereby exchange of words, of wairua and of feelings can bring people to a better understanding of one another” (p.47).

The confrontation Lyn received was like a wero/challenge, and although it was reversed in this instance the intention was the same – the man was unsure of the reception he would receive from the ‘tangata whenua’ nurse and came with a strong show of strength to appear more bold. Lyn picked up the impression of his ‘warrioriness’.

... the way that I experienced him and the way that I think of him now is he was a ‘warrior-type’; but all his aggression, all his warrioriness ... he was trying to do it [get help] in the wrong way. (Lyn)

As Lyn listened to him her impression of him as menacing changed into an awareness of his ‘warrioriness’. She thought he was being a warrior to hide his fear. She also appeared to use her professionalism for the same reason, however she seemed to judge that this man posed a risk only to himself as she started to worry about *his* health.

When Lyn described him as a warrior perhaps she was judging that his fierceness was his way of trying to maintain pride, strength and bravery. He came to get help aware of his history of Māori men being warriors, protecting their mana and esteem and protecting the people from outsiders. A warrior is expected to portray bravery and resilience, to lead by example and be unafraid to fight and to die. The modern

warrior has the same ideals but their stamina and strength are displayed in different arena from the battlefields of the past. There is less opportunity to display prowess and leadership in battle, and instead there is the household, the workplace, the sports field and the social environment. Lyn seemed to recognise the need this man had to be seen as a warrior and she seemed to recognise also that the warrior was masking vulnerability.

The understanding to take from this encounter is that this warrior felt he could not talk to anyone close to him within his whānau or social circle about his problem for fear of seeming weak and shamed, and instead chose a stranger at the hospital; somewhere there was the space for him and an emotional distance between him and the other to give him opportunity to evaluate her intentions. This choice left him vulnerable and exposed. That he did go to her means he had made a decision based on the evidence available to him, that she had helped his brother in the past and may therefore be trustworthy. There is an inner conflict for him perhaps – going outside the whānau with the risks of being isolated versus seeking help within the whānau and feeling ashamed. He seemed to have decided to go to Lyn, who was outside the whānau but did have a connection to him via his brother's experience.

There is often fear and uncertainty for whaiora coming into a mental health clinic; being unfamiliar with the processes and people there, feeling vulnerable and anticipating being negatively evaluated. Lewis, a Māori whaiora told of his first visit to the clinic:

I [had] attempted to take my life and it was from the GP that I went to have a psychiatric evaluation in Hastings. I was pretty angry then because I didn't really know what was gonna happen because I thought, 'oh yeah, they will lock you up for sure, dog!' and I'm already feeling like I'm a caged lion.
(Lewis)

Despite a recent suicide attempt, Lewis told of his extreme reluctance to seek any help because of negative past experiences from life and other 'systems'. His self-talk, inner dialogue was full of anger and mistrust and fear. He spoke of his fear of being locked away perhaps because he thinks he will be seen as dangerous. He also articulated his worries about becoming trapped and only seeing his doctor and the mental health team out of fear for his life. He was asking "what will happen to me?"

He was not going into 'the system' willingly but out of self-preservation. What would the clinician who met him on this occasion have thought about him? He may have appeared angry and dangerous and the clinician may have felt nervous meeting him. Decisions are made by both parties at these first meetings and it is the role of the clinician to provide calmness and reassurance.

Ann, another client, talks about meeting in the space of the waiting room, feeling unsure and afraid:

...and you are sitting in the waiting room where you are like, nervous, really not wanting to be there, but then he came out and he goes "Oh, I am Dr _____, Ann" and I go, "hi" and he goes "you want to come through." But the way he had approached me was like... he had Aroha... I picked it up. And when we went down to the room he could see I was quite nervous. I was like a wreck, I felt I didn't want to be there but then he made me feel comfortable, "Do you want a drink? Do you want this? Do you want that? Do you want to lie down?" I thought, 'wow' you know, talk when you want to talk; you don't have to rush. (Ann)

Ann described being afraid of her first interview with the psychiatrist. The strangeness of the environment made her feel out of place. The greeting and hospitality from the doctor and the sense of aroha or love and care she felt made the difference for her, and she was able to feel welcome and ready to engage with him. This is the sense of wairua or spirit Tauroa et. al. 1998, p.47) spoke of which is important to establish peace and understanding between people. Jason describes how he approached his clinician:

... like when I first met him I was very standoffish. Very, very standoffish, because well I didn't really know him. (Jason)

Jason articulated his need to remain aloof and seemingly unfriendly until he felt sufficient trust in the clinician to be open. He very much sensed the domain of space and used it to his advantage as a means of keeping a good distance between himself and the clinician until he felt safe.

Lewis on the other hand had difficulty reassuring himself about the safety of the space he waited in.

*... and then like I was sitting down in the reception area and then this doctor comes over (who has a major physical disability) and I thought to myself 'f***!' they send the disabled man so that like it will 'pacify' me and then I won't... and then I will feel too f***ing guilty to go and like... you know. But in actually that in itself was huge I think, and if I wanna be truthful I didn't feel threatened by him.*
(Lewis)

Lewis observed the doctor, who was different from himself in ethnicity and physicality, across the space of the reception area and started to make assumptions about the intentions of the doctor, thinking he was perhaps a ploy to calm Lewis down. He goes on to challenge himself about this assumption. Being assessed at the mental health service seemed to be very threatening for Lewis, who hides his insecurity behind a tough exterior. In all these encounters the space of distance mattered. It gave each party room to see, to notice, to sense the mood, to question assumptions, to begin to build trust.

A non-Māori clinician from overseas, Kelly told how the whaiora felt reassured because Kelly did not know her or her whānau:

One of the reasons she gave me for wanting to see me was that I didn't know her family, I didn't know those connections and have a pre-existing knowledge of her family and maybe what that family was all about. She seemed to have a bit of a hang-up about how people perceive her and her family, because they are quite well renowned in the district apparently. So that was quite pertinent to her because she didn't want to be stereotyped. So we started on an even playing field of getting to know one another, that whakawhanaungatanga kind of process with no pre-existing ideas or stereotypes. (Kelly)

The whaiora seemed quite concerned that she would be prejudged if the other knew her family background. Kelly seemed to recognise the need for distance for this whaiora in order to establish a relationship based on the present and not the historical. She interpreted the term whakawhānaungatanga as getting to know each other, rather than the Māori meaning of 'making family connections', but this unique interpretation and use of that concept seems to fit this context, for this whaiora.

Ann, however, told of a time when there was too little thought given to her need for distance from a clinician:

Someone (in the mental health unit) obviously thought it would be nice to have Māori cultural input. I wouldn't let anybody near me so they thought they would get a Kaumātua to bless me. Yeah he knew who I was. He said he was related to my grandmother. He was touching me and grabbing me, trying to calm me down. I didn't feel comfortable. It just didn't feel right. No, no, no I couldn't be touched! I didn't want anybody near me! I only saw him once.
(Ann)

The first concern for Ann seemed to be the choice being made for her about her needs. She says “somebody thought” and “they thought”, clearly indicating that the thought had not been hers. Removing choice and not considering what Ann wanted did not aid her recovery although the thoughtfulness of “somebody” did show a caring outlook for her cultural needs. There is therefore the existence of caring but an absence of tact –or having the ‘right touch’. The closeness generated by the caring was nullified by the distance created by the assumptions and lack of tact.

The second issue Ann points out is being approached in this way by someone who is a stranger to her despite his whakawhānaungatanga (kinship claim). Again, this man’s approach was both culturally correct and not right for her. He acknowledged their shared whakapapa (ancestry) but failed to recognise that they were still strangers and therefore needed to begin a relationship with the distance of people who did not yet know each other.

Third, Ann objected to being in too close a physical proximity to a stranger who “touched and grabbed” against her wish. Rather than creating a comforting closeness by his touch it is clear he widened the rift between them. Ann’s triumphant “I only saw him once” is her statement about taking back the power to make her own choices.

Durie’s (1999) exposition of the domain of space refers to the maraeātea, the ceremonial space in front of the wharenuī (meeting house), the open-grassed area which provides a deliberate physical gap between hosts and guests, to demonstrate the contrast between them, to emphasise their different circumstances and “to judge the intentions of the other, without presuming that the outcome was to be friendly” (p. 353).

When we speak about distance, we first mean it as the space between us. We cannot occupy the same physical space as another. This is a physical impossibility.

Similarly we do not view phenomena from the same place as another. We see the same phenomena, but from a different angle. In thinking terms, the interpretations we make about a given situation, such as meeting in a health setting means we bring our own lens to the encounter and our judgments about that encounter are coloured by our past, by the moment we are in and by our expectations about the meeting.

Therefore, although we may even hold similar histories, beliefs and intentions to the other, our interpretations are made from a slightly (or very) different viewpoint.

Gadamer refers to this viewpoint or perspective as the horizon:

The horizon is the range of vision that includes everything that can be seen from a particular vantage point. Applying this to the thinking mind, we speak of narrowness of horizons, of the possible expansion of horizons, of the opening up of new horizons, and so forth (1979, p.302)

Non-Māori clinicians and whaiora each have the benefit of the view of their own horizon, but cannot know how the other ‘sees’ things. When they meet in the clinic they stay back to create a space from the other and they touch only briefly in a ceremonial way, with a handshake or a hongi. The other space is the gap between what each party believes they know and that which they do not know. This space I am choosing to call the dilemma of positioning in objective distancing. Each party holds uncertainty about what the other may believe, interpret from a situation and how they intend to act. This uncertainty can look like fear, avoidance, aloofness, ignorance, aggression or unwillingness to engage.

The uncertainty the Māori whaiora and the non-Māori clinician feel is evident in the stories throughout this thesis. In these accounts, uncertainty, rather than suggesting paralysis and withdrawal implies that each party knows they have to learn about and from the other. They have an awareness that there is validity in not only that which they already know but in that which they discover with fresh eyes and ears. This wisdom suggests they each “move forward with eyes on the past” (Buetow, 2004, p.420).

The Circle of Dialogue

When Durie (1999) talks about the domain of the circle he means the practice of standing, taking turns to speak on the paepae, either individual speakers turn-taking (tū atu tū mai) or one group after the other (pāeke), and ending with the reciprocity of the gift (koha). For Gadamer, this back and forwards dialogue at the point of meeting is to gather information:

...to discover where he is coming from and his horizon. This is not a true conversation – that is, we are not seeking agreement on some subject – because the specific contents of the conversation are only a means to get to know the horizon of the other person. (1979, p.302)

Both notions make the point that dialogue is the prerequisite for any understanding between different parties.

At the mental health clinic, the circle is represented by the sharing of information back and forth between the whaiora and the clinician – the question and answer of dialogue. If each party feels they are being dealt with honestly and equally there is a sense of reciprocity (koha). Koha strengthens ties and obligations between the parties and is represented in two ways at the clinic. One is the financial koha, as the whaiora brings funding from the government for health care. In this koha arrangement the clinician is obliged to meet the expectations of the funder and the whaiora has to recognise that money is invested in their care. The second koha is the gift of being listened to and acknowledged by the other. The stories of whaiora Jason and Anthony very much illustrate these notions, referring to honest and relaxed conversations paced to suit them, at a level understandable to both and involving the koha of being cared for and heard.

Definitely, I seen him as an 'equal'. I didn't have to see him as somebody who has got a higher status than I had. And yeah, I suppose he come down on my level and we just spoke like mates, you know. There wasn't all these prim and proper right words for this and that, it was just basically normal dialogue that we were using. (Jason)

Jason articulates the feeling of 'mateness' with his clinician partly because their dialogue was normal, without clinical jargon, ambiguity or 'big' words. As well as saying he understood the words Jason seemed to have the understanding that the relationship was friendly and equal. By using Jason's preferred words and style of

dialogue, talking 'like mates', the clinician's intention seems quite clear. It seems the clinician intended that they be equal partners in the relationship.

I always thought it would be your friends and your family that would be the biggest help in your life. And looking at it now it's just... I just probably felt more comfortable talking to a stranger ... because he didn't know my background, he didn't know anything about me... and I think we built a really good relationship, as a counsellor and client.

(Jason)

Jason came with his understanding that those closest to him physically and emotionally, such as whānau would be his greatest help. He expected to feel less comfortable with a person who was not close to him. He tells us that the counsellor/stranger was actually easier to talk to because of the lack of a pre-existing relationship - they did not know each other, they had no prejudgments, therefore they had to start with a blank page between them upon which to draw a relationship.

Rick also spoke about valuing the differences and distance between himself and his counsellor:

Within the first 5 to 10 minutes of our first session I had already judged that he was here to help me. So I could as a bloke, as a male, as a Maori male, I could take my korowai of masculinity off and just be me as opposed to... you know, you get the brown bros together and there's a brown bro psychology that takes over you know, and sometimes the individuals get submerged into that group psyche and that's not who the person is, not what is actually real, eh? And in that sense, he was non-threatening, he wasn't one of the bros, but more because he wasn't closely connected, you know emotionally, socially, all that sort of thing. That's why I felt trust. (Rick)

Family and friends, with their closeness have long knowledge of a person, and make their own assumptions about the cause of the mental illness. Perhaps they are too quick to jump in, to offer well-meaning but mis-guided advice. The clinician, being at a distance, has to ask and listen to put together the pieces of information about the patient. They themselves are not part of the story of all that has been before. This is perhaps why an objective outsider can sometimes ask the question that reveals and be more open to new interpretations and understandings.

