

WHAKAWHĀNAUTIA TE HAUMANU MĀORI

Birth of a Māori Therapy: A Scoping Literature Review

Presented By

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TUHINGA WHAKARĀPOPOTO | ABSTRACT

Increasing prevalence rates of psychological distress remains a detriment to the wellbeing of Māori. This study explores how a British colonial hegemony has systematically predisposed and perpetuated high negative health statistics for Māori. A process of colonisation that has dismantled societal norms and continues to violate the mauri, mana and wairua of ngā iwi Māori.

Western evidence-based therapies are predominantly the chosen interventions for tangata whai i te ora seeking therapeutic support. The stance that therapeutic interventions, which evolved from Western colonial epistemologies, can heal the mana, mauri and wairua of Māori is challenged, in favour of a Māori therapeutic alternative. An alternative present within its own Māori ontology.

The last four decades have borne witness to the advent of Māori health models and frameworks to better inform allied health and therapeutic delivery for positive outcomes for tangata whai i te ora cohorts. This study will investigate whether, within these models and frameworks, is there a Māori therapy silently laying await? A therapy that can provide culturally authentic and safe delivery of care for Māori.

This research provides a scoping review of literature authored by allied health practitioners and talk therapy practitioners to extract key themes, components that contributed to the formation of a Māori therapy – *he haumanu Māori*. A Kaupapa Māori Methodology and Pūrākau Method was used to ensure reliability and validity of themes identified. The findings of the results were able to provide building blocks towards constructing a therapy schema for a Māori therapy. A therapy that inherently has a relationship with wairuatanga, a pivotal and encompassing dimension of health for Māori.

Twelve models and frameworks were included in the final data set and their respective Māori constructs – ngā mātāpono me ngā uara were charted for analysis. Recommendations for key components towards *he haumanu Māori* include; a macro-model, a pūrākau atua Māori infused therapeutic theory, mātauranga-informed therapy framework and tikanga-informed counselling skills. A gap in the literature that warrants further investigation is the gathering and assessment of Māori counselling micro-skills.

RĀRANGI TAKE | CONTENT

| | |
|--|----|
| TUHINGA WHAKARĀPOPOTO ABSTRACT | 1 |
| RĀRANGI TAKE CONTENTS | 2 |
| KUPUTAKA GLOSSARY | 5 |
| ATTESTATION OF AUTHORSHIP | 8 |
| HE MIHI ACKNOWLEDGEMENTS | 9 |
| HE KARAKIA WHAKAPUARE | 10 |
| WĀHANGA 1: INTRODUCTION | 11 |
| 1.1 Study Aims | 11 |
| 1.2 Research Rationale | 11 |
| 1.2.1 Te Tiriti O Waitangi – A Predisposing Factor | 12 |
| 1.2.2 Māori – A Young Growing Population | 14 |
| 1.2.3 Prevalence Rates – A Compounding Problem | 15 |
| 1.2.4 Māori Models of Health and Māori Engagement Frameworks | 16 |
| 1.2.5 Are Evidence-based Therapies Effective for Māori? | 17 |
| 1.2.6 He Korowai Oranga: Māori Health Strategy | 18 |
| 1.3 Identifying the Research Opportunity | 21 |
| 1.4 Formulating the Research Objective & Questions | 22 |
| 1.4.1 Research Objective | 22 |
| 1.4.2 Research Questions | 23 |
| WĀHANGA 2: METHODOLOGY & METHOD | 24 |
| 2.1 Kaupapa Māori Methodology | 24 |
| 2.2 A Pūrākau Method | 25 |
| 2.3 Te Ao Raranga The Weaving Universe: A Māori Philosophy | 26 |
| 2.3.1 Te Ao Raranga – An Overview of the Research Paradigm | 28 |
| WĀHANGA 3: SCOPING LITERATURE REVIEW | 32 |
| 3.1 Scoping Review Design Protocol | 32 |
| 3.2 Limits of the Scope | 32 |
| 3.3 Information Sources | 33 |

| | | |
|-------------------------------------|---|-----------|
| 3.4 | Eligibility Criteria | 34 |
| 3.5 | Inclusion & Exclusion Criteria | 35 |
| 3.6 | Search | 35 |
| 3.7 | Selection of Sources of Evidence | 36 |
| 3.8 | Data Charting Process | 37 |
| 3.9 | Data Items | 37 |
| 3.10 | Critical Appraisal of Individual Sources of Evidence | 37 |
| 3.11 | Synthesis of Results Method | 37 |
| WĀHANGA 4 – RESULTS | | 39 |
| 4.1 | Synthesis of the Results | 39 |
| 4.1.1 | Previous articles | 41 |
| 4.1.2 | Identification of new articles via databases | 41 |
| 4.1.3 | Identification of new studies via talk therapy journals | 41 |
| 4.2 | Characteristics of Sources of Evidence | 41 |
| 4.2.1 | Dimensions of health and wellbeing | 42 |
| 4.2.2 | Whanaungatanga (Connections) | 42 |
| 4.2.3 | Whakawhanaungatanga (Building relationships) | 45 |
| 4.3 | Results of Sources of Evidence | 45 |
| 4.4 | Synthesis of Results | 46 |
| WĀHANGA 5 – DISCUSSION | | 48 |
| 5.1 | Summary of Evidence | 48 |
| 5.1.1 | Formulating a Māori Therapy | 50 |
| 5.1.2 | Paucity of Māori Therapeutic Models & Frameworks | 50 |
| 5.1.3 | Pieces of the Puzzle | 51 |
| 5.1.4 | A Gap - Māori Therapeutic Micro-skills | 52 |
| 5.2 | Limitations | 53 |
| 5.3 | Funding | 54 |
| WĀHANGA 6 – CONCLUSION | | 55 |
| 6.1 | Interpretation and Summary of the Results | 55 |
| 6.2 | Implications and Next Steps | 56 |

| | |
|--|----|
| HE KARAKIA WHAKAKAPI | 58 |
| RĀRANGI PUKAPUKA REFERENCES | 59 |

LIST OF FIGURES

| | | |
|----------|---|----|
| Figure 1 | Adapted from Te Ao Raranga: The Weaving Universe: A Framework of a Māori Philosophy | 27 |
| Figure 2 | CBT Macro Model | 49 |
| Figure 3 | ACT Macro Model | 49 |

LIST OF TABLES

| | | |
|---------|--|----|
| Table 1 | Flow Diagram – Synthesis of Scoped Literature of Māori Models and Frameworks of Health & Wellbeing | 40 |
| Table 2 | Previous Study Sources of Evidence – Māori Models & Frameworks | 43 |
| Table 3 | New Sources of Evidence – Māori Models & Frameworks | 44 |