Jason draws a distinction between a non-Māori counsellor and a Māori counsellor based on his assumption of the expectations another Māori would have of him:

I actually found it easier to talk to him. I think if I spoke to a Māori I would've probably been more withdrawn; I wouldn't have exposed myself as much, I suppose. I just felt more comfortable with a Caucasian, because I think I would probably think that being with a Māori they'd have really high expectations or... how could you put it? I think it's because, being Māori, if you are older, you've always got respect and I think you look at where "he's chief thinking 'oh no warriors don't do that!'" Sort of, that's how I look at it. He's a chief I am an upcoming warrior – no, warriors don't have problems, you don't have problems. That's how I felt but when I talked with a Caucasian, it was like hmph, I can easily just talk to you. (Jason)

He describes being concerned that he would be judged against the standards expected of a warrior, and be found less than acceptable. He says he would feel embarrassed to expose his vulnerabilities to a Māori and this is perhaps why he has put a brave face on things rather than admit to his problems to family and friends. He feels that a warrior would not show he needed help to other warriors. The counsellor, being an outsider, is not threatening to Jason's sense of self-esteem and he feels safe to share his vulnerability.

Jason is conscious of the power differentials within his own culture, but feels there are no issues of power in his counselling relationship. He describes the levels of hierarchy he perceives in his own experience of Māori society. He may also be describing his previous experience of feeling inadequate when people in authority have spoken with him in the past, making him feel inferior. He enjoyed the experience of being an equal party in dialogue with his counsellor, of having his turn to speak and feeling the clinician was listening, of trusting the nature of the circle of conversation. The importance of speaking so the other person understands us is shown in Anthony's story about his non-Māori keyworker.

It was lovely just to have [my keyworker] as a friend you know... I'd like Louise as a friend rather than a keyworker you know... I realise that she was doing a job and it's sort of like... she's got a responsibility [to get] a patient successfully adjusted you know... sort of like a friend ... you know. (Anthony)

Anthony experienced the keyworker's input as friendship. He was fully aware of her responsibility as a clinician but he sensed she wanted to create an equality, like friendship, to help him. He seemed to feel very close to Louise whilst recognising her true role. Perhaps she sensed his loneliness and wanted to create a feeling of not being alone for him. He is wistful "I'd like Louise as a friend". This story speaks of trust, genuine caring, closeness and support created by the reciprocity of the circle.

Summary

The stories in this chapter were about the unique opportunity provided by first meetings, and feeling uncertain how to relate to another person. The uncertainty and distance between people is even greater when the patient is Māori and the clinician is not. The doubts confront each person – what assumptions are being made, how much to reveal and how closely to approach the other. These stories revealed that the most successful first meetings happened when there was an awareness of difference, a recognition of the unique horizon of self and other, and when there was sound judgment about maintaining an appropriate distance. This is the dilemma of positioning in objective distancing. It requires an awareness of the need for space in which to build engagement rather than the overfamiliarity of immediate closeness, an awareness of one's own ignorance and a willingness to engage in the question and answer of dialogue.

Gadamer's view was that this first dialogue is not to establish concordance but to "discover where (the other person) is coming from". This notion, according to Durie, is shared by Māori in their oratory tradition. He describes the circle, or turn-taking, of speaking on the marae so each party can know the intention of the other. The stories of first clinical encounters in this chapter also show the intention of getting to know where the other is coming from and what their viewpoint or horizon may be. This chapter showed that the first meeting always involved uncertainty and differences between Māori and non-Māori in the clinical space. It also showed that maintaining a tactful, objective distance created the opportunity for new learning and growth. In the following chapter the stories reveal the evolving relationships based not on similarities but on differences and space for sharing and understanding.

Chapter Six

Walking with the Other

Nga iwi e	To all the tribes
Nga iwi e	To all the tribes
Kia kotahi ra	Let us all unite
Te Moananui-a-kiwa	We the peoples of the Pacific

In the previous chapter the phenomenon of the first meeting between Māori whaiora and non-Māori clinician revealed the uncertainty each party held and the distance between them. The distance enabled information to be gathered and allowed the intentions of the other to be revealed. At that time the clinician and the whaiora satisfied the mutual need to know the horizon, or point of view of the other and to recognise the difference to the other. The Māori and non-Māori positioned themselves in order to observe the horizon of the other as well as their own. This chapter shows the progression of the parties towards establishing a Kaupapa or agenda and the development of a working relationship. The uncertainty and distance revealed in the first meeting remains, but as the stories show, the distance creates space for play, learning and exploration.

Gadamer described relationship as being a two-way street, where each contributes a part to create the whole picture:

This whole relationship is articulated in the word ‘therapy’ which derives from the Greek *therapeia* meaning service...it does not imply that the doctor is simply exercising mastery of their craft. ...it suggests a relationship of respect and distance between doctor and patient. In this connection doctors expect something of themselves and also expect patients to make their own contribution as well.
(Gadamer, 1996, p.128)

To describe how a relationship develops in the Māori world on the maraeātea, Durie (1999) uses the concepts of Time, Authority and Generosity, Safety and the

Metaphorical. He says the completion of tasks in set time-frames is less important than the validity of the experience. There are few firm times set for hui (meetings) on the marae apart from meal-times. Authority and Generosity refer to the privilege held by the tangata whenua (people of the land) and the responsibility of building the bonds between 'the people from there' and 'visitors'. Safety, for Māori means the observance of tapu (to avoid danger) and noa (to make things safe) which promote good health and allow open discussion. Metaphors are often employed in Māori oratory to convey the matter-at-hand and are a "blend of political bluntness, diplomatic tact, artful expression and veiled allusion" (Durie, 1999, p.357). These domains and Gadamer's sense of a collaborative relationship are revealed in the stories of whaiora and clinicians in this chapter.

Giving and Taking Time

The gift of time was touched on by Lyn, Lewis and Ann. They spoke of the importance of not rushing, not being forced nor having anything imposed upon them. Time seemed to be experienced both as being *given time* and of someone *taking the time*. Lyn, a non-Māori mental health nurse, told about a long day she spent with a young Māori man:

They asked me to assess this young Māori man who had tried to kill himself but he did not want to speak to anyone. So what I did is I just sat with him; he wouldn't talk to me; he was quite staunch and the staff wouldn't let him go until they felt he was safe. So I sat with him for most of the day and his family came and went and I interacted with his whanau in front of him. Toward the end of the day, he finally started to interact with me himself. During the day I had thought that if I talk openly in front of him about my concern for him, finding out who he is, what he's about and what's happening in his life, relationships and family, I can try and build something with him instead of just "You are suicidal. We are going to send you to the Unit". So he talked to me a little bit, and acknowledged everything I had gained during that day.
(Lyn)

Lyn recognised this young man was keeping himself apart from others perhaps out of shame or distress. When her initial efforts to get him to talk failed she instinctively backed away from him to give him both space and time to make up his mind whether to trust her or not. He was perhaps keeping himself safe by choosing not to reveal himself. He would have become aware that she was not rushing him but giving him

the gift of her time and caring. Lyn used the time sitting with him to gather information about him from his whanau, forging a relationship with him by becoming more intimate with them. At the same time she did not impose herself on him, letting him set the pace. This story shows the importance of trusting the instinct to let things unfold in their own time rather than push the whaiora away by crowding him or alienating him, or abandoning him. The patience was rewarded for both Lyn and the young man when he came to see her intention was benign and accepted her earlier invitation to communicate.

Lewis described how the clinicians he worked with were unvarying in their attitude towards him. Someone having time for him equated with a sense of care:

And so giving me that time made it feel genuine ... that somebody is genuinely caring about me because a whole lot of other people that I thought cared about me did not have time for me, you know? And here were two people that were giving me time. Because I think we started off with like three sessions a week. (Lewis)

Lewis described feeling cared for because of the three sessions a week he was given in the early part of his recovery. In patient-centred care the ideal is for the service to fit around the needs of the whaiora rather than the whaiora fitting into the service. When the service given fits the individual, it sends the message that he, the whaiora, is the most important shaper of the relationship. For Lewis therefore, the meaning of having time made for him was of feeling genuinely cared for. The time and space he was aware was being created for him, opened the way for openness and trust with the therapeutic encounter.

Giving someone time means giving them power to decide how to proceed in the relationship. That is seen as genuineness by Lewis, perhaps making the power-sharing more meaningful. He then went on to describe the collaborative approach that time enabled to unfold:

You know I didn't feel forced ... there would be the odd prod or poke to get us going along, but then like if it didn't work, or wasn't going to happen, we backed off. And that was good. There was the finding... and again that comes from giving time to finding what was working for this dude; and again that just reinforces the sincerity and genuine concern and care; and it made me feel like a person. (Lewis)

The process as well as the content of the sessions seemed important to Lewis. The therapy actions of the clinician were more about the meaning he ascribed to them – they were offered but if they were not working he could back off. He described holding this position of power in that relationship as he was able to set the pace and use the time for “finding” what would work for him. Having both time and power made Lewis feel like “a person”.

Anne also described not feeling rushed by her doctor and not feeling pressured to talk. She was very aware of her need to “get it out” and her doctor seemed to sense that it would happen in its own time:

He never rushed me. And if I didn't want to talk then he never used to make me talk. But then I would look at him and I would go “oh” then I'd talk; if you know what I mean? You can look at somebody and not want to talk, or you can look at them and you want to talk. Because I knew I had to get it out and I could not keep it in, because it was just eating away inside. . He said “when you are ready to open up, you open up on your own.” And that's what I liked about him, because at least he didn't... he just didn't do it straight away; we opened it over weeks and weeks and weeks.
(Ann)

Ann, like Lewis, described being in charge of the pace of her recovery because the time was given to her by the doctor. She knew she needed to talk and was able to choose when to do this. Her doctor invited her to talk when she was ready to talk, not just because he was waiting. This suggests the doctor kept a space open for her to decide when and what to reveal. ‘Giving time’ to someone and ‘taking the time’ to be with someone therefore has many meanings: patiently waiting, creating space, not crowding, giving power and caring.

Authority and Generosity

Durie describes mana (authority) and manaakitanga (generosity; caring) on the marae as being fundamental to the arts of negotiation and enhancement of the other. Rather than the clinicians (tangata whenua of the clinic) wielding power over the whaiora (visitors to the clinic) because of the mana of *being* the clinicians, they have a duty to “negotiate mutually rewarding relationships” (p.358) with actions of generosity (manaakitanga). In the clinical setting one demonstration of generosity is seeing to

the comfort of the other, even whilst feeling discomforted oneself. The gift of giving comfort to Māori whaiora is evident in these stories.

Discomfort is often a feeling of being out of one's 'comfort zone', feeling unsuited or inadequately skilled for a task. The clinician who acknowledges their own discomfort and attempts to prevent the discomfort from touching the whaiora is engaging in manaakitanga. Rosemary, an experienced non-Māori clinician, spoke about going to the home of a young Māori man. She had not been aware he was Māori until they met and when they did she was not sure she would be the right person to help him:

I have done a variety of cultural trainings and have still felt inadequate ... ah no... I haven't felt inadequate; I've felt as if I have been told I have insufficient knowledge to manage different situations (so) I didn't feel comfortable when I first went to see _____ so I had to say to him "I am not sure this is a good match. Is this okay? There [are] other services" and I talked about other (Kaupapa) services and that there were male workers as well. He said "No, no, you'll do!" Right, okay then! I thought.
(Rosemary)

Checking out whether the match was right for the whaiora showed Rosemary's uncertainty and her worry that he would not get the best care from her. Her understanding, or misunderstanding from bicultural training was that as a Pākehā she would be insufficiently knowledgeable to work with Māori, and he should be referred to services or people who could relate to him. She offered him other options, without relaying her uncertainty to him directly, and the gift of choice was reciprocated by him choosing to work with her. Thus the to and fro of this dialogue created the basis of a relationship. From her position of authority, Rosemary gave the power back to the whaiora in a spirit of humble generosity.

The rationale for bicultural training is: "to develop training programmes to ensure appropriate response and cultural safety of tangata whaiora and whanau" (Te Puawaitanga, p. 16), but rather than increasing Rosemary's confidence to work with Māori people the effect of the training was to increase her doubts and to question whether she was the right person to work with this whaiora, and to seek to avoid establishing a relationship with this whaiora. Had Rosemary successfully convinced him to go to a different service the opportunity for the positive work that

subsequently transpired would have been missed. It was by recognising and acknowledging her limitations that the way opened to proceed. This tentativeness was important as it allowed the whaiora to choose and to strengthen the engagement with Rosemary.

Dave's story tells of his effort to explain his commitment to learn te Ao Māori (Māori ways) to a whaiora:

She said "What do you know about Māori ways of working?" and I said "well although I am Pākehā, I have worked in a Kaupapa Māori rehab before so I have a little bit of an understanding about some things and I know less about lots of other things as well." And I said "is that important that I know that stuff?" To her it was, and I said "Am I the right person?" and she said "well yeah, because you have been up front about everything." (Dave)

Dave was asked to describe his competence working in "Māori ways" by his Māori client. He felt he had to acknowledge being a Pākehā and therefore to make obvious the cultural divide between them. He shared the story of his journey to learn about Māori worldviews. This tentativeness is supported by Miller et. al, who suggested that the most effective therapists are doubtful about their ability and approach and question what they are doing by seeking feedback from their client (Miller, Duncan, Brown, Sorrell & Chalk, 2005). Dave was attempting to negotiate a relationship with the whaiora by acknowledging he had much to learn. The whaiora accepted his generosity and was also magnanimous in her reciprocal gift of allowing him to work with her. The invitation to continue the dialogue was accepted and a relationship could develop.