KUPUTAKA | GLOSSARY

| | |
|-----------------------------|--|
| Ahunga Waiora Māori | Māori Dimension(s) of Health |
| Aroha | Love, compassion, empathy |
| Atua Māori | Māori deitii |
| Haka | Performance dance |
| Hapū | Grouping of families with genealogical links to a shared tribe and region. |
| Hauora | Wellbeing, vitality drawn from the balance of physical, psychological, systemic and spiritual health. Holistic health that includes a relationship with the environment. |
| Hauropi | Ecology |
| He haumanu Māori | A Māori therapy. |
| He karakia whakapuare | Opening Prayer |
| He karakia whakakapi | Closing Prayer |
| Hinengaro | Mind, thought, consciousness |
| Hohou rongo | To make peace |
| Iwi | A grouping of hapū, a tribe. |
| Iwi katoa | All iwi |
| Kaitiakitanga | Guardianship, stewardship |
| Kaumatua o te Kāhui Ariki | Kaumatua of the Māori Royal Household |
| Kāwanatanga | Government, governorship |
| Kotahitanga | Unity, togetherness, solidarity |
| Kōrero tuku iho | Lore, history orally handed down |
| Kuputaka | Glossary |
| Mana | Prestige, authority, charisma, power, influence, status, spiritual power within |
| Mana motuhake | Self-determination, autonomy, sovereignty |
| Mana whakaheke | Inherited status |
| Manaakitanga | Respect, nurturing, kindness, generosity |
| Mātai tuarangi | Cosmology |
| Mātauranga | Knowledge, wisdom, understanding |
| Mātauranga Māori i tuku iho | Māori knowledge passed down over generations |

| | |
|--------------------------------|--|
| Mauri | Life force, vital essence, source of emotions - the essential quality and vitality of a being |
| Mōteatea | Long traditional chants, to grieve |
| Ngā iwi Māori | Māori tribes |
| Ngā mātāpono me ngā uara Māori | Māori principles and values |
| Oriori | Gentle whakapapa lullaby, chants |
| Pono | Be true, valid, honest, genuine |
| Pūrākau | Myth, ancient legend, story |
| Rangatira | Noble, high rank, chief, leader |
| Rangatiratanga | Right to exercise authority |
| Rārangi take | Contents (Page) |
| Rārangi pukapuka | References |
| Ritenga Māori | Māori customary rituals |
| Rohe | A tribal geographical region |
| Tangata whai i te ora | Person seeking holistic health, often referred to a mental health patient/client. |
| Taonga | Prized treasure, possession |
| Te Aka Whai Ora | Māori Health Authority |
| Te ao hurihuri | Physical world |
| Te ao wairua | Spiritual world |
| Te kauae raro me runga | Terrestrial and celestial esoteric wisdom |
| Te pūrākau orokohanga Māori | The Māori creation story |
| Te Taiao | The environment |
| Te Tiriti O Waitangi | The Treaty of Waitangi |
| Te Whatu Ora | Health New Zealand |
| Tiakitanga | Guardianship, caring of, protection |
| Tika | Correct, right, just, fair, true |
| Tikanga | Customs, traditions, protocols, lore |
| Tinana | Body, physical, reality |
| Tino rangatiratanga | Sovereignty, rule, power, autonomy |
| Tohunga | To be an expert, priest, healer |
| Tuhinga whakarāpopoto | Abstract |
| Waiata | Song |
| Wāhi tapu | Spiritual sites |
| Wānanga | Māori process of discussing and learning |

| | |
|---------------------|---|
| Wairuatanga, wairua | Experiential interaction with cosmogeny, deity, ancestors, consciousness, multi-dimensional, - spirituality |
| Whaikōrero | Formal speech making |
| Whakaaro Māori | Māori thinking |
| Whakapapa | Genealogy |
| Whatumanawa | Seat of emotions, heart, mind |
| Whānau | Māori concept of family |
| Whanaungatanga | Connection, relationship |
| Whakawhanaungatanga | Process of establishing relationships |
| Whenua | Land |

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.

Signed:

Mark Kūkupa Manaia

Date: 29 June 2023

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Tina he takā

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Haumi e

Hui e

Taiki e

Te Kore, Te Pō, Te Ao Mārama

(Ko te kaituhi kāhore i mōhiohia.)

WĀHANGA 1: INTRODUCTION

1.1 Study Aims

The aim of this research is to consider what constitutes a Māori therapeutic solution for Māori dis-ease and tangata whai i te ora through locating key concepts and criteria that contribute towards an Indigenous informed therapy. The research supports a Māori understanding of holistic health – hauora, which concentrates on naming the positive outcome required when the whole state of a person is impacted. The terms: dis-ease - a disrupted state of 'ease' or an imbalance in wellbeing; and tangata whai i te ora - a person pursuing wellbeing, are intentionally chosen to signal the research outcome is a contribution towards a Māori therapeutic approach that is holistic and solution-focused.

The research will conduct a scoping literature review (Arksey & O'Malley, 2005; Levac et al., 2010) of Māori health models and frameworks to elicit key components towards a therapy centred in a Māori worldview. Writings from authors in allied professions such as counselling, psychotherapy and psychology will provide helpful insights into what is currently happening within the talk-therapies. Literature from Māori allied health professions and authors will also be included in the literature review to examine contributions from Māori working in these disciplines.

1.2 Research Rationale

This dissertation is an extension of research at the interface, the interchange between Western and Indigenous societal paradigms (Strang et al., 2018), conducted by myself when formally known as Strang and now known as Manaia. The research was undertaken with Dr Tanya Allport and Haze White from Wai-Research, the research arm of Te Whānau O Waipareira, a Kaupapa Māori health service in West Auckland. The research project was supported by an editor, Dr Te Kani Kingi and guidance from the Pou (Patron) of Wai-Research, Tā Mason Durie.

Kimihia te Hauora Hinengaro: Pathways to Mental Health, (Strang et al., 2018) is a study which explored the relevance of including Māori cultural elements in therapeutic care for urban Māori in West Auckland. The study was supported by a literature review (Wratten-Stone, 2016) which found that a primary reason for poor mental health outcomes of Māori, is the absence of culturally relevant therapies and services that differ from current Western provision.

Wratten-Stone's findings noted that high prevalence rates of mental illness and low utilisation of services among Māori and other ethnic minorities, supported immediacy towards developing culturally targeted therapeutic services (Wratten-Stone, 2016). In conjunction, 'culturally competent care' was reported as a common theme when considering positive Māori mental health outcomes, which Wratten-Stone (2016) included as, "a well-educated and culturally safe workforce; effective and applicable treatment modalities that may be adapted for use in Māori populations; and the use of assessment and diagnostic tools that are relevant to Indigenous worldviews" (p. 23).

A principal finding by Strang et al. (2018) is that for therapeutic services and interventions to have a maximum effect on positive behavioural change, emotional regulation and healthy interpersonal skills, the service provision should ensure that both cultural and clinical interventions are offered; "they need to operate alongside each other and in concert" (p. 6). The combined literature review and study (Strang et al., 2018; Wratten-Stone, 2016) found that culturally infused clinical services for Māori and/or urban Indigenous populations are essential for successful mental health outcomes and that 'culturally competent care' is a supported requirement for this success.

A once thriving and self-determined society, how have Māori found themselves in a predicament that requires a mental health intervention that is culturally relevant?

1.2.1 Te Tiriti O Waitangi – A Predisposing Factor

Te Tiriti O Waitangi | The Treaty of Waitangi (Te Tiriti) is New Zealand's founding document, signed at Waitangi on 6th February 1840 between approximately 540 rangatira Māori (Māori chiefs) who held rangatiratanga (chiefly authority) over iwi and or hapū (tangata whenua) and representatives of the British Crown (tangata tiriti) (New Zealand History, 2017, May 17). Te Tiriti accounts three articles written in two versions, te reo Māori and te reo Pākehā. There is also a fourth oral article. The articles outline broad principles upon which British officials and rangatira Māori made a political compact to found a nation state and build a government to primarily govern the expanding migration of British settlers into New Zealand (New Zealand History, 2017, May 17).

The two versions have been uncomfortably contested since their signing in 1840, providing a landscape of dissent between tangata whenua and tangata tiriti. This dissonance is attributed to Article 1 where the English version attests that Māori ceded full sovereignty of Aotearoa (New Zealand) to the Queen of England. In contrast, Māori posit that consent was given to the British governor to have full authority to govern or

kawanatanga, over the settler population only (Campbell, 2011; New Zealand History, 2017, May 17).

Comprehension of this stance is supported by a term in the Māori version – Article 2, which more closely and readily translates as sovereignty, tino rangatiratanga (full chiefly authority) was ensured over taonga – all prized treasures (Campbell, 2011; New Zealand History, 2017, May 17). Māori prize ecology and responsible sustainability of ecosystems. Taonga therefore includes: land - habitat, forestry - wildlife, rivers – fresh water, ocean - fisheries, and language – culture (Campbell, 2011; New Zealand History, 2017, May 17). Intangible taonga is also included, such as, mana whakaheke - inherited status, wāhi tapu -spiritual sites, mātauranga, tikanga, kōrero tuku iho - knowledge, lore, history orally handed down, wairuatanga - experiential interaction with cosmogeny, deity, ancestors, guardians, people and environment (Jones, 2013; Marsden & Royal, 2003; Mead, 2003).

Article 3 offered Māori equality of citizenship, promising the same rights and privileges as British subjects, and Article 4, an oral agreement known as the wairuatanga or ritenga clause where Governor Hobson declared to the many rangatira gathered at Waitangi his personal assurance and protection of Māori cultural freedom and spirituality (Amopiu, 2020; Campbell, 2011; Kidd, 2021). Contemporary fracture of societal norms between Māori and Pākehā are attributed to the ensuing and consistent dishonouring of all 4 articles of Te Tiriti by the British and subsequent colonial power.

From 1860 – 2000 Māori have lost significantly that which was assured by the articles of Te Tiriti – land, water, ancestral homes, access to forests and fisheries, language, culture and spiritual freedom. In 1860 Māori held 80% of the land in the North Island, approximately 23.2 million acres. By 2000 they held as little as 4% (New Zealand History, 2021, April 21). The systematic loss of land and access to resources, the requirement for relocation from rural ancestral lands to city state housing, low wage employment and segregation from mainstream Pākehā education; has silenced equitable opportunities for Māori to attain health, wealth and wellbeing (Walker, 1990).

Legislation such as the Tohunga Suppression Act 1907, an act that made gathering with tohunga – a traditional healer, illegal, punishable by fine and up to 12 months imprisonment, further cemented colonial intention to hinder Māori autonomy to pursue hauora (New Zealand Legal Information Institute, n.d.). An intentional act to limit the freedom to maintain tradition, culture and spiritual practices; vital aspects to maintain the psychological and social health of a society. These are a small sample of examples,

methods used to deprive and create systemic health inequities for Māori (Came & Tudor, 2017).

The failure for the Māori way of life to be protected, low opportunity to partner and participate in Pākehā society; amongst a myriad array of societal disenfranchisement, you will discover causation for intergenerational predisposing factors to mental unwellness for Māori. Campbell (2011) regrettably concludes that the only provision of Te Tiriti that the colonial governance has unfalteringly upheld is Article 1 of the English version – that Māori ceded full and unfettered sovereignty to the Queen of England.

1.2.2 Māori – A Young Growing Population

Māori is an abridged term applied to the Indigenous people of Aotearoa. A more accurate term of reference for the Indigenous people of Aotearoa is by rohe - a tribal geographical region, hapū - grouping of whānau or family with genealogical links to a respective rohe and iwi - a grouping of hapū. To illustrate, tangata whenua may be of the iwi, Ngāti Whātua. Ngāti Whātua is located over two rohe, Te Tai Tokerau (Northland) and Tāmaki-Makaurau (Auckland); they may have whakapapa - genealogy to ancestors from Te Tai Tokerau only. In a smaller area within Te Tai Tokerau, normally centralised around a single or closely located marae - a gathering place and associated buildings; they would be akin to a group of whānau or hapū who share common ancestry associated to one or more marae. The term Māori also encapsulates people of Indigenous descent who do not identify with a tribal affiliation, for example some urban Māori.

Population statistics from recent censuses, support that the Māori population is growing at an upward trajectory. The Māori population grew by 31 percent over the 12-years from 30 June 2006 to 30 June 2018, an average growth rate of 2.3 percent per annum (StatsNZ, 2020). StatsNZ (2022) estimate the Māori population at June 2022 to be 892,200 or 17.4 percent of the national population. An increase of 15 percent from the recorded 2018 Census of 775,836 Māori people (StatsNZ, 2018). Indicating that half the percentage growth over a 12-year span (2006-2018), has been reached in the four years post (2018 -2022). Compared with national median ages of male and females 37.0 and 39.1 years respectively, Māori are a very youthful population with median ages for males and females of 25.5 and 27.6 years respectively (StatsNZ, 2022).

1.2.3 Prevalence Rates – A Compounding Problem

The New Zealand Health Survey (NZHS) is an annualised publication since 2011 that provides statistical information about the health and wellbeing of New Zealanders (Ministry of Health - Manatū Hauora, 2022a). One of the measures recorded is the prevalence of psychological distress or anxiety and depressive disorders for adults (15+ years) (Ministry of Health - Manatū Hauora, 2014). Using the Kessler-10 distress scale, a participant score of 12 or more would meet the inclusion for psychological distress (Health Navigator New Zealand, 2022). After adjusting for age and gender, (NZHS 2019/20), Māori adults were 1.9 times as likely to have experienced psychological distress as non-Māori adults (Ministry of Health - Manatū Hauora, 2020a).