The therapist-as-expert has the role of being 'in charge' of the care of the whaiora but has the responsibility of ensuring the whaiora remains 'in charge' of themselves. Tactfully separating the illness from the person demonstrates the willingness to share the care and maintain the mana of the whaiora. Lewis described an incident when he got angry and left the clinic, retaining his dignity:

But I think one of the key things in the trust with (my clinician) was her seeing the true Lewis and looking past the symptoms and the anger and the rage I often felt. There was one time when I was supposed to come up with my wife but she was already there when I arrived. I walked into the reception area and she was talking to (my clinician) and I just felt angry and I walked out that day eh? The clinician always let me go if I was angry.
(Lewis)

Lewis spoke about how his clinician saw beyond his angry outbursts to the ‘true Lewis’, which demonstrated to him the strength of their relationship. There seemed to be a feeling of gratitude that his clinician knew him and trusted him well enough to respect his right to leave if he chose to do so. His story is about having his identity validated and his actions respected. He was relieved his clinician did not see his anger as mental illness. Being able to see beyond the outward appearance of a person – their ethnicity, gender or emotion – to the true person seems to be the basis of a good relationship. It reveals the willingness of the clinician to not apply a stereotype but to seek out who the person truly is. This is an example of authority from the perspective of being the clinician, balanced with generosity to allow the whaiora to be himself.

We become accustomed to our rituals and day-to-day procedures, expecting a certain process and outcome. When the unexpected occurs, things can go wrong and when they do go awry there is often confusion, disorientation and the instinct to avoid pain and distress. The human response is to step back from the situation, to create a space in which to get a better view of the issue and re-evaluate the situation. Dave, a non-Māori counsellor shared this story about giving standard information about professional ethics and the legal rights of mental health service consumers to a young whaiora’s mother, and how he was completely thrown off balance when his words were interpreted differently by her:

I started saying “my job is to make sure that your rights and your son’s rights aren’t breached”, and I don’t know how that came across to her but she started saying things like “you can’t tell me that things are wrong”, “how dare you say that”, “I came in here to suss you out and now you are going to start telling me how I am a bad mother”. And it just got really strange ... she got very defensive saying that I would be telling the Police about all this stuff. Then she said “What would you know. You are Pākehā” - which I am.
(Dave)

This conversation clearly had different meanings for the parties. Dave and the whaiora's mother seemed to interpret the spiel about patient rights differently. The non-Māori and Māori, the clinician and lay person, had very different histories related to legal protection.

When we misunderstand each other in conversation we can become flustered and stop communicating in a helpful way. Things, as Dave said, can get strange very quickly. The strangeness was not necessarily because of the conversation per se but due to the parallel understandings that were happening. There was a subtext here that Dave did not pick up on initially, "I don't know how that came across wrong", because he was not expecting there to be another way of seeing this issue. He took for granted that someone would be reassured by being reminded they had 'rights'. This is about the historical horizons each culture brings. Perhaps this woman's interpretation was of a barrier being erected between her and her son by the mental health system. Her mention of the police suggested that she was afraid of negative consequences if she agreed to these rights.

In this context Dave was trying to reinforce the rights of the whaiora with his pre-understandings as someone for whom this is routine and non-threatening. The mother's pre-understanding of legal-speak seemed to lead her to a different interpretation, of disempowerment and the historical abuse and loss of the rights of Māori people, such as the alienation of land and the suppression of traditional spiritual knowledge via the Tohunga Suppression Act of 1907 (Walker, 1990). Dave was clearly caught off-balance by her sense of effrontery "she got very defensive", and had no readily available responses for her. He chose instead to retreat rather than continue the discomfort by persisting. When she said "You are Pākehā" perhaps she meant 'you are part of those who abused our rights in the past, therefore you will not understand', perhaps trying to draw his attention to the distance between them and the reason for their different interpretation. Sensing he had come too close, Dave stepped back and allowed space to open between them by agreeing with her that, yes he is Pākehā.

This story demonstrates that when we become aware there is a conflict or an impasse we may need to step back and reinterpret the taken-for-granted understanding we

hold. Dave does reflect on the conflict he experienced. His talk about patient rights showed that his understanding of rights was benign and reassuring, based on the framework he recognised of professional accountability, best practice, and legal Acts. The woman, however viewed these same components as being confronting, disempowering and alien. The ‘strangeness’ for Dave therefore happened when he was presented with this woman’s different interpretation of the parts - the notion of having Rights bestowed when one feels one has rights already; the notion that legal rights mean more than mother’s rights and her experience that Rights are not the same for Māori and Pākehā/non-Māori.

These stories described acts of sharing information and deciding on the suitability or unsuitability of the non-Māori therapist for the whaiora. They show that when a clinician is open to the question of their ability and engages in a discussion with the whaiora about the way forward they exercise their responsibility to work collaboratively with the whaiora despite their privileged position of being the ‘expert’ in mental health. Their tentativeness shows they make no assumptions about being ‘right’ until both agree they are.

Safety

In the therapeutic relationship, initial hesitancy and uncertainty ideally moves towards a place where each feels safe with the other. For Māori, Durie describes Safety as the interrelated terms tapu and noa. Tapu creates an avoidance of activities and places “to prevent accidents and calamities” (p.356) and noa is the state of things, activities and places being rendered free of danger. In the mental health clinic, as on a marae you are visiting, the safe and unsafe places and practices are largely unknown to the whaiora. The responsibility to reduce danger and increase safety in this clinical environment – to reduce uncertainty - belongs to the clinician.

The safe feeling, when one can relax, knowing the clinician has identified and neutralised danger is talked about by whaiora Lewis and Ann. However, when the clinician travelled into the whaiora’s space; their home and their culture, the whaiora assumed the responsibility for ensuring safety - as clinicians Elvis and Jo described.

Lewis described feeling safe at the clinic, and how the safety had been created by the clinician's concern for his wellbeing:

Although we were in 'this' room here, there was another sort of environment that we established, and that gave me a sense of like, sense of safety, first. Because that was a really important factor too, like all the time that was a genuine, real concern from (the clinician and the doctor) about my safety and my wellbeing and... she was real, he was real.
(Lewis)

Lewis had the perception of being in both a physical space and a metaphysical space simultaneously. He felt that the safe environment he and his clinicians created together had little to do with the actual room they sat in. Sitting parallel to the physical room, Lewis sensed another room, not constructed of walls, but of care and concern for him. The "genuine, real concern" for his wellbeing transformed the therapy room from a physical space into a spiritual space which meant more to him than where they actually sat. That spiritual safe place seemed to give him the sense of security he needed.

Ann also described being able to relax in the clinic, because of the welcome she received:

I was allowed to lie on his couch, he would go "lie down, lie down, be yourself like you are at home", you know and I thought that was really cool. To lie down on the couch was really cool cos I done that once or twice and I felt relaxed, instead of feeling tense like when you first went in there.
(Ann)

Having attention to her physical comfort and feeling safe enough to accept the offer is Ann's story. The doctor recognised her weariness and tension and offered her a comfortable place to rest. She must have felt quite safe to have laid down on a sofa in a consulting room. This speaks of a deep level of trust and an understanding that the doctor was safe and would not hurt her.

The next two stories told of the whaiora's attention to the safety of the clinician. They illustrate Gadamer's point that each party has a responsibility to contribute to the therapeutic relationship. Perhaps the whaiora in these stories were aware of areas in which the non-Māori clinician could be on thin cultural ice which could possibly

endanger their relationship. They seemed to help out the clinician, and may have reduced the risk of the relationship failing.

Sometimes an unsafe place is not a physical space but a cultural space. Elvis, newly arrived from overseas and unfamiliar with Māori language described his attempt to avoid insulting a whaiora by mispronouncing her first name:

There was a Māori patient that I saw urgently with a colleague; with already the information that she was a bit sensitive culturally and had requested to see a Māori cultural person [who was not available] so I ended up seeing her. She had a European name and a Māori name that I struggled to pronounce, so I didn't even try and pronounce it. I was a bit too scared to pronounce the Māori name so I just called her by her European name. It was a kind of funny thing because I would've expected her to struggle to engage in a conversation with me, made worse by my avoidance of her Māori name, but she didn't. (Elvis)

Elvis was 'too scared' to pronounce her Māori name so he didn't try. He felt it would be dangerous to try it, and by getting it wrong, risk insulting her culture. He knew he deliberately avoided her Māori name and assumed she was aware of his avoidance too, but he commented that she did not mention it. She would have likely noticed his overseas accent, and assumed he did not know how to pronounce Māori words. At this point she seemed to have assumed responsibility for allowing him to stay in the safe terrain of English language.

Jo also told about a young whaiora's preparations prior to a meeting:

We met at her house one time and I asked if she wanted to say a karakia before we started. She said "Oh no, I've done all that before you arrived" and it was like walking into something that was really comfortable and nice and you know she'd done that work before I got there? I guess thinking about it now her preparing her house, which I thought was for her, was probably about making me welcome and comfortable as well. (Jo)

Jo intuitively sought to ensure the comfort of the whaiora by remembering to acknowledge her spiritual needs. Her pleasure is evident that the whaiora had already attended to her own comfort and safety. When Jo reflected on this experience it occurred to her that the whaiora was not only making the place safe for

herself, but making it safe for Jo as well. Each of these women felt responsible for looking after the comfort of the other. Their individual contributions of parts of the process enhanced the whole experience for them both.

These stories highlighted the importance of people feeling safe – in the place they are in and the person they are with, in order to reveal their vulnerabilities, their knowledge and their lack of knowledge. Both non-Māori and whaiora recognised this need and responded to it to benefit the other person. When each party takes care of the other by reducing danger and making things safe a sense of trust could flourish.

Talking

Communication as a normal day-to-day activity enables ideas to be shared with others. Durie speaks of the formalised art of whaikorero on the marae which can be direct and blunt but is more likely to be subtle, multi-layered and even non-verbal. He refers to this type of allegorical language as the domain of the metaphorical, where linear, to-the-point speech is less valued than that which “appeals to more than one sensory modality” (p.357). This type of communication however appears to be more concerned with establishing one’s own point and it is the reply which gives the opportunity for the other to make their point. Gadamer on the other hand, points more to the question and answer of dialogue, of “finding the right word or discovering the perfect expression in the words of someone else” (p.137)

The following stories describe the process of communication between Māori whaiora and non-Māori clinicians as they attempt to share something of themselves with the other. All the storytellers felt that these conversations marked a peak experience for them in their recovery, even if at face value there was nothing remarkable in the content of the conversations, or even when there were no words. They each discovered, as Gadamer suggested, the right expression in the words or the actions of the other.

Lewis felt the non-verbal and peripheral aspects of interacting with his clinician had a powerful effect on him, more even than the words:

(The clinicians) were 'real' people to me. I read a lot of body language and I pick up and feel a lot of energy from body language just from being into taiaha and stuff ... There was this energy that I felt around him (the doctor) and that was like quite soothing and pacifying. But yeah, his accent and his tone and pitch of his voice did a lot for me actually.
(Lewis)

Lewis reminds us there are numerous elements at play when we converse with someone. He noted particularly the lack of artifice and the genuineness of this doctor, and a sense of calming energy about him. This energy may be what Māori call the mauri, or life-force, every animate and inanimate object possesses. He explains his ability to read body language and energy come from his learning of the taiaha (traditional long staff), a skill requiring attunement to the spiritual as well as the physical elements. In his state of help-seeking Lewis valued the wairua, the generous spirit, of the doctor as much as the dialogue.

Anne felt it was easier to be honest with her doctor than even her own father:

And then I would go in there and I would tell him (personal things), and it was quite good to release that. Not many people knew. Not even my father knew anything about how I felt. Dr _____, he'd try to guide me and he'd guide me really well and I thought, 'oh, man you really know how to do this', you know. But he knew when I was having a bad day to not pry, but to let me open up.
(Ann)

This communication seemed to be characterised by very little dialogue but by the opening of a pathway for her to talk. She told him things about herself she could not share with her closest family. Perhaps the clue is that she felt the doctor was guiding her and not leading or pushing her. She knew he would not insist she talk when she was having a bad day and did not expect her to say anything. If she chose not to 'open up' that suggested the relationship was equal and not one where the doctor held all the power. She chose the pace of their conversations.

For Hollie, the motivation to be open and honest seemed to come from her clinician's bluntness:

*[My recovery] was mainly because of Mary really because she was so truthful. She more or less said "you **** me around, I'll **** you around" ha-ha but not in those words and every time I did something wrong or something... she was truthful with me, like "do you want a kick up the butt?" Or you know... something like that and yeah ... I could open up to her about stuff that I probably wouldn't tell other people.*
(Hollie)

Honesty underpinned the relationship Hollie described between herself and her non-Māori clinician. Her story shows her to be a plain-speaking woman who enjoyed being able to talk to someone equally plain-speaking. Sometimes as this story shows, it may be necessary to have assertive dialogue for two strong people to genuinely communicate. Perhaps it was the deliberate absence of metaphor that worked for Hollie. For her it seemed to be more important to have issues presented to her bluntly without the softening of imagery. Durie too spoke of the blending of the direct with the metaphorical in oratory; the choice dictated by the topic as much as by the speaker and the listener. In this story Hollie and her counsellor knew exactly what the other meant. Perhaps Hollie really needed a counsellor who could show her she was tough enough to help her towards recovery. The relationship may have been less successful if Mary had been shy and didn't speak Hollie's language. They both seemed to recognise that a matching toughness was necessary from Mary for them to have an equitable, honest relationship.