The NZHS prevalence rates for adult psychological distress for Māori adults have steadily increased, near doubling over a decade: 7.6% - 2011/12, 9.6% - 2014/15, and 13.6% - 2019/20 (Ministry of Health - Manatū Hauora, 2015a, 2020a). Higher rates of psychological distress and addiction is also experienced by Māori youth or *rangatahi* compared to non-Māori (Theodore et al., 2022). Findings from a New Zealand cross-sectional youth health and wellbeing surveys 2001, 2007, 2012 and 2019, investigating prevalence in key mental health indicators among New Zealand secondary school students, reported rangatahi Māori were highly represented in all indicators (Sutcliffe et al., 2023).

Like Māori adult prevalence rates, rangatahi Māori showed an upward trend across survey time markers, of an increasing population presenting with anxious and depressive mood symptoms (Sutcliffe et al., 2023). Prevalence amongst rangatahi Māori for symptoms of depression (28%), low mood (42%), anxiety (48%), self-harm (32%), suicide ideation (25%) and suicide attempts (12.8%) were all higher than other ethnic groups (Sutcliffe et al., 2023).

The Māori population in June 2022 is estimated at close to nine hundred thousand people with a third of the population under 15 years of age (StatsNZ, 2018, 2022). The current adult prevalence rate of 13.6% for psychological distress which is twice that of non-Māori is demonstrating a fast upward trend or increase. Alongside a large population cohort of under 15 years who also measure high across mental health indicators, an inference can be made that the New Zealand mental health system will experience a steady and increasingly large cohort of Māori youth entering adult domestic mental health services, which is currently already overrepresented.

Exasperating the significant high rates of mental illness amongst Māori are frequently documented high statistics in precipitating and perpetuating factors: violence and addiction, lower socioeconomic indicators, racial discrimination, food insecurity in deprived neighbourhoods, truancy, obesity, cardiovascular disease, lung cancer, diabetes, low utilisation of primary and secondary care, self-harm, lower life expectancy and suicide (Kingi, 2011; Ministry of Health - Manatū Hauora, 2015c; Theodore et al., 2022). The statistics are palpable, over-whelming, and it begs the question what are the mental health solutions utilised to address the current and emerging wellbeing concerns for Māori?

1.2.4 Māori Models of Health and Māori Engagement Frameworks

Māori models of health surfaced as a response to assist allied health practitioners working with large Māori populations within the health and social service sectors (Durie, 1985). The Māori health models support considerations and concepts that should additionally be incorporated into health service delivery for Māori, beyond a biomedical and/or psychological diagnosis and treatment process only. Māori models of health typically incorporate a metaphor or analogy to illustrate interconnected dimensions that constitute Māori well-being, such as a house or an octopus (Durie, 1985; Pere, 1991). Seminal Māori health models such as Te Whare Tapa - The Four Sides of the House and Te Wheke - The Octopus (Durie, 1985; Pere, 1991) are recognised as foundation forerunner models to subsequent Māori models of health.

The application of a Māori model of health requires reflection on both the image and the associated dimensions of health, to conceptualise essential health factors for Māori care provision. For instance, Te Whare Tapa Wha (Durie, 1985) the four walls of a house respectively represent in turn – tinana - physical, hinengaro - psychological, whānau – social or systemic and wairua – spiritual. The four walls of the house each require stability and interconnectivity to function robustly as a safe abode. Working the metaphor, a health practitioner should provide care interventions that simultaneously address disease on all four health dimensions, to ensure tangata whai i te ora attain renewed hauora - wellbeing. Māori models of health challenge biopsychosocial interventions to encompass culturally relevant systemic and spiritual health considerations.

Māori health frameworks are an extension to Māori models of health. They provide guidance on how to embody from inception, that Māori dimensions of health are present at client engagement and throughout treatment. The practice of whakawhanaungatanga - Māori relationship building through karakia – prayer, mihi -

culturally correct greetings and manaakitanga - enhancing mana through the acknowledgment of whakapapa and sharing of kai – food; informed therapeutic practice (Bennett et al., 2014; Lyford & Cook, 2005). Cultural meeting processes such as hui and pōhiri have also contextualised culturally safe engagement, assessment and therapeutic meta-mapping for Māori cohorts (Drury, 2007; Pitama et al., 2014; Pitama et al., 2007).

The development of Māori health models and frameworks have been created by Māori allied health authors to challenge and ensure mātauranga me tikanga Māori informs evidence-based interventions delivered to tangata whai i te ora. At the heart of Māori models and frameworks are Māori constructs derived from mātauranga me tikanga Māori such as; wairua, mana, manaakitanga, and whanaungatanga to name a few.

1.2.5 Are Evidence-based Therapies Effective for Māori?

Māori health models and frameworks (Wilson et al., 2021) are often used as ad hoc appendages to Western therapeutic modalities which are heavily formulated within a cognitive prioritised epistemology (Hall, 2013, Rolleston et al., 2020). Clinical therapeutic practice within Aotearoa is influenced by a biomedical theory base, such as psychiatry and psychology (Deacon, 2013; Engel, 1977), which is informed and applied under a Western European or Northern American lens of scientific-evidenced-based best practice (American Psychologist, 2006, p. 273; Canadian Psychological Association, 2012).

Cognitive Behavioural Therapy (CBT) an evidenced-based therapy is branded the gold standard in psychotherapy intervention (David et al., 2018) and is widely practiced throughout Aotearoa (Bennett, 2009). David et al. (2018) premises three reasons for the gold standard status of CBT:

- (1) CBT is the most researched form of psychotherapy.
- (2) No other form of psychotherapy has been shown to be systematically superior to CBT; if there are systematic differences between psychotherapies, they typically favor CBT.
- (3) Moreover, the CBT theoretical models / mechanisms of change have been the most researched and are in line with the current mainstream paradigms of human mind and behavior (e.g., information processing). (p. 1)

For these three premises to be true, the assumption is that Western psychological theories that sit behind 'mainstream paradigms of human mind and behaviour' and their associated research measures are universally agreed. CBT is the 'most researched form of psychotherapy', speaks to a dominant hegemony that readily funds research into the validity of a self-identified mainstream paradigm of psychological theory. Theories that

have been created within its own cultural construct of truth called the scientific method and therefore are by design, a strong fit for continued scientific research and claims of evidenced-based superiority to other psychotherapies.

Hofmann et al. (2012) conducted a review of 269 meta analyses examining the efficacy of CBT across a range of disorders, problem behaviours and study populations. The conclusion, CBT is a treatment used for a wide range of psychological problems; it's evidence base is very strong, especially for anxiety; however, despite the enormous literature base, there remains a clear requirement for high quality studies examining the efficacy of CBT (David et al., 2018; Hofmann et al., 2012). For some problem presentations the efficacy of CBT is questionable and suggest further improvements in CBT strategies (Hofmann et al., 2012).

Where CBT are effective with treating disorders and problem behaviours in mainstream populations, the literature surrounding the efficacy of CBT, lack strong evidence as to their applicability to Indigenous populations (Bennett, 2009). Assessing my professional training and acumen as a practitioner and clinical manager of therapeutic services over several Non-Government Providers, Western best practice therapies are considered universal in application and prioritised with Government funding. The funding of evidence-based therapies thus hold a dominating position as mental health interventions for Māori (Strang et al., 2018), even in the absence of critical-mass evidence as to their effectiveness for Māori (Bennett, 2009; Strang et al., 2018).

The eradication of the Māori way of life in replacement for a deemed superior Western colonial hegemony has created multi-morbid, predisposing causation for Māori dis-ease. It offers insult to injury for Māori, that the solution for the reacquisition of hauora is to be achieved solely under a revised but similar cultural hegemony called the health system (Rolleston et al., 2020) and its supporting biopsychosocial therapeutic interventions. A system that has been historically opposed to Indigenous concepts and practices on how to achieve wellbeing for Māori.

1.2.6 He Korowai Oranga: Māori Health Strategy

Is there a current appetite from the New Zealand Government – Crown, to fund an Indigenous therapy centred in mātauranga me tikanga Māori?

In 2013/14 the Ministry of Health – Manatū Hauora refreshed it's Māori Health Strategy – He Korowai Oranga which provides high level guidance for the New Zealand

Government (Government) and the health and disability sector, to achieve hauora Māori for whānau, hapū and iwi across Aotearoa (Ministry of Health - Manatū Hauora, 2020b). Pae Ora – Healthy Futures is the vision and aim for the Government’s strategy and is supported by three focal health considerations: Whānau Ora - health and wellbeing of families; Wai Ora – healthy environments; and Mauri Ora - health and wellbeing of an individual (Ministry of Health - Manatū Hauora, 2015b). Like other Māori models of health these Māori health constructs are required to be in unison, to accomplish a Māori holistic experience of hauora.

Whānau Ora is a kaupapa Māori approach that privileges whānau autonomy to prioritise services and supports, that they deem necessary to establish health aspirations, participate in te ao Māori and modern society (Ministry of Health - Manatū Hauora, 2019; Te Puni Kōkiri - Ministry of Māori Development, 2022). Wai Ora signals the importance of habitation and accessibility of clean environments for health and wellbeing (Ministry of Health - Manatū Hauora, 2022b). Wai means water and including its practical application to sustain life to people and place, it is symbolic of Māori healing and spiritual vitality – wairuatanga. Wai Ora extends the Government health strategy to include quality housing, safe drinking water and air, healthy food and to address other determinants of health such as education and poverty (Ministry of Health - Manatū Hauora, 2022b).

Mauri Ora premises the importance for Māori as an individual consumer of health services to have accessible pathways to care across all life stages; where the health system works to ensure that the approaches and delivery of services from prevention to treatment is appropriate for Māori (Ministry of Health - Manatū Hauora, 2014, July 31). Mauri ora is the life force, a living energy that pervades all life and connects the individual to whānau, hapū, iwi, te taiao - environment, te ao hurihuri - physical world and te ao wairua - spiritual world.

The Waitangi Tribunal is a permanent commission of inquiry set up by the Treaty of Waitangi Act 1975 to make recommendations on claims brought by Māori as to breaches to articles of Te Tiriti made by the Crown (Ministry of Justice - Te Tāhā o te Ture, 2023). In November 2016, the Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575) began hearing historical and contemporary claims concerning grievances relating to the health system and the poor outcomes it has produced for Māori (Ministry of Health - Manatū Hauora, 2020d). To date 220 claims have been lodged seeking redress across a range of issues relating to the health system, that include: health equity, primary care, mental health, disability services and alcohol, tobacco and substance abuse (Ministry of Health - Manatū Hauora, 2020d).

Whilst the Wai 2575 inquiry adjudicates formal recommendations for redress by the Crown, the Ministry of Health have implemented a Te Tiriti O Waitangi Framework that underpins, Whakamaua: Māori Health Action Plan 2020-2025 (Whakamaua) (Ministry of Health - Manatū Hauora, 2020e). An action plan that guides the Government and health and disability system to give effect to He Korowai Oranga and contribute to the achievement of Pae Ora (Ministry of Health - Manatū Hauora, 2020e). The framework upholds Māori interpretations of the four articles of Te Tiriti, as recommended by the Courts and the Waitangi Tribunal in the 2019 Hauora report (Ministry of Health - Manatū Hauora, 2020c).

The primary health care system is to exercise obligations under Whakamaua by following these recommended Te Tiriti principles: *Tino rangatiratanga* – to guarantee iwi, hapū, whānau self-determination in the design, delivery, and monitoring of health and disability services; *Mana motuhake* – the right for Māori to have authority to live according to Māori philosophies, ngā uara - values and tikanga – practices, to be Māori; *Mana tangata* – the Crown's commitment to equity in health and disability outcomes, including addressing racism and discrimination to achieve hauora; *Mana Māori* – valuing and active protection of ritenga Māori - customary rituals, tikanga and mātauranga Māori - Māori practices, philosophy and knowledge, are present and protected throughout the health system (Ministry of Health - Manatū Hauora, 2020c).

A strategy and the subsequent operationalisation of an action plan requires funding. The Crown is obligated to properly resource kaupapa Māori health and disability services, where funding recognises and supports the expression of hauora Māori models of health (Ministry of Health - Manatū Hauora, 2020c). He Korowai Oranga strategy is not a top down approach, the principle of partnership is central, requiring Crown and Māori to partner in governance and co-design to achieve the He Korowai Oranga strategy. The Pae Ora (Healthy Futures) Act 2022 took effect 1 July 2022 which alongside the renewed strategic direction, legally requires the Ministry of Health to fund Te Tiriti informed health initiatives and to partner governance in a new way (New Zealand Legislation, 2022).

Health New Zealand - Te Whatu Ora is the newly established Crown agent to run the New Zealand health system. It is responsible for improving service outcomes and working in partnership with the Māori Health Authority - Te Aka Whai Ora to jointly develop and implement a New Zealand Health Plan (Future of Health, 2022, September; New Zealand Legislation, 2022). Te Aka Whai Ora is charged with supporting, guiding and ensuring obligations under the Te Tiriti principles stated, are administered correctly and represent the voice of iwi, hapū and whānau (Future of Health, 2022, July). The

community voices of Māori will be captured and shared via iwi-Māori partnership boards (New Zealand Legislation, 2022).

He Korowai Oranga and its supporting Māori health model and framework (Pae Ora), coupled with the Pae Ora (Health Futures) Act 2022 and its newly established agents, is a strategic and legislative directive for the Government and its health Ministry to address predisposing and precipitating negative health statistics for Māori. Health inequities resultant from prolonged expulsion from the Māori way of being, experienced from the systematic dishonouring of Te Tiriti O Waitangi (Future of Health, 2022, July).