One of the non-Māori doctors attempted to help a whaiora, Ngawai, by strengthening the communication she had with her children. He arranged for the family to attend together:

Talking... openly (at the family sessions) was really different... like we never spoke like that as a family even if we were at home. You know we would just make sly comments and not really actually pinpoint what was wrong with our family. And I never quite listened to my kids. I would joke and they would joke with me so we never really got serious until we had those sessions with Dr S.
(Ngawai)

Ngawai described the doctor's attempt to help her by getting the family to talk to each other. She had noticed that they did not speak openly until they were with the doctor. Having a stranger amongst them seemed to highlight their usual style of talking and opened up new ways of talking and listening. Although he was not Māori he seemed to have a sense of the important role of whānau (family) in the health of the individual, and felt that strengthening the family would aid the mother.

Ngawai goes on to describe the process of the family sessions:

He's Pākehā, from England, but he looked like he was just trying to talk like us... like how Māoris talk... you know... ha-ha ... yeah he was just trying to go with the flow like how Māoris are you know. That's what I saw. He didn't talk stuck-up as if he didn't want to listen to stories or whatever was going on with the family... he was trying to figure them out... you know... trying to be like a bit of a gangsta sort of thing but... nah he wasn't stuck-up. He was there to help our family.

(Ngawai)

This doctor seemed to try to find the words and phrases that would resonate for the family. He succeeded in remaining himself, despite adopting the family's style, as Ngawai pointed out he is Pākehā who was trying to talk "like us". For talk to be effective it has to draw the listener into the conversation, and the doctor adapted his language to be acceptable for the family. Ngawai, and probably her children, were mindful that the doctor was not one of the family, but there was acknowledgment of his effort to "go with the flow" of the family. They all would have been aware he did not usually talk "like Māoris talk" but may not have noticed that he was working at shifting the power balance from himself, the white, educated doctor, back to the people who could most effectively help Ngawai. What Ngawai also appreciated was his willingness to listen to them, which highlighted for her that she and her children had stopped listening to each other. This doctor's gift to the family was to re-engage them with each other.

Lewis told of his deliberately circumspect conversations with his clinicians, telling them things in a veiled way to cope with his feelings of shame:

Because sometimes I could talk about certain things just in general and not specifically lay on the table what it was that I was talking about, ha-ha. And I don't know whether that had anything to do with trust, because otherwise I just wouldn't have talked and I would've just been an arsehole. But it was more to do with the shame that I carried; scared of what other people might

think if they saw what I really felt on the inside. And I was given time, by (the clinician and the doctor) and being able to come and talk.
(Lewis)

Lewis said he would talk about things in a general way and not “lay on the table” what he actually meant. Māori speech, when it is about anything important does tend to be circular, rather than linear and to-the-point. When the speaker talks in generalities using anecdotes and stories, the listener first understands the parts and glimpses the whole issue over time. It is also an example of the ‘hermeneutic circle’ in action. “The movement of understanding is constantly from the whole to the parts and back to the whole (Gadamer, 1979, p.291).

In Lewis’s story he aptly describes the process of therapeutic trust – his clinician seemed to understand that the most deeply hidden thoughts, memories and beliefs of a person will not be freely revealed but must be pieced together from the small offerings made by the whaiora. As Lewis said this is a time-consuming process, moving towards and away from an issue in the ‘hermeneutic circle’. Polkinghorne (1983) describes the hermeneutic circle thus: “The movement from the prejudgmental notion of the meaning of the whole, in which the parts are understood, to a change in the sense of the meaning of the whole because of confrontation with the detailed parts” (p.226-227). Working in such a way takes time, time to step back, to ponder, to see, before offering tentative insights back to the other. It is in the circling around that trust builds.

Summary

This chapter spoke of the successful relationships between people of different cultural backgrounds: Māori and non-Māori, mental health clinician and tangata whaiora. It began with an explanation of the maraeātea concepts of relationship-building: Time, Authority and generosity, Safety, and the Metaphorical, but the stories reveal how the meaning of these concepts is much more complicated than initially thought.

When the parties first met they viewed each other across the space of cultural difference, then tentatively approached, still unsure of the intention of the other. Each brought their unique viewpoint, or horizon, to the meeting - it was a horizon the

other may not have encountered before. For a relationship to develop each needed to step towards the other. Those horizons initially veiled from the other needed to be exposed, compared and contrasted, seeking commonality with which to build something unique.

This chapter revealed the importance of taking the time to build trust. In their stories whaiora told of valuing the gifts of time, patience and being in a position of power when setting the rhythm and pace of their recovery. There was also a strong feeling of the importance of safety in many stories – prerequisite to expose one's vulnerability. Safety was shown to be the responsibility of both the clinician and the tangata whaiora as they shared the task of recovery. When one felt safe one could take risks such as speaking about trauma or criticising the actions of the other. This led to the revelation that privilege and responsibility were held by each party at different phases of the relationship, with acts of kindness seen in their interactions.

Finally, this chapter showed the varied modes of communication between the parties. There was silence that soothed and revealed, plain-speaking that challenged and encouraged insight, honesty to confront one's own ignorance and fear, and the subtle intangible body language experienced as aroha.

The overarching understandings from this chapter are the interrelatedness of the elements of a solid cross-cultural relationship - that understanding between Māori tangata whaiora and non-Māori clinicians requires a safe place and time to find the right words. Further it requires a willingness to share the privileges and responsibilities of a relationship. This illuminates another important notion of the coming together and moving apart, circling the important issues and gradually gathering in the meanings from the self and the other to arrive at understandings acceptable to both.

Chapter Seven

Going forward

Tirohia kia marama	Observe to gain enlightenment
Whawhangia kia rangona te ha	Participate to feel the essence
<i>(Traditional Whakatauākii)</i>	

The previous findings chapters described the meeting of the Māori whaiora and the non-Māori clinician and the beginnings of a relationship. Initial uncertainty about the other and their different horizon led to questioning about the ‘rightness’ of the therapeutic relationship. The other was then seen as a person - ‘the Thou’ according to Gadamer, and the parties tried not to speak for the other but listened to what they had to say. After the first tentative steps a relationship was allowed to form which deepened with time, patience, and room for closeness and withdrawal. There was then the opportunity to observe the worldview or ‘horizon’ of the other, the prejudices held by each other, and to begin to work towards recovery. What seemed to emerge thereafter was the realisation of the importance of reading both aspects of the situation in which they found themselves. Doing so encouraged both parties to be in touch with the previously unseen side of the issue- the point of view of the other - as well as the aspect they were used to seeing. Thus the simultaneous viewing of both aspects; one’s own and that of the other, created a new and vibrant picture of the issue.

With this unique co-created horizon the Māori and the non-Māori proceeded along the recovery pathway as equals. This collaborative and trusting relationship, sometimes almost a friendship, allowed both parties to contribute to the recovery of the whaiora and the gifting of knowledge one to the other. The stories in this chapter described how joint discovery of the discordant aspects of the whaiora’s life revealed the means by which pride and health could be restored.

On the maraeātea, Durie (1999) described the phenomenon of shared meaning as belonging to the domains of Interconnectedness and Synchronicity. Meaning, he said, is revealed by recognising similarities, and it is also linked to time.

Interconnectedness therefore is the search for commonalities. In Māori oratory it is displayed by the linking of the mundane with the profound in tauparapara (chant or incantation), and in clinical settings by the correlations drawn between the distressing experiences of mental illness and lifestyle, strained relationships, physical ailment or reduced self-awareness. Synchronicity in Māori oratory occurs when seemingly unrelated events take on a new meaning; when they are linked together by time. In clinical settings this may be explored within the history and life events of the whaiora, when linkages can be made. Whilst not to the same extent as Durie's concepts there is an echo of the domains in the actions of the clinician and the whaiora as they seek to restore self-esteem, whānau relationships and mana.

The stories in this chapter describe non-Māori clinicians facilitating relationships beyond that which they have established with the whaiora. The clinician seemed to recognise the need for the whaiora to connect with others who can aid their recovery, and to develop personal resilience. These stories are therefore about the relationship culminating in a recovery journey with the clinician moving away as the whaiora is moved closer to whānau, medical care and self-reliance. Stories showed the non-Māori clinician and the whaiora developed unique blended ways of working together. They used Māori ways, non-Māori ways and more unique ways in complementarity, without coercion or artifice, but with tentativeness and bravery. As each party came to understand the mental health and recovery phenomena, new ways of working evolved that took into account the aspirations and understandings of both parties.

Blending Māori notions of wellness

Lyn, a mental health nurse, recognised the whānau's need to respond to the mental illness of a whaiora she had been working with:

"We had a family meeting, a hui at home, which was really quite powerful. I just went and was part of it, but was not the centre of it at all. It was run by his family, you know, 'this is what we are doing for him'" (Lyn)

Lyn included herself in the whānau hui (family meeting) – 'I was part of it', not standing outside the group but joining with them in the task of supporting the young man. She would likely have been closely allied with him until the hui when she acknowledged that she needed to move from the centre, towards the periphery and then away from the family. She recalled they had said 'this is what we are doing for him' and once the connection was re-established she seemed to realise she was no longer needed and the family would 'run things' from then on.

Ngawai came seeking help for her illness and was asked by her non-Māori doctor to bring her grown children to a family session:

It was a bit of a mission to get my children to come and see Dr _____ with me but in the end the children really liked it and it helped us grow more as a family. To me Dr _____ really opened up a door for me and my children to become closer. Usually they're so strong headed about going to these things with me but they came and we spoke about it after our appointments and it made them feel better that they could do something for me.
(Ngawai)

There was definite reluctance by the children to come into the clinic with Ngawai. She had had to work hard to persuade them to attend with her but because of her awareness of the distance that had developed between them she felt it was the right thing to do. In Māoridom there is much said of the importance of the whānau and the benefits of solidarity to wellbeing (Metge, 1990).

Ngawai said the doctor 'really opened up a door for me and my children'. There is both a physical and a metaphorical door here: First there is the doctor's welcome and invitation to the manuhiri to enter his therapy room and second, there is the opening up of doors of communication between him and them, and amongst themselves as a family.

It is of note that Ngawai speaks of *her children* feeling better after their appointments, rather than commenting on herself feeling better. Perhaps she felt better because her children felt better. It was clearly important to her that her children felt welcome there as she seemed relieved that ‘they liked it’. Her children perhaps liked the opportunity to draw closer to her and to restore the solidarity which had been missing for some time – ‘he helped us grow more, to become closer as a family’. In this story the non-Māori doctor helped the family to help Ngawai to recover. He seemed to understand that it was not Ngawai the individual, but the whānau group that required care in order for her to recover.

In this story, Jo, a non-Māori counsellor with many years of experience, understood the importance of using Māori concepts with a young Māori woman.

She was in quite a distressed state because of what was going on with her life. So I heard her story and it just seemed to me her whole spirit had been broken. And I used the Māori word for it “wairua” which made her sit up and kind of take notice - it was sort of a point of connection, her getting some sense that I kind of understood what it was like for her. And so at the end of the first session I said “How’s it been? Has it been useful?”. She said “Oh the fact that you put a few Māori words in just gave me a sense that you knew where I was coming from”. And from that moment on I knew that we would be ok. (Jo)

Jo recognised this whaiora’s problem seemed to be about spiritual unwellness. By considering this as a possibility she enabled the process of recovery for this whaiora. Despite bravely using the Māori concept of wairua, she still maintained her tentativeness by checking if it was alright for her to do so. Jo felt it was important to let the young woman know she accepted their cultural differences but that she was willing to try to identify a Māori concept such as wairua and formulate how damage to the wairua could lead her to feel distressed. Jo did not try to impose a non-Māori concept of mental illness, instead suggesting a Māori concept, because she seemed to feel that a “point of connection” was necessary. She was checking out whether her own non-Māori person’s pre-understanding of the meaning of wairua was right and if it was safe to use it as a common reference point. Jo’s tentativeness, even her use of Māori words, felt a bit risky for her and was rewarded by the whaiora’s reassuring words “you knew where I was coming from”.

Blending non-Māori notions of wellness

Sometimes the stories told how the whaiora felt most comfortable when their illness and recovery were re-framed in more non-Māori ways. Sometimes it seemed that the clinician being someone from outside their culture was an important part of their recovery. Stories show the different ways non-Māori notions of being or working eased the recovery pathway for the whaiora.

Jason spoke of his unexpected awareness of the power balance between himself and his non-Māori clinician:

Yeah, I broke down crying quite a bit in front of MW. I felt comfortable breaking down in front of him, releasing all the stress and what not, what I had. Well the other way I put it is I felt that he wouldn't judge me. Where if I had a Māori counsellor he would probably have judged me... warriors don't cry! (Jason)

Jason described being afraid of being judged critically by a Māori counsellor as he cast himself in the role of a warrior – showing only toughness. Perhaps he chose to see a non-Māori clinician because of his assumption about power differentials within the Māori hierarchy. Significantly, he described feeling safe enough to show his tears to a person from a different cultural background, one he assumed did not expect warrior-like toughness. This may of course be an inaccurate assumption, as the counsellor's culture may indeed have its own history of warfare, warriors and expectations of men's behaviour. If that is true the counsellor chose to put aside his notions of idealised maleness and instead deliberately created a safe, non-judgmental place for Jason to express himself freely.

Jason also felt that they had developed such a close, equal relationship that the clinician could be quite personal with him. The relationship seemed to rely on them meeting kanohi-ki-kanohi, face-to-face, to get to know each other and accurately pinpoint issues:

Well he would actually know (how I was) as soon as I walked in "you are not looking too good today. What's up?" I took that as constructive criticism. If it was a family member I would've taken that personally! But I would just open up to him and go "this, this and this" and kind of work my way around 'things'" (Jason)

Getting to know each other on a deeper level helped Jason to feel cared for by the counsellor. The counsellor learned to 'read' Jason and see beyond his exterior. This story also implies Jason trusted the clinician who could say 'you're not looking too good today' – he felt he was really 'seen' and it was comforting for him to be acknowledged rather than judged. He went on to say that if family had made a similar comment to him he would have taken it as a personal slight rather than as an expression of concern. It would seem therefore that Jason felt less judged than he would be by whānau. Perhaps it is that equality, emotional distance and empathetic closeness created in the relationship which allowed this openness.

Hollie was also impressed with her non-Māori clinician's hybridised way of working with her:

M used Māori ideas plus her own ideas together – that's why she was the ideal person for me. She made me feel comfortable when she explained a few things that she's learned from her Māori husband's family and how she understood them. And she would tell me about Māori things that worked for Māori people which made me feel a bit more comfortable in opening up. Probably if she was a Pākehā lady who didn't know much about Māori ways I wouldn't have told her nothing... but because M had a bit of history around that area it made me more comfortable to tell her that; and that was a lot of help to me.
(Hollie)

Openness to Māori ways of working was a strong inducement for Hollie. When the clinician disclosed her own experience of being part of a Māori family it was seen as common, safe ground for Hollie. She trusted a Pākehā counsellor because of her knowledge of Māori ways, a trust that would not have developed with a Pākehā who did not disclose such experience. What is noteworthy is that the clinician did not have to be Māori, it was enough that she had learned Māori ways from her husband's family and combined them with Pākehā practices. This story speaks about the need for clinicians to be open to new cultural experiences, to see how those experiences could usefully combine with their own practice and to be willing to try these blended practices in their work.

Working in human to human ways

These next stories show unique relationships and recoveries which do not draw heavily from either Māori or non-Māori ways of working and seem to be co-constructed from the experiences of both parties. Enlightened openness to human relationships as described by the I,Thou concept of Gadamer (1979) becomes apparent here. The whaiora and non-Māori clinician both discard objectifying the other, recognising that they do not know the other better than the other knows him or herself. The stories seem to show whaiora and non-Māori clinicians have listened to what the other has to say and found a new human-to-human way to relate. Further, they show that highlighting cultural difference, and trying to work cultural appropriateness into a relationship is not always necessary for a successful outcome. Within the field of research there are new terms for the methodologies that deny the absolute rightness of both Western paradigms and call for indigenous paradigms to be opened up to subgroup of voices (Chilisa, 2012). These methodologies are termed the “space in between” or the “third space” (Bhabha, 2004, p.54). The third space seems an apt description to borrow for the interactions seen in the following stories.

Anthony describes appreciating the relationship he developed with his non-Māori keyworker:

[My keyworker] L was down to earth... she was a good listener... she was quite humble. I appreciate them giving me a person like L to make sure that I recovered. And it was lovely just to have us as friends you know... I'd like L as a friend rather than a keyworker. I realise that she was doing a job... she's got a responsibility to see that the patient is successfully adjusted you know. It made me feel good about the health system because by giving me someone like L they regarded me as special... you know.... and I know it's a funny thing but... when you part ways with L... you part ways with the health services and if you just keep well you won't have to see them again you know... it's a bit sad...but friend or not... you know... it's her job... good bye.

(Anthony)

For Anthony, his recovery was almost incidental to the relationship he enjoyed with the clinician. He described a feeling of friendship, being regarded as special, and being listened to were valuable to him. His clinician created the relationship by being a good listener, being humble and down-to-earth. These are not culture-bound characteristics; they are natural human attempts to show friendship and a willingness to help. Anthony, despite being aware that the clinician was only ‘doing her job’,

felt that she and the health system were treating him as a special person. He said that feeling of friendship made him feel good and cared for. For him, being discharged was like the ending of a friendship with his clinician and he is even quite wistful about being recovered. Getting well for him still meant being sad when parting from her.

Ngawai also described how being heard by her non-Māori clinician aided her recovery:

I think my two sons were like “yeah Pākehā s eh!” when I asked them to come to my sessions. But I reckon they really enjoyed it with Dr S. They never spoke down on him after we left our appointments so I reckon he did something good in those sessions... he listened to us. He opened his ears and his heart to listen to what’s the problem between me and my family and what was wrong with me... why I went the way I did.

(Ngawai)

Ngawai seemed to have been apprehensive about bringing her family to the doctor’s session with her. They seemed to have made an early assumption that the doctor, being non-Māori, would not work in a way that would suit them. She noted however that “they never spoke down on him”, suggesting her children revised their assumptions after they met the doctor and accepted him just as a person, not just as “a Pākehā”. She thought this happened because of his willingness to listen to them wholeheartedly, not only with his ears. This non-Māori doctor therefore listened to them and showed them how to listen to each other. It helped them to recognise the whānau problems which had led Ngawai to be unwell. It seems that when one really listens, not just with the ears but with the heart, the other feels valued. It requires that one does not assume to know but seek to know the other.

Hollie told about her non-Māori counsellor’s efforts to keep her engaged in her recovery plan:

Yeah my counsellor just kept ringing me, to “get my butt in there”. She was so persistent and just rung me all the time when I’d miss appointments and stuff like that. She was going out of her way to help me. Like if I never had a ride or stuff she would help – just to get me to my appointment - yeah send the car to pick us up. It was raining as one day and I had to be there to see the doctor to get my [medication] I had no ride and she sent a car to pick us up to go. Yeah “at least she thinks about us” I’d say. (Hollie)

The counsellor's persistence, "ringing all the time and going out of her way, sending a car for us" speaks of both an assertiveness in her approach and a deep caring for Hollie's welfare. She seemed to show her concern in her actions as well as her words. Not just talking the talk but walking it as well perhaps. Hollie interpreted this tenacity as her counsellor "thinking about us". When we know someone is concerned for our physical wellbeing perhaps we are more willing to also be concerned and put effort into recovering.

Summary

What emerged in this chapter was the willingness of the whaiora and the non-Māori clinician to work together. Their efforts highlight the relationship between aroha and mana; between care and respect. Joan Metge, (1995) explained that although the concepts of aroha and mana are often viewed as oppositional to each other they actually constitute a complementary pair. She says "where mana is responsible for differences of status among whānau members, with the potential for jealousy and competition, aroha motivates them to work together for the good of all" (p. 98). Although this mana/aroha complementarity is described here as reinforcing whānau working relationships it is also apparent here in the working between the non-Māori clinicians and whaiora.

Another Māori concept embodied in these stories has been mahi-a-ngakau, meaning work done *from* the heart, or work *laid upon* the heart, or a sense of duty or perhaps work that one feels passionate about. The non-Māori clinicians and whaiora in these stories demonstrated mahi-a-ngakau by wholeheartedly creating therapeutic relationships despite unfamiliarity about the culture of the other, uncertainty about one's suitability and the occasional misunderstandings which highlighted ignorance. The duty implied in this concept is perhaps the duty to care for each other, not only in regards to physical needs but also mental health and spiritual needs.

Seeing the other as a human, recognising the prejudices one holds and exposing those prejudices to scrutiny seemed to allow room for compromise, creativity and being outside one's comfort zone. It allowed both participant's worldviews to be the 'right' worldview.

What emerged in these stories was the blending of Māori and non-Māori ideas into new and vibrant ways of working. The fusion of horizons allowed both to see the outlook of the other and to create a shared view which led them onwards in their pursuit of wellness.

Chapter Eight

Discussion

Introduction

This study grew out of an interest in recovery from mental illness. More specifically the interest was in the recovery that happened within therapeutic relationships, when the patient and clinician were from different cultures. In the context of Aotearoa New Zealand the pairing of interest was Māori patient or whaiora and non-Māori clinician. I wanted to understand what was hidden in the unfolding of these relationships rather than accept the taken-for-granted assumptions that whaiora may not receive care that they value from a non-Māori clinician. Revealing that which has been hidden goes beyond the impressions we can see with our own eyes. Seeing with our own eyes only reveals a part of the truth – the challenge is to come closer to seeing with the eyes of the other, to share the view of their horizon, to see how they see things and create a new view. Perhaps then more of the whole picture is revealed to us.

As Gadamer (1979) said the intention has been to bring the far near so that it speaks to us, in a voice that is new and also more clear (1979). I have sought to amplify the understandings of the cross-cultural possibilities in mental health care to develop other effective options to stand beside the traditional ‘By Māori, For Māori’ ideology recognised to date as best practice. The literature about successful Māori/non-Māori therapeutic relationships is emerging only tentatively. However, the reality of current service delivery is that many non-Māori clinicians are working with Māori whaiora and so an increased understanding of what ‘works’ in this dynamic is important to increasing cultural safety for both service users and practitioners. I follow Gadamer’s direction in seeking to bring a message that is both new and has a fresh clarity.

This thesis has therefore aimed to uncover and uplift the strengths that exist in a cross-cultural therapy relationship by revealing what works well. The data tended to fall into three stages of the recovery journey: meeting, gaining shared understanding,

and working jointly. The hui process described by Mason Durie (1999, 2007) fitted well with these findings and Durie became a dialogical partner (Smythe & Spence, 2012) to my thinking and writing. This thesis showed how the phases of the growing relationship between whaiora and clinician mirrored the three stages Durie described in his model. What was also revealed was that the relationships fell naturally into this process, based on growing confidence, trust and shared horizons.

Furthermore the thesis revealed the application of recommended recovery competencies such as those proposed by Jacobson and Greenley (2001), who identified the importance of the combined contributions of the recovering individual and the service provider when, “both consumer and provider come to see each other as human beings” (p.484).

Finally the research finding contributed to the ever growing body of literature suggesting that culturally safe practice enhances the recovery experience for the whaiora.

The thesis of the thesis

We’re all different

No two people are the same, even if they are siblings, or from the same ethnic group, or go to the same church. There are always likely to be more differences than similarities. It is the interplay of the differences that creates the relationship and makes it more vibrant – like the green, blue, grey and silver of the inner pāua shell, each colour unique but a beauty arising from the subtle blends.

Because therapy involves dialogue this thesis focused on the experiences of both Māori whaiora and non-Māori mental health clinicians who described therapeutic experiences which had been very positive and led to recovery. Seeking the peak experiences revealed both the struggles and successes of learning about the other person. In other words, ‘peak’ does not imply that building a relationship was necessarily easy or without tension. However, the participants from both sides of the relationship revealed the genuine satisfaction that emerged from getting to know each other and working through the differences together.

Space between

When we meet someone, whether at the mental health clinic or on the maraeātea there is a space between us. Whether it's a ritualised gap such as waiting to be welcomed onto the marae or the necessity of waiting for an appointment there is a sense of anticipation and expectation. The gap intensifies the gravitas of the occasion and delineates the roles of the parties. It signifies that this is no casual meeting. The gap sets the parties apart and creates the understanding that there are unspoken rules here.

Circling

The parties sense the space between them and tentative approaches are made by each person. Verbal and non-verbal information is shared to and fro in a dialogue across the space. Within the safe boundaries of the clinic a degree of intimacy can develop, slowly and tentatively. This sharing of information begins to establish trust and openness with the safe distance remaining between them. The clinician being at a distance has to piece together an understanding of the whaiora and their problem from the information offered. The circular sharing of information also has the benefit of levelling the playing field as neither party can see all the picture at first. The view at first is only of one's own horizon, but by circling around each other a new shared view emerges.

Being uncertain

The space between parties when they meet and begin to establish a common ground allows recognition of difference and assumptions to be revealed. The mechanism of uncertainty ensures an appropriate distance is maintained during the process. Even after greetings and the setting of agendas happens uncertainty remains as a boundary. Each party constantly checks in with the other to avoid the pitfalls which can happen with overfamiliarity and unwarranted assumptions. There is a pace to the degree of self-exposure that matters. Respect and tentativeness from each party leaves room for the other to reveal aspects of themselves when they are ready.

Learning and growing

The scene is set for learning about the other during the early dialogues. Information is shared to and fro, turn-taking, testing one's prejudices and assumptions. It seems neither professes to know anything much about the other until they get the confirmation of what is 'true'. Questions clarify the viewpoints and past experiences of the other. With this tentative talking across the gap there is an opportunity to learn about the other, gradually diminishing the sense of distance between. A growing sense of closeness emerges as each comes nearer to the other in revealing self.