1.3 Identifying the Research Opportunity

Could the talk-therapy provision in Aotearoa for Māori be improved with a holistic Indigenous approach, a departure from a Western biopsychosocial importance only? Is Indigenous cultural inclusion in Western clinical treatment pathways required to ensure culturally safe practice and positive outcomes for Māori? As shared the answer is yes, (Strang et al., 2018; Wratten-Stone, 2016) but how much and by whom sets the inclusion level? Does such deliberating still position Māori as an 'other', an outsider to their own health solution, a holistic provision of care?

To be noted as cultural, delineates those identified as cultural from an assumed often invisible dominant group. A dominant group that has set in place intergenerational disease and also the health solution for this disease. Or is it that an opportunity presents that a well-funded and widely utilised clinical approach that is culturally embodied by design more relevant to solve high prevalence rates and negative Māori health statistics. A Māori therapeutic solution that is invisible inside its own ontology and epistemology. A Māori therapy – he haumanu Māori, that sits comfortably on its own terms within its own philosophical construct.

It is yet to be fully seen if the partnership between Te Whatu Ora and Te Aka Whai Ora will mature and ultimately achieve the strategic ambition it has started. Optimistically Te Aka Whai Ora appears to be a champion Māori health authority to ensure Te Tiriti principles stated, are included in health service co-design and implementation for Māori. Te Whatu Ora is required to fund Māori lead health solutions to achieve obligations stated in the strategic and legislative direction of the Government and its Ministry of Health. The opportunity for a funded Māori therapy would appear timely.

1.4 Formulating the Research Objective & Questions

Evidenced-based best practice is a continuation of colonial epistemology. APA Presidential Task Force on Evidenced-Based Practice (2006) shares that:

The purpose of EBPP [Evidence-Based Practice in Psychology] is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. (p.273)

However, the rationale of this research would support the development of an effective Māori therapeutic intervention, located outside Western scientific-best-practice, to enhance public health for Māori. The undertaking of this research is to ask what is a Māori therapeutic solution for Māori dis-ease and tangata whai i te ora? A solution that can provide an Indigenous informed therapy and enable a work force to provide culturally competent services. The benefit to Māori is autonomy over therapeutic best practice for hauora Māori.

1.4.1 Research Objective

The objective of the research is to conduct a scoping literature review of Māori health models and frameworks to elicit key components towards a therapy centred in a Māori worldview. The research will broadly review literature from selected allied health databases to charter commonality and gaps of Māori constructs found within identified Māori models and frameworks. Published writings from authors in allied professions such as counselling, psychotherapy and psychology will be examined to provide insights into what is currently happening within the talking therapies.

A universal foundation with in te ao Māori is wairuatanga. Not to be assimilated or scaled to a Western understanding of religion, the Māori concept of spirituality broadly embodies inter-relational considerations that inform psychological, emotional and physical encounters with people - alive and deceased, environment, cosmos both tangible and non-tangible. Possessing a healthy wairua is conceptually linked to a holistic approach to wellbeing or hauora, it personifies the importance of health factors such as a safe home and neighbourhood, access to healthy food, opportunity, care, nature and freedom to participate in your culture with others and the environment.

In addition to finding themes in the literature that support key components for a Māori therapy, the scoping review will also explore these components relationship to wairuatanga.

1.4.2 Research Questions

There are two primary questions this study sets out to answer:

1. What are the key components for a Māori therapy?
2. What is the relationship between a Māori-centred therapy and wairuatanga?

WĀHANGA 2: METHODOLOGY & METHOD

This research engages with an Indigenous approach utilising Kaupapa Māori Methodology (Pihama et al., 2002; Smith, 2008) and a Pūrākau Method (Lee, 2009; Mikahere-Hall, 2019) to review literature on Māori health models and frameworks by authors in allied and talk therapy professions. Chapter 2 will contextualise the relationship of these methodology and method with a Māori ontology and epistemology; to broaden and accurately exhibit their interconnected functionality to a Māori philosophical worldview, promote a Māori Research Paradigm and platform Māori autonomy to measure reliability and validity.

2.1 Kaupapa Māori Methodology

The design and implementation of this research will be guided by Kaupapa Māori Methodology, a widely recognised and culturally appropriate methodology for research conducted within te ao Māori (Smith, 2008). Kaupapa Māori is an approach that is grounded in a Māori knowledge base that validates Māori worldviews through inviting the sharing of mātauranga, appropriate engagement with others, relationships with the environment, language, and cultural identity, whilst challenging hegemonies that would otherwise dominant an Indigenous voice (Pihama et al., 2002; Rolleston et al., 2020; Smith, 2008; Walker, 1990).

Kaupapa Māori has grown beyond its root beginnings challenging mainstream education to establish Kura Kaupapa Māori education pathways and Indigenous academic research methodology (Pihama et al., 2002; Smith, 2008), to evolve as a political, educational and professional movement (Campbell, 2011). By affirming mātauranga Māori across societal sectors, the movement resists and addresses systematic and Government sanctioned oppression to alleviate the resultant mamae or pain, hurt experienced by Māori (Campbell, 2011). Moana Jackson (1992) (as cited Campbell, 2011):

As Māori we are now seeking to reclaim the validity of our own institutions, the specifics of our own faith, and the truths of our history. That process will not only nourish once more the Māori soul, it will also eventually undermine the conceptual framework of the Pākehā word and the oppression which has flowed from it. (p. 47).

Contemporary Indigenous societies have emerged for Māori communities who are attempting to maintain traditional beliefs and practices, whilst immersed in Western societal norms (Strang et al., 2018). Kaupapa Māori research is at the interface

experiencing both the shortfall or the provision of evolving innovation, that endeavours to fuse knowledges influenced by both Indigenous traditions and modern Western practices. An endeavour to provide fresh insight that can support positive outcomes for contemporary Indigenous societies (Durie, 2004).

In this way, Kaupapa Māori methodology is at the interface and should be differentiated from Western scientific research which employs stand-alone empirical scientific principles (Rolleston et al., 2020; Smith, 2008). Indigenous research focuses on positioning the validity of traditional knowledge, to exist alongside other forms of knowledge, so to provide research to achieve hauora gains for Māori (Durie, 2004; Smith, 2008; Strang et al., 2018).

2.2 A Pūrākau Method

In modern usage the word pūrākau is a noun that translates as a mythology, legend or story (Te Aka: Māori Dictionary, 2023), however, when translated into English, a reduction of its true deeper meaning and application occurs. In ancient times and to the initiated, layered meaning was gleaned through carefully guided interpretation of a pūrākau; historically learned at te whare wānanga or te whare pūrākau, ancient schools of higher learning (Jones, 2013; Marsden & Royal, 2003). An oral culture, Māori created forms of recital that overlaid a story or legend with embedded knowledge to enable an ease of remembering, retelling and cultural employment.

Pūrākau encompass whakapapa - genealogy, tangata - people, tupuna - ancestors, hauropi - ecology, atua Māori – Māori deities, matai tuarangi - cosmology (Jones, 2013; Marsden & Royal, 2003). Sources of pūrākau include listening or performing: whaikōrero - formal speech making, waiata – song , oriori - gentle whakapapa lullabies, moteatea - long traditional chants, haka - performance dance, to name a few (Pohatu, 2013).

Within these forms of kōrero pūrākau or storytelling, comprehension of the interaction of characters such as famous tupuna and atua Māori, fashioned how ngā mātāpono me ngā uara Māori – Māori principles and values, can assist a healthy Māori way of existence. Principles and values that now constitute and inform modern day Māori models and frameworks of health.

A central theme of pūrākau is whakapapa. Whakapapa kōrero - reciting of genealogy, is a systematic organising method that details through narration, relational interconnectivity with people and place; past, present and future; including te kauae raro me runga -

terrestrial and celestial esoteric wisdom (Marsden & Royal, 2003). Te pūrākau orokohanga Māori – the Māori creation story is a pūrākau that has extensive scripts of whakapapa, unique to all iwi, that set a precedence for all subsequent forms of pūrākau. It provides an account of first principles and values born from a Māori ontological narration of cosmology.

Understanding the whakapapa of ngā uara me ngā mātāpono sourced within pūrākau is a crucial method for this research to identify, extract and validate reliable key components from the literature to answer the research questions. A Pūrākau Method specifically legitimises pūrākau as a credible source of culturally responsive Māori constructs for inquiry (Lee, 2009; Mikahere-Hall, 2019).

2.3 Te Ao Raranga | The Weaving Universe: A Māori Philosophy

Dr Kiri Prentice's model Te Ao Raranga | The Weaving Universe is a framework of Māori philosophy based on traditional Māori metaphysics (Prentice, 2022). The name refers to an edited collection of writings – The Woven Universe, by respected academic and tohunga Māori Marsden (Marsden & Royal, 2003). The framework details a centrifugal approach utilising Marsden's weaving metaphor to conceptualise a Māori understanding of existence through a process-relational philosophy (Prentice, 2022).

Durie (2011) articulates two generalised approaches on how people think to arrive at truth. Scientific thinking adopts a centripetal approach, following a well-worn cognitive path, where meaning making is derived from dissecting the whole to discover conclusions from the analysis of the component parts (Durie, 2011). Indigenous peoples who characteristically hold close and enduring relationships to land and environment, tend to reach conclusions by thinking outwards from the centre, a centrifugal approach (Durie, 2011).

Rather than a first emphasis on inward introspection, understanding comes from the centrifugal subjective experience of a wide reciprocation of relationships, than the centripetal objective analysis of internal structures (Durie, 2011).

Te Ao Raranga offers a framework to the relational complexity of how meaning and knowledge is acquired and practiced for Māori. The author of Te Ao Raranga, Dr Kiri Prentice is an accomplished Māori psychiatrist and academic. She holds roles as: Deputy Medical Director Māori – Pharmac; Deputy Clinical Director Māori, Mental Health Services – Te Whatu Ora Northern; and Professional Teaching Fellow, Medical –

University of Auckland. Prentice (2022) is a presenter on Māori mental health and creates educational content on her website, Māori Minds. A site dedicated to exemplifying the value of incorporating mātauranga Māori in mental health services and delivery.

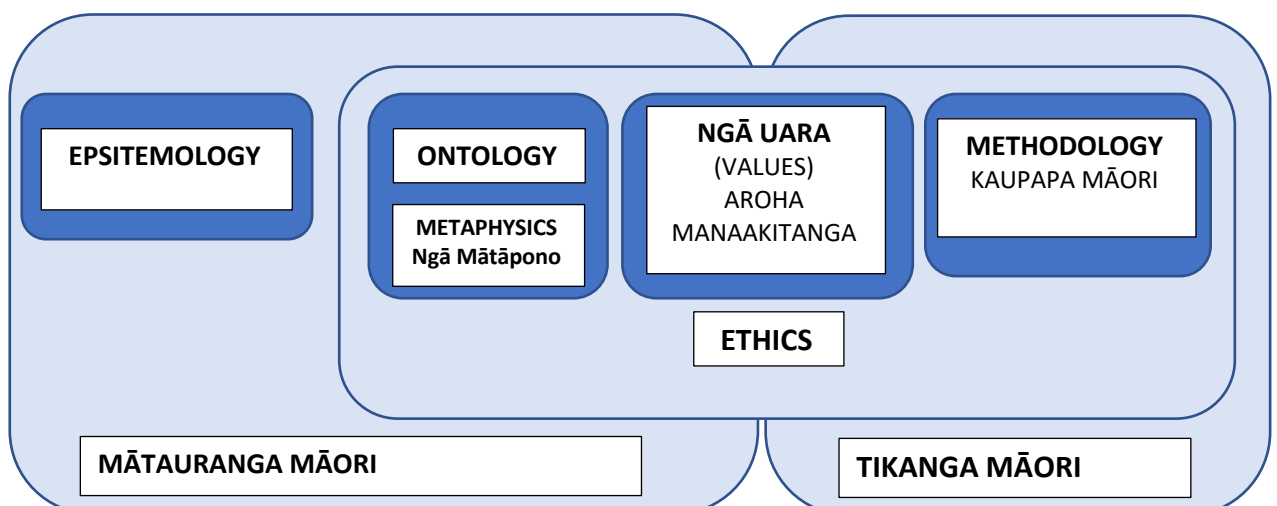
Although not intentionally designed as a research paradigm, Te Ao Raranga is a framework that umbrellas and organises the centrifugal complexity of interrelationships, centred from a Māori cosmogenic beginning and how these origin accounts inform an ontology and epistemology that forge ngā mātauranga Māori (Prentice, 2022). The framework extends to privilege Māori methodology and method which in turn privileges ngā mātauranga Māori.

Kaupapa Māori Methodology and Pūrākau Method are tikanga and when implemented correctly can be used to explore mātauranga Māori to gain deeper understandings of Māori constructs - ngā mātāpono me ngā uara Māori. The action of tikanga has an arching effect. The implementation of tikanga provides a reliable Māori process to ethically validate ngā mātāpono me ngā uara Māori, thus qualifying a Māori world reality and enabling the production of new mātauranga Māori.

Prentice's Māori philosophical framework enables the key components for a Māori therapy, scoped from Māori health models and frameworks, to be accurately located within their ontological whakapapa and avoid translation pasteurization. Te Ao Raranga is the chosen research paradigm for this study.