Giving and taking time

Time is a resource which can be measured out in time-bound portions or freely given as the situation requires. With the health service time is generally governed by the competing schedules of client load, administration, and meetings. One could argue that the clinician had limited time to 'give', yet that was not how the whaiora experienced 'time' within their encounters. They told stories of when time was given to them. They seemed to use that space to linger over their deliberations, to pace their responses, discovering what was important to them in their own time. Being given the time to decide a course of action or to complete a task is a gift which may cost little to the giver but is of great worth to the receiver. Time also had the meaning of being treated with patience, gentleness and calmness. For Māori whaiora it meant being able to settle one's body, one's emotions and one's thoughts before engaging in a difficult process of revealing inner self to a clinician.

Being rushed on the other hand created a confusion of physiology, emotion and thought. It is likely that the clinicians did have time constraints, yet they seemed to have learnt the art of pacing the time they had to attune to the needs of the client. They did not hurry them. Rather they invested the time in whatever mattered most, right then. They revealed the art of slowing themselves amidst a busy schedule.

Privilege and responsibility

The authority figure wins respect when they create opportunities for the other to feel at ease. The dual actions of working within the tension of being in authority and acting with generosity are fundamental to the development of mutually rewarding

relationships. Often it is only apparent who the important person actually is when they are observed to be the one giving comfort to the other. This is when the true balance of power is revealed. There were stories from clinicians that revealed their sense of feeling alone and vulnerable amidst a gathering of whanau, or even in the one-on-one relationship with a client when cultural issues were to the fore. The clinicians were mindful that they could so easily 'get it wrong', breach protocol and/or make a fool of themselves. Both whaiora and non-Māori clinicians spoke of being treated kindly by the other and each therefore sensing the mutuality of their relationship.

Being Safe

Safety means being able to walk into an unfamiliar territory without overwhelming fear because you have reassured yourself or been reassured by someone else that perils and dangers are being managed. When a therapeutic relationship is between culturally different people the responsibility for achieving safety is shared by both people because of the culturally different perils likely to be encountered. Each of them has their culturally different experience and knowledge to draw upon. Safety in all areas cannot be adequately managed by just one of them. There is a responsibility to use one's foreknowledge of potential dangers to warn the other and to take necessary steps to remove or mitigate the danger. If one proceeds into a situation perceived as threatening assuming the other also is aware of the danger without checking that out, one fails in their duty to protect the other. The pathway to recovery as this thesis has revealed has its traps; by identifying them to each other the recovery pathway is made safer.

Finding the right words

Gadamer (1979) says the point of dialogue is to find the right expression in the words of someone else. Language, whether verbal, non-verbal or sensed in the spiritual realm is how we share the content of our thoughts. Finding the right words to express something so another understands you is not always easy, particularly when describing something one has not encountered before such as mental health issues. It is like the party game where pairs sit back to back: one has to describe an item they are given, such as a ballpoint pen, without naming it or what it's used for, and the

other has to draw the item based only on their partner's instructions. As in this game, the choice of words is fundamental to a conversation if one is going to deliver and receive messages which are intelligible. Finding what helps the other to get 'your' meaning sometimes only occurs when we modify our dialogue.

Being creative

Non-Māori clinicians and whaiora who initially viewed recovery through only the lens of their culture, discovered multiple other permutations of recovery when the horizon of the other was simultaneously viewed. Treatment approaches tended to be novel blends of talking, waiting, being quiet, taking medication, being assertive, using karakia, bringing the whanau, or seeing the individual whaiora alone. These blended approaches were achieved when each person felt they had worked out the intention of the other, gave each other time and space, created a safe environment and shared responsibility for recovery. When this closeness was achieved common goals and the means to reach them were enacted. Creativity flourished in these encounters as each brought knowledge from their own history to the relationship. What was noticeable is that the presence of prejudice, or pre-understanding of self and other which had revealed itself in the uncertainty and tentativeness of the engagement, was a positive and generative force in recovery. Without bringing one's own understandings and contrasting those with another's understandings there would have been no growth and no new understandings generated.

Lampert (1997) puts forward the argument that 'culture conflict' and dispute over the meaning of a history is essential to cross-cultural interpretation. The assumptions and misunderstandings described in the stories within this research which led to dispute and discussion, made it highly desirable for the two to find understandings which would fit both their worldviews, and to work creatively with those new understandings. The creative responses showed two humans working collaboratively, without relinquishing their worldviews, to create new human-to-human horizons.

Working with the findings of the thesis – Meeting Pania

This thesis is a professional doctorate, opening up cross-cultural experiences in mental health. I feel the need to pause, to reflect on the work itself, to return the focus to the clinical experience. I have tried to shed light on what works well when non-Māori clinicians work with Māori whaiora, and yet this journey began because I questioned my own cross-cultural mental health experiences. It feels important that I shift the lens to my work, that I ask myself whether the insights from this thesis have influenced my practice. Have the insights from this thesis influenced how I work cross-culturally? It feels important to open up my practice to scrutiny in the new light of the findings from this thesis. This is therefore the story of working with Pania. Her name is changed for confidentiality, but this is a real story.

Pania was waiting in the reception area. She was an attractive young woman in her mid-twenties. She looked Māori to me. She has very curly dark hair which she wore tied up beneath a headscarf, olive skin and brown eyes. I looked hard at her face (we Māori believe we can tell to which iwi/region of Aotearoa/New Zealand someone belongs by their complexion and features) and decided she looked like a ‘coastie’, one of ‘us’ from Ngāti Porou/East Coast. I smiled at her and extended my hand:

- “Morena, I’m Inez”. Her reply startled me.

- “Hi I’m Pania. Nice to meet ya”. Australian accent. Not Māori?

Later in my office we both had some questions for the other. I started, trying to understand my misassumption:

- “Your accent surprised me! You look Māori. Where are you from?” (That’s a typical question to ask Māori people – to establish some whakapapa and whanaungatanga – misassumption number one from me)

- “Yeah I’ve been getting that all the time. I am Māori but my mum moved us to Melbourne [Australia] when we were little. I don’t know where in New Zealand we’re from really. I’ve come home for my kids mostly... to try to learn about my whakapapa and their dad’s too, you know”. It turns out she’s lived in Melbourne for over twenty years. Pania had her own surprise for me:

- “And then there’s you - you’re Maori? I was expecting someone white” [We both laughed because at that time I used a non-Māori married last name]. (My misassumption number 2 was that she would *know* I was Māori from how I look regardless of my name).

I started wondering what this Australian-Māori was doing here. She looked well enough to me. What help could I offer that she couldn't get in Melbourne? Was she Australian or Māori? This was when I picked up on my own faulty assumptions about Pania and realised I was interposing my own beliefs about her which may not be accurate. I made myself step back to provide space and time for her to tell me her story. Here is a praxis of that story:

Pania's children's father was deported from Australia back to Hawke's Bay, and although they had been split up for some time she felt it was important that the children have a relationship with him and their whanau.

Pania's mother is Ngāti Kahungunu from Hawkes Bay and there is some whanau Pania knows here. Her father is Māori but has been estranged from his former wife and daughters for many years. His wife took the girls to Australia to get away from his violence and inter-generational sexual abuse. The daughters have disclosed being abused by him. Pania was raised Australian with no knowledge of tikanga Māori until she met the father of her two children, a young Māori man from Hawkes Bay. Although that relationship did not last she realised she wanted to find her father and learn his whakapapa - so she came home when her former partner did. Her mother and sisters back in Melbourne were very upset and angry with her for wanting a relationship with her father's whanau. Pania had enrolled in courses in Māori language and visual arts. The first assignment in the language course was to investigate one's whakapapa/genealogy, and she had had her initial contacts with her father's family rebuffed. Her mental health problems were related to stress, self-doubt and guilt about her journey of self-discovery.

When I actually listened I heard that she felt alienated from Māori culture, from her mother and sisters, and from her father's family. I realised that I had almost alienated her further by calling her 'Australian' in my head.

I heard how important it was for her to engage with her family's past, (even though some of it would be unpleasant), and realised my prejudice was that her father wasn't worth getting to know.

I heard that she wanted to learn cultural knowledge she had not experienced as a child and to be more Māori. I realised that despite my labelling her 'Australian' she was as Māori as any other Māori in her own unique way.

I heard that having grown up without knowing part of her whakapapa she had fears about the rightness of her current decisions. I decided I wanted to make it safe for her to discuss her anxiety and come up with creative options to recover.

As we were circling the topic of belongingness and identity as Maori I decided it may make the space safe for her if I shared some of my own whakapapa. My intention in disclosing my whakapapa was to establish some common ground, make the topic of whakapapa safe and leave the door open for her to choose to have a therapeutic relationship with me.

We went on to work together for some time. Pania remained Australian, as she was raised, but also regained her identity as a Māori woman. To help her to feel less anxious about her search for identity we found ways to blend her Australian outlook, such as the focus on the nuclear family, with her new-found Māori appreciation of belonging to a wider family. I took away a new understanding that some people feel they must know about their roots even if it means confronting some skeletons in the closet.

When I reflect on this example of my practice I understand that I as a Māori psychologist will encounter every whaiora, Māori or non-Māori, with my prejudices or pre-understandings intact. Indeed my pre-understandings are part and parcel of who I am and influence every decision I make, no matter what I am doing. The new learning for me from the findings in this thesis is the importance of knowing what those pre-understandings might be and how they will affect how I interact with someone else. The option of treating everyone the same does not exist because my pre-understandings meet head-on with the other person's and create a unique environment for that interaction. The stories in this thesis showed me that once I became aware of misjudging a situation I needed to step back and remember I know nothing about the other person's worldview. If I can give them time and allow space for them to tell me how they see things, and then try to show them something of what

I see we might uncover the common ground we need for a relationship. When I did that with Pania I could see who she really was and what she needed from me.

Relationship-building seems to be important at every stage of the recovery journey.

My own experience as a therapist, running alongside the analysis of the data in this thesis, has resonated with the findings. I have become more mindful of how the client comes to the maraeātea, as stranger, perhaps anxious, always unknown. I recognise more sensitively my role as tangata whenua and the power I have as the person-of-the-place. I appreciate the rich possibilities that lie in the dialogue in which I come to know more about who my client is, and they in turn get to know something of who I am. The time allocated for my appointment is reframed as time to be gifted in a manner that is attuned to the pace and needs of the person. I am there to work-with them on their journey towards recovery. I am more confident in working with the tensions as we circle each other, noticing as the space between becomes closer. I value the reciprocal nature of the relationship, understanding that the client can also help me to be 'safe' within this relationship. As in my experience with Pania, not only was I rewarded in witnessing her regain her sense of equilibrium, but I am mindful that I too was enriched by the shared experience. Even when two people appear to be from the same culture, that may not be the case. I have learnt to accept that every new therapeutic encounter begins with the possibilities of a cross-cultural gap to be navigated with wisdom and grace.

Linking back to Other Literature

The bulk of the research into Māori health has been generated by Māori researchers in Māori settings, using Kaupapa Māori methodologies which "come out of the practices, value systems and social relations that are evident in the taken-for-granted ways that Māori people live their lives" (Smith, 2005, p.90). With the intention of making things better for Māori, that research has tended to be issue-focused, offering both solutions and explanations from within Māori frameworks (e.g. Durie & Kingi, 1997, Huata, 1999, Fenton, 2000; Moeke-Maxwell, Wells & Mellsop, 2008, Masters, 2002, Cram, Smith & Johnstone, 2003; Wirihana, 2008; Ianovski, 2009; Abel & Marshall, 2009).

The present thesis has used a positive lens to focus on strengths rather than problems and offers insights into what works well. Other researchers have also sought to understand the mechanisms and knowledge behind recovery for Māori, (Pitama, 2012; Waitoki, 2012) and one other has examined bicultural working between a Māori whaiora and a Pakeha counsellor (Crocket, 2010). My thesis has attempted to illustrate recovery as it occurred between Māori whaiora and non-Māori mental health clinicians when their engaging and working was not overtly situated within established bicultural frameworks and expectations. The whaiora and the clinicians in this thesis tended to be aware of something good happening without working to any specific guidelines of methods or actions. Nevertheless, it seems that more often than not their practice would have been congruent with bicultural guidelines.

Professor Sir Mason Durie's 2008 'three phases of health intervention' showed how Marae encounters can be models of interaction for Māori clients in health or school settings, and has evolved out of his earlier notions of Māori psychology as it occurs on the maraeātea (Durie, 1999). The present research, whilst not setting out to demonstrate this model, has surprisingly revealed the unsearched for innocent mirroring of the phases of whakapiri (engagement), whakamanawa (enlightenment) and whakamana (empowerment) Durie described. The stories showed how the relationship between Māori whaiora and non-Māori clinician fell naturally into similar phases and explained themselves much as Durie had predicted. Durie's explanatory model is a Kaupapa Māori model; the ways of working described in this thesis, whilst similar, are the components of a natural humanistic therapeutic relationship.

Recovery as articulated by previous researchers is a journey and a destination; multidimensional and deeply personal (Anthony, 1993). It has been described as being reliant on attitudes and experiences of the recovering individual as well as an environment of tolerance, listening, empathy, compassion, respect, safety, trust, diversity and cultural competence (Jacobsen & Greenley, 2001). Furthermore the qualities of a culturally competent mental health worker include being able to listen and communicate respectfully, assist the self-recovery efforts of the individual, and develop good relationships with the service user (Lakeman, 2010).

This thesis, bringing a hermeneutic lens to cross-cultural relationships and the recovery of the whaiora in mainstream care, has highlighted the ideals of recovery

articulated in the literature reviewed. Stories pointed to the value of being listened to, having space and time to develop harmonious relationships and having their cultural and personal identity affirmed by the clinician. Another strong theme was the trust that developed and enabled Māori and non-Māori concepts to be modified in their recovery journey. Such personalised therapy was seen to occur because both the whaiora and the non-Māori clinician maintained a respectful distance and approached the other tentatively.

Taking the time to view the horizon or worldview of the other alongside one's own familiar worldview provided a fertile space for new understandings to flourish.

Implications for Mental Health Practice

All psychological 'talking therapies' require certain therapist characteristics such as Rogers (1957) assertion that the therapist's ability to be empathic, congruent and exhibiting unconditional positive regard for the client were not only essential but sufficient. These characteristics are theorised in the seminal work of Bordin (1976) to assist in the development of the 'therapeutic alliance' emphasising the client's collaboration and comprising the components: tasks (the substance of the therapy), bonds (such as trust) and goals (outcomes). That such regard, genuineness, trust and collaboration opens pathways for positive work between the client and the therapist is unquestioned. This thesis has sought to look deeper into these truths into what *enables* the regard, trust, and genuineness between therapist and client from different ethnic backgrounds. The new understandings are that alongside the essential characteristics of the therapist there are the requirements of being uncertain, giving and taking time, allowing space, sharing horizons and co-creating new horizons.

The Ministry of Health "is charged with setting the direction for Māori health and guiding the sector as we work to increase access, achieve equity and improve outcomes for Māori" (Ministry of Health, 2016). One of the ongoing suggestions has been the need for more Māori health professionals especially in services with high Māori access. Hawkes Bay District Health Board has a key performance indicator to increase the Māori health workforce by 10 percent each year until it matches the percentage of Māori residing in the region (Hawkes Bay District Health Board, 2013). Until then the reality is that only 10.6% of the total workforce (including

nursing, medical, allied health, support and administration management) of the District Health Board is Māori, while Māori make up 22% of the Hawkes Bay population (Hawkes Bay District Health Board, 2013b).

Whilst reflective practice and bicultural training are positive processes for all clinicians, it is important to acknowledge their successes and the understandings co-created by them and the whaiora they work with. Whilst mental health services must continuously strive to have a diversity of cultures represented in their staff, they should be encouraged to recognise the accumulated knowledge already present within their teams.

If non-Māori clinicians stay mindful of the degrees of ignorance they possess about Māori culture and Māori recovery and maintain a deferential position to Māori knowledge then they are less likely to make competing cultural knowledge claims. In admitting they do not know the answers the way is open for reciprocity and trust to build. A position of assumed subordination leads the non-Māori clinicians to accept uncertainty, cultural distance and a position of *not knowing* that is valued and respected by Māori whaiora. This standing back allows the space for communication and collaboration in the context of a recovery journey.

Recommendations for Practice

“Is this okay?”

Mental health practitioners must be vigilant of their assumptions about ethnically different clients. Many of the ‘positive’ assumptions such as the client’s being close with their whanau or familiarity with the Māori language can serve as a barrier - the assumed knowing of the Pakeha practitioner. A non-Māori clinician needs to approach the Māori client with the assumption that they know ‘nothing’ about them or their beliefs and values, as opposed to thinking they know what is best for them based on a bicultural handbook. This research has shown that it is futile trying to avoid misunderstanding and conflict, and that in fact these two conditions provide the fertile ground for honesty and collaboration. Practitioners should be encouraged to ask the whaiora “Is this okay? Each of us in healthcare practice have reflected on the discomfort we feel with some patients. This thesis suggests this discomfort creates ‘the gap’, which is where the questions and the answers for this whaiora reside.

Difference is good

In the context of the therapeutic alliance it is equally important to allow room for the historical horizon of the whaiora, the historical horizon of the practitioner and the overlap created between. Practitioners should be encouraged to reflect on their history and their traditions and to share these reflections with the whaiora for whom they are providing care. It is not 'best' practice to "treat all my patients the same" for we can never know a stranger until we have invested time to build trust and thereby come to know him/her, and they to know us. It is not best practice to present oneself as free from historical influences for both the practitioner and the client come with a lens of pre-formed understandings. This thesis shows that astute practitioners have a unique interaction with *every* person they encounter. We should not treat all our patients the same, we should treat everyone differently, valuing the uniqueness of who they are in their context of time, place and history. These views are supported by others writing in the area of the cultural interface of practice (i.e. Gadamer, 1927; Jacobson & Greenley, 2001; Buetow, 2004).

Recommendations for Research

New light through old windows – a positive lens

Cooperrider et. al. (2008) developed a methodology with the underpinning to make things better, to grow organisations and communities, and to empower participants to dream of best possibilities. Further research into cross-cultural practice in healthcare could be challenged to build upon this appreciative approach which seeks out those things that work well between Māori and non-Māori. Bushe (2005) encouraged this approach, saying, "an appreciative process theorizes that you can create change by paying attention to what you want more of rather than paying attention to problems" (p.126).

The search for meaning

It is the goal of phenomenological hermeneutics to research the meaning in the experiences of people. It encourages the researcher to look beyond that which is near and accepted as truth to a deeper scrutiny of the interactions that define cross-cultural relationships and which we have taken for granted. This research into the therapeutic

relationship between Māori and non-Māori could be extended to examinations of those between peoples of other ethnic groups and other cultural groups. The question is “what is working well in our organisations?”

Longitudinal studies

This thesis has explored the meanings of Māori/non- Māori experiences from a fixed point in time, retrospectively seeking stories. I recommend a longitudinal study following new mental health clinicians for their first 2 years of practice tracking how they experience working with whaiora. The insights would be fresh and dynamic with the tentativeness, curiosity and enthusiasm of the novice practitioner. An alternative longitudinal study could follow whaiora along their recovery journey. Repeated interviews may reveal the tensions, pitfalls, discoveries and successes of bicultural engagements. Such studies would provide glimpses of current practice, show how practice is evolving and what could be enhanced.

New horizons

Another viewpoint of interest would be that of the support networks of whaiora; their whānau, who could be interviewed about their experiences and understandings about the recovery of their family member. Their views, from outside the clinician/whaiora dyad may reveal aspects previously overlooked such as whanau views about being included or excluded, being heard or silenced, and observations of the recovery journey.

Extending Appreciative Inquiry

This research used only the first of four suggested steps in its appreciative inquiry, *Discovery*, to open up the issue to discussion. Further research into cross-cultural success could follow the full cycle of Appreciative Inquiry after the *Discovery* step. With the participants and researcher working collaboratively they could continue with the *Dream* step, when the themes are drawn from the stories about how things could be even better, *Design* could take the findings on to show possibilities for the service being researched and the *Destiny* step could furnish an action plan, projecting the best of the past into the future (Cooperrider, Whitney & Stavros, 2008).

Different Methodologies

Cross-cultural working in mental health would be very amenable to study by a Grounded Theory research project. Grounded theory studies are generally focused on “social processes or actions: they ask about what happens and how people interact” (Sbaraini, Carter, Evans & Blinkhorn, 2011, p.1). It may reveal the common social practices in play and the belief systems which support those social practices.

Recommendations for Education

No-one likes a know-it-all

My mother used to say “no one likes a know-it-all” when we came home from school with our heads full of knowledge thinking we knew better and more things than anyone else before us. The same applies to practitioners who believe they know how to work with people from different cultures. All health professions acknowledge the importance of cultural competence and bicultural training often attempts to educate practitioners about the ‘right’ way to relate to other ethnicities. There are some wonderful experiences when people stay overnight at a marae, sharing food and space, hearing the history of the tangata whenua, listening to words of Te Reo and learning how to avoid offending with cultural faux-pas.

But there are also downsides to bicultural training; participants may form the impression that all Māori are the same and must be treated in such-and-such a way. The tick-box approach can result in care that is entirely wrong for the individual who has had their own unique life experience. Cross-cultural education needs a shift of focus away from the ‘rules’ of cross-cultural interaction and towards a curiosity about the other.

Training should include reflecting on one’s own history and prejudices, and the importance of maintaining openness in all dealings – being mindful of the necessity of space between whaiora and non-Māori clinician, the need to approach tentatively, taking time, finding the right words, trying to view the horizon of the other, and being open to new understandings. There needs to be an awareness in student practitioners that there is no right way to work with Māori – there are a myriad of ways, one of which will be right for ‘this’ person.

Limitations of the study

Hermeneutic analysis seeks to cast light on text and dialogue to discover the meaning therein. One can never be sure that the meaning one takes from a text is the same as the meaning the author intended. In this research the stories have been directed through my lens; a Māori woman who has practised clinical psychology for almost twenty years, with a professional and personal penchant for seeing the possible and the positive in almost every situation. The stories thus describing the participant's horizons have been refracted through my horizon to the horizon of you, the reader. There are a myriad of possible interpretations available however I believe that given the same appreciative question the findings of other researchers would be similar.

In purposively selecting the participants I wondered initially whether I was 'loading the dice' to produce only stories which told of warm, fuzzy encounters. I believe the stories however did describe hard journeys for both whaiora and non-Māori clinicians, leading to positive outcomes. In the telling of the stories there were some criticisms of other services but on the whole I have left these out as the intention was to show what worked rather than how others had failed.

Conclusion

This study set out to gather stories of the best experiences in mental health recovery for Māori whaiora, working with non-Māori clinicians in a mainstream mental health service. It sought to understand how those positive experiences happened. The contribution this thesis makes to understanding such cross cultural relationships is to show cultural safety in action. The findings seem to suggest that some conditions remain constant at each stage from first meeting, through the development of a relationship and on to helpful actions. The first understanding is that difference exists between the whaiora and the clinician, but that it need not be a barrier. When it is acknowledged with respectful openness, it can be beneficial to the therapeutic alliance. The difference creates a feeling of uncertainty which in turn leads to the felt sense of space between the two. It is within this space that tentative approaches and backing down happens, where knowledge and responsibility are shared, where the horizon of the other can be glimpsed, and where common ground can be found. Navigating within this space requires time for conversation and new understandings to emerge. Creative solutions evolve from those new understandings. The findings

from this thesis suggest that in cross-cultural therapeutic relationships neither the Māori nor the non-Māori need to relinquish their truths in favour of the truth of the other - new truths are generated by blending the two. This open acknowledgement of difference and not-knowing means the non-Māori clinician will become vulnerable, and for this vulnerability to be safe for them, and helpful for the whaiora, they will require professional support and encouragement.

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Glossary

Māori words and phrases used in the thesis

Aotearoa	North Island - now used as the Māori name for New Zealand
Aroha	affection, sympathy, charity, compassion
Atua	God/s
Hā	breath, essence
Hapū	kinship group, subtribe - section of a large kinship group
Hongi	to press noses in greeting
Hui	gathering, meeting, assembly
Iwi	people descended from a common ancestor and associated with a distinct territory
Kaimanāki	person supporting or looking after another
Kanohi-ki-kanohi	face to face, in person
Kapa haka	Māori cultural group, Māori performing group
Karakia	to recite ritual chants, say grace, pray
Karanga	a ceremonial call of welcome to visitors onto a marae,
Kaumātua	old man - a person of status
Kaupapa Māori	Māori ideology - a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society.
Koha	a gift, offering, donation
Kōrero	to tell, say, speak
Kuia	grandmother, female elder
Mahi-a-ngakau	work done from the heart
Mamae	ache, pain, injury, wound
Mana	prestige, authority, control, power, influence, status
Manaakitanga	hospitality, kindness, generosity, support
Manuhiri	visitor, guest
Māori	native, indigenous, belonging to Aotearoa/New Zealand

Marae(ātea)	the open area in front of the <i>wharenui</i> , where formal greetings and discussions take place. Often also used to include the complex of buildings around the <i>marae</i> .
Mātauranga Māori	the body of knowledge originating from Māori ancestors
Mātauria	knowledgeable
Mauri	life principle, vital essence, special nature
Mokopuna	grandchild
Ngāti Kahungunu	tribal group of the southern North Island
Ngāti Porou	tribal group of East Coast area north of Gisborne
Noa	be free from the extensions of tapu, safe
Pāeke	the speaking procedure where all the local speakers speak first
Paepae	threshold of a house
Pākehā	New Zealander of European descent
Pāua	abalone, <i>Haliotis</i>
Pou	post, upright, support, pole
Pōwhiri	rituals of encounter, welcome ceremony on a marae
Taiaha	a long weapon of hard wood with one end carved
Tangata	person, man, human being, individual
Tangata kainga	local people of a <i>marae</i> , home people
Tangata whenua	local people, hosts, indigenous people
Tauparapara	incantation to begin a speech
Tapu	be sacred, prohibited, restricted, set apart
Te Ao Māori	Māori world(view)
Tēnā koe	hello! (speaking to one person)
Te Reo	Māori language
Te whare tapa wha	A Māori model of health
Tikanga	correct procedure, custom, habit, lore
Tū atu tū mai	alternating speakers between locals and visitors
Tukutuku	ornamental lattice-work around the walls of meeting houses
Waharoa	gateway, main entranceway
Wahine	woman
Wairua	spirit, soul
Wero	formal challenge at <i>marae</i>
Whaiora	patient, person seeking wellness

Whakamana	legitimise, empower, validate
Whakamanawa	enlightenment
Whakapapa	genealogy
Whakapiri	close association
Whakatauākii	proverb, significant saying
Whakawhānaungatanga	process of establishing relationships
Whānau	extended family, family group
Wharenuī	meeting house - main building of a marae

Appendix A: AUT Approval

Ref: 1095374

15 February 2012

Inez Skogstad
22 Brookvale Road
Havelock North 4130

Dear Inez,

Re: Confirmation of Candidature

The submission of your D9 will be noted at the University Postgraduate Board at their meeting to be held on 21 February 2012 along with the submission from your primary supervisor, Dr Liz Smythe.

I am pleased to inform you that your D9 was approved by the Faculty of Health & Environmental Sciences and the Board will now confirm your candidature in the Doctor of Health Science.

As a recognition of this milestone, the University would like to provide you with your own AUT business cards for you to use when attending conferences and networking with other researchers. We have attached the 'AUT Business Card Order Form' for you to complete and return to us in the envelope provided.

The University will cover this initial printing expense, however, reprints will be at the candidate's expense. Please contact the University Postgraduate Centre when a reprint is required.

If you have any questions, please feel free to contact me.

Yours sincerely



Martin Wilson
Manager, University Postgraduate Centre
martin.wilson@aut.ac.nz
+64-9-921-9999 ext 8812

cc
Dr Liz Smythe
Lisa Herd



23 March 2012

Appendix B: HBDHB Ethical Approval page 1 of 2

Inez Skogstad
Clinical Psychologist
Hastings Community Mental Health Team
Hawke's Bay District Health Board

Dear Inez

RE: Hawke's Bay District Health Board Research Application - Reference 12/03/104

Thank you for your application to conduct research within the Hawke's Bay District Health Board. I am pleased to advise that your application has been successful, subject to:

1. Obtaining Central Regional Ethical Approval for this study (please forward a copy of this to this office once received)
2. Providing written evidence of Maori consultation.

I have also enclosed the signed locality assessment form.

Please find enclosed a signed copy of your application. At the conclusion of your research, HBDHB will require a research report (as outlined in your application).

Should you have any queries during your research, please do not hesitate to contact me during normal working hours.

Regards

Sally Houlston RN, BN, MN
On behalf of the
Research Committee

DEPARTMENT OF NURSING

Health Services, Hawke's Bay District Health Board

Private Bag 9014, Hastings, New Zealand

Telephone: 06 878 8109 Extn: 4505 Fax: 06 878 1342 Email: sally.houlston@hbdhb.govt.nz

7 FUNDING

Please indicate your source of funding for this Research

Self-funded from grants and scholarships.

8 ADMINISTRATIVE AND ETHICAL AGREEMENT

The undersigned agrees to provide written evidence that an Ethics Committee has assessed any research involving human participants and approval has been given to the ethical considerations of the proposal.

A copy of the application to the relevant Ethics Committee and a completed Locality Assessment is to accompany this form. The Research Coordination Committee is responsible for signing off Locality Assessments.

Ethical Committee approval being sought	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Ethical Committee approval obtained, and copy enclosed	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Ethical Committee approval not required	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

I understand that a copy of my final report is to be provided for the Research Coordination Committee for filing. I will retain the right of copyright relative to this report.

I agree to share the results of this research in an appropriate forum.

I am aware of Hawke's Bay District Health Board Policies and Procedures, and I agree to abide by these Policies and Procedures.

✓ Sent electronically

Signed

(Principal Investigator)

(Date)

**PLEASE COMPLETE ALL SECTIONS AND RETURN TO:
NURSE RESEARCHER, HAWKE'S BAY DISTRICT HEALTH BOARD, PO BOX 9014, HASTINGS**

Administrative Use only

☒ Approved ☐ Not approved

Registration Number *12/03/104*

Signed *[Signature]*
(Research Coordination Committee)

21/3/12
(Date)

Appendix C: Central Region Ethics Committee Approval page 1 of 2

1 May 2012

Mr Inez Skogstad
22 Brookvale Road
Havelock North
Hastings 4130

Dear Mr Skogstad

Re: Ethics ref: **CEN/12/03/005** (please quote in all correspondence)
Study title: **Maori Mental Health Recovery: Success Stories of Non-Maori Clinical and Ex-clients who Identify as Maori**
Investigators: **Mr Inez Skogstad**

This study was given ethical approval by the Central Regional Ethics Committee on 1 May 2012. A list of members of the Committee is attached.

Approved Documents

- National application form
- Part 4: declaration signed
- Form A: signed
- Amended Participant Information Sheet, Version dated 2 March 2012
- Amended Consent Form, Version dated 2 March 2012
- Interview Guide, Version 1, dated 1 February 2012
- Maori Consultation, dated 24 April 2012

This approval is valid until 20 December 2013, provided that Annual Progress Reports are submitted (see below).

Access to ACC

For the purposes of section 32 of the Accident Compensation Act 2001, the Committee is satisfied that this study is not being conducted principally for the benefit of the manufacturer or distributor of the medicine or item in respect of which the trial is being carried out. Participants injured as a result of treatment received in this trial will therefore be eligible to be considered for compensation in respect of those injuries under the ACC scheme.

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site

- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by 1 May 2013. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Requirements for the Reporting of Serious Adverse Events (SAEs)

SAEs occurring in this study must be individually reported to the Committee within 7-15 days only where they:

- are *unexpected* because they are not outlined in the investigator's brochure, and
- are not defined study end-points (e.g. death or hospitalisation), and
- occur in patients located in New Zealand, and
- if the study involves blinding, result in a decision to break the study code.

There is no requirement for the individual reporting to ethics committees of SAEs that do not meet all of these criteria. However, if your study is overseen by a data monitoring committee, copies of its letters of recommendation to the Principal Investigator should be forwarded to the Committee as soon as possible.

Please see www.ethicscommittees.health.govt.nz for more information on the reporting of SAEs, and to download the SAE Report Form.

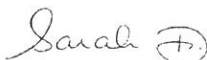
Statement of compliance

The committee is constituted in accordance with its Terms of Reference. It complies with the *Operational Standard for Ethics Committees* and the principles of international good clinical practice.

The committee is approved by the Health Research Council's Ethics Committee for the purposes of section 25(1)(c) of the Health Research Council Act 1990.

We wish you all the best with your study.

Yours sincerely



Sarah Delgado

Administrator

Central Regional Ethics Committee

Email: sarah_delgado@moh.govt.nz

“Maori mental health recovery: Success stories of Non-Maori clinicians and ex-clients who identify as Maori”

Information sheet for participants

Introduction

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. You do not have to take part in this study.

This information sheet tells you the purpose of the study and what will happen to you if you take part. It also gives you more detailed information about the conduct of the study.

Please ask if there is anything that is not clear to you or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

This study is part of a Doctor of Health Science degree. The aim is to gather stories of successful and positive interactions and communication between mental health clinicians and past mental health service consumers that are thought to have aided recovery.

Why would I be suitable to take part?

I am interested in talking to you because you either

- have had a mental health problem in the past.
- or you are a mental health clinician.

I expect to recruit up to 15 people who have been discharged from mental health services and up to 15 clinicians.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time prior to the completion of data analysis and without giving a reason. If you have been a client of the service a decision to withdraw, or a decision to not take part, will not affect any current or future care you receive.

What does the study involve and what will I have to do?

You will be invited to meet for about one hour with the researcher to describe a time when you felt care given to you worked really well. The interview will take approximately one hour and will be recorded and transcribed by me. You will then have the transcript in an edited form returned to you to check that it is what you wanted to say and to change any things that are not what you wanted to say.

Where will the study be held?

The researcher is based in Hastings. I would like to interview you at the Hawkes Bay Hospital marae or in your own home if you prefer.

What are the possible disadvantages and risks of taking part?

There are no foreseen dangers in telling me your story.

What are the possible benefits of taking part?

There will be no direct clinical benefits to you. The results of the study may help us to better understand how non Maori clinicians may best offer care to Maori mental health patients.

If I need an interpreter, can one be provided?

Yes if you wish to use te reo Maori, an interpreter will be available.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. First, you should speak with the researcher who will do their best to answer your questions. If you remain unhappy and you wish to complain formally, you can do this through the *Code of Health and Disability Services Consumers' Rights*. Contact telephone numbers and addresses will be given to you to keep if you decide to take part in the research.

Will my taking part in this study be kept confidential?

Yes. All the information about your participation in the study will be kept confidential and stored securely. Any information that may identify you will be removed so that you cannot be recognised. The details will also be clearly explained on the Consent Form.

What will happen to the results of the study?

The results will be written up in the form of a dissertation for a Doctoral degree. The results may be published in scholarly journals and presented at meetings of other researchers and health professionals. You may request copies of any publications arising from the study. You will not be identified in any report or publication.

Who is organising and funding the research?

The study is being supervised by senior lecturers at the Auckland University of Technology (AUT). The study is being funded by the researcher.

Will it cost me anything to be involved in this study?

No. There is no cost to you to be involved in this study.

Will I be paid for being involved in this study?

No. There is no payment for being involved in this study.

Who has reviewed the study?

The study has been reviewed and approved by the AUT Doctoral Research Committee. It has also been examined and approved by the Health and Disability Ethics Committee (Central Region) and the Hawkes Bay District Health Board Research Committee.

Where can I get more information about the study?

If you have any questions or concerns about your participation in this study, you should contact the researcher Ms Inez Awatere-Walker on 06 8788109 extension 4713 or 027 3535727 or at email inez.awatere-walker@hbdhb.govt.nz

Thank you for taking the time to read this information sheet.

Appendix E: Clinician Consent Form



CONSENT FORM - Clinician

“Maori mental health recovery: Success stories of Non-Maori clinicians and ex-clients who identify as Maori”

Lead researcher: Inez Awatere-Walker

- I confirm I have read and understood the information sheet dated for the above study.
- I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time prior to the analysis of the data without giving any reason, without my legal rights being affected.
- I understand that I will be interviewed about the positive aspects of the care I provided as a mental health service clinician and that this will be recorded and transcribed by the lead researcher.
- I understand all information about my participation in the study will be kept confidential and I will not be identified in any report or publication.
- I agree to take part in the above research study.

Name of participant

Date

Signature

Researcher

Date

Signature

1 Copy for participant, Original for researcher.

Appendix F: Whaiora Consent Form



CONSENT FORM – Former service user

“Maori mental health recovery: Success stories of Non-Maori clinicians and ex-clients who identify as Maori”

Lead researcher: Inez Awatere-Walker

- I confirm I have read and understood the information sheet dated for the above study.
- English I wish to have an interpreter Yes/No
Maori E hiahia ana ahau ki tetahi kaiwhaka Maori/kaiwhaka Pakeha korero Ae/Kao
- I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that my participation is voluntary and that I am free to withdraw at any time prior to the analysis of the data without giving any reason, without my future mental health care or legal rights being affected.
- I understand that I will be interviewed about the positive aspects of the care I received from a mental health service and that this will be recorded and transcribed by the lead researcher.
- I understand all information about my participation in the study will be kept confidential and I will not be identified in any report or publication.
- I understand that if I wish to complain about my treatment during this study I can do so formally through the *Code of Health and Disability Service Consumer's Rights* and I have been given contact information for this purpose.
- I agree to take part in the above research study.

Name of participant

Date

Signature

Researcher

Date

Signature

Appendix G: Example of Working with the Data

Raw data:

The bit that I find amazing, that in itself was an awesome day, about two months later I was sitting in my office minding my own business, as you do, and this is in the days – I was setting up a service – and some days weren't busy (and you could muck around) and other days were really busy and there wasn't a huge infrastructure; so I was sitting in there and there was a very strong knock on my door 'bang, bang, bang', so I got up and opened the door and there was a man there, who I went "ugggh", because he was Maori, I had never seen him before, he looked quite scary, he was a bit 'wild eyed'. He was really tense, I could see the muscles in his jaw going and he was standing there with his fists clenched, and I thought, he has come to beat me up or something, what have I done? So I said, "hello, are you in the right place?" I am Lyn the mental health nurse, can I help you? He was just about talking through 'gritted teeth', he said "you've helped my brother, now I need some help!"

Crafted Story:

So I was sitting in there and there was a very strong knock on my door 'bang, bang, bang', so I got up and opened the door and there was a man there, who I went "ugggh", because he was Māori, I had never seen him before, he looked quite scary, he was a bit 'wild eyed'. He was really tense, I could see the muscles in his jaw going and he was standing there with his fists clenched, and I thought, he has come to beat me up or something, what have I done? (Lyn)

Initial interpretation:

Lyn describes experiencing fear and uncertainty when she is confronted by a Maori man she does not know at her door. Her initial impressions are that he looked scary and wild-eyed, and her fright and non-comprehension initially startle her into bringing an overly professional manner forward protectively. Her professional demeanour seems to act as a shield. Despite him continuing to appear menacing he asks for help and Lyn's compassion and humanity immediately replaces her fear as she invites him in.

As Lyn listens to him her impression of him as menacing changes into an understanding that he was projecting his 'warriorness' as a protective foil for his fear. She does not appear to realise that she had been projecting a brittle professionalism for the same reason. She realises that this man poses a risk only to himself and she worries about his health.

The man was clear that his family had given him direct orders to see her (because she had proven her usefulness and trustworthiness to them in the past) but he does not know her. Perhaps he feels vulnerable and needs to project an aura of being tough. His tension gives away his struggle to maintain his composure.