Figure 1

Adapted from Te Ao Raranga: The Weaving Universe: A Framework of a Māori Philosophy, (Prentice, 2022)



2.3.1 Te Ao Raranga – An Overview of the Research Paradigm

Prentice's Māori philosophical framework maps the interplay between two central Māori concepts - mātauranga and tikanga to contextualise a te ao Māori ontology and epistemology and their interchange to Māori methodology and method; for further details please see - April 2022 <https://www.youtube.com/watch?v=B8tQE3PZkgM>, (Prentice, 2022).

As shown in Figure 1, I have adapted the framework to specifically denote ngā mātāpono me ngā uara Māori as the conduits between mātauranga and tikanga. An overview of Prentice's model is provided to illustrate the symbiotic interplay between the framework's sub-categories, so to illuminate the research paradigm for this study and the theoretical foreground for identified components, themes for a Māori therapy.

Mātauranga

Mātauranga is Māori knowledge derived from a Māori philosophical worldview (Mead, 2003). Examining Te Ao Raranga (Figure 1) mātauranga Māori is the knowledge safe-keep of philosophical subcategories: a Māori ontology and a Māori epistemology (Prentice, 2022).

Māori Ontology

Māori ontology is what Māori understand the nature of existence to be which are exemplified with metaphysical principles – ngā mātāpono, like wairua, mana and mauri (Prentice, 2022). Wairua, mana and mauri are extensive first principal constructs and best explained in their relationship to each other, than an individualised taxonomy (Prentice, 2022). In this study I interpret wairua, mana and mauri as interdependent and in the following ways. Wairua is an all-pervasive **consciousness-in-potential** available in all aspects of creation. Mana is **potential-consciousness-expressed**, an embryonic aspect of wairua expressing itself. Mauri is the **movement-of-potentiality-expressed**, mana in relationship with mana.

To illustrate, I liken this interpretation to the growth of a seed, flourishing into a majestic kauri tree. The environment is wairua and the seed planted into the earth is mana. As aspects of wairua, the environment is also alive with mana. The mana of the sun, the rain, the air, the soil all feeds and nurtures the mana of the seed, allowing it to burst from its confines to mature into a resplendent king of the forest. The kauri shares it's mana with the whole environment, which is nurtured in kind. The movement of mana interacting

with mana is mauri. This interdependent relationship - whanaungatanga, is considered sacred, tapu by Māori.

Coined by Prentice (2022), Māori have an *ontology of whanaungatanga*. Māori consider whanaungatanga – relationships, and the process of establishing relationships – whakawhanaungatanga, as a fundamental principle to the nature of reality and existence (Marsden & Royal, 2003; Prentice, 2022). Whakawhanaungatanga is not restricted to kinship or people, but also non-kin, animate and inanimate life forms, including energy (Marsden & Royal, 2003; Mead, 2003). The inherent energy in life is relational and where the constructs wairua, mana and mauri are readily experienced to support knowing and conceptualising new understanding - mātauranga.

Prentice incorporates the metaphor of a woven universe from Māori Marsden's edited writings (Marsden & Royal, 2003) to succinctly describe the complexity of a Māori philosophy of existence (Prentice, 2022). She describes an evolving and interweaving of complex and simple relationships - whanaungatanga, from a sub-atomic cellular interchange to the birthing of a new solar system (Prentice, 2022). Prentice (2022) explains, "...that life in existence are ever changing, always in flux, and always in a process of becoming". The arrangement of a Māori reality can be summarised as - life in relational existence with itself - whakawhanaungatanga.

A central consideration for Māori is how people connect with the multitude of relationship dynamics found in existence. Whakawhanaungatanga performed through mihimihi and pepeha is more commonly extended to relationship building with tāngata – people, whenua - land, moana - sea, awa – rivers; yet these connections are precursors to a wider ontological notion of reality, specifically from the smallest measure of matter to the uncharted reaches of the cosmos. An ontology of whanaungatanga values meaning making through a subjective stance of reality, where human existence is deeply rooted in the participation of relational experiences of life lived (Marsden & Royal, 2003). Deciphering reality is contextual and subjective, rather than an objective categorisation of the animate and inanimate, so to understand them in a mechanistic manner (Prentice, 2022).

Māori Epistemology

A Māori epistemology is how Māori actualise understanding of knowledge or mātauranga through customs or practices such as: whakapapa kōrero, pōhiri, whaikōrero, pūrākau, waiata (Marsden & Royal, 2003; Prentice, 2022). A wide range of definitions are

attributed to mātauranga Māori: philosophy, knowledge, worldview, education, customs, values, and practices (Mead, 2003; Prentice, 2022). Prentice (2022) offers Māori Marsden's metaphor of flesh and bones to explain how Māori structure, acquire, and engage with knowledge.

In this metaphor, whakapapa is the skeleton or bones and mātauranga is the flesh (Marsden & Royal, 2003). An oral culture, Māori customary practices such as formal speech making, story, song, chants embody the skeleton with flesh. These practices recite genealogy or whakapapa. In this way complex knowledge sets of existential reality are organised, interpreted, applied and remembered. The function of these customary practices are to provide the continuation of knowledge, pedagogy, and importantly the visibility of metaphysical principals such as wairua, mana and mauri.

Tikanga

An essential extension of mātauranga Māori is tikanga (Mead, 2003). Tikanga is derived from the word tika, which means to be correct, act in the right way, be fair, accurate, lawful, proper, valid (Te Aka: Māori Dictionary, 2022). Tikanga is a code of conduct and protocols that guide behaviour, but not in a judicial manner. Tikanga enacted delivers outcomes of empowerment where the experience is understood, accepted and importantly - felt (Mead, 2003; Prentice, 2022). It is the feeling of tika that ensures its continuity.

Mātauranga is considered to be housed in the mind (Mead, 2003), and tikanga is the practical expression of the heart (Marsden & Royal, 2003) wisely activating knowledge into practice. The purpose of tikanga is to replicate reliable experiences of fairness, truth and ritual correctness (Mead, 2003) in order to validate the gathering, production and continuity of mātauranga Māori. Tikanga Māori is informed and firmly embedded in mātauranga Māori, it is the practical face of mātauranga Māori and cannot be understood without making use of mātauranga Māori (Mead, 2003). Tikanga Māori might be described as a Māori philosophy in practice (Mead, 2003; Prentice, 2022). Tikanga safely guides how, when and where customary practices are implemented.

Māori Methodologies, Methods and Ethics

Prentice (2022) aptly categorises Māori methodologies and methods under the sub-category of tikanga – the practical application of this study's research paradigm. Kaupapa Māori Methodology (Pihama et al., 2002; Smith, 2008) and Pūrākau Method

(Lee, 2009; Mikahere-Hall, 2019) are examples of tikanga-applied Māori methodologies and method.

The framework (Figure 1) orientates ngā uara as the tangible link between mātauranga and tikanga Māori. Examples of ngā uara include aroha (love, compassion), manaakitanga (respect, nurturing), whanaungatanga (connection, relationship), kaitiakitanga (guardianship) and wairuatanga (balance, mana exchanged, tapu-sacred, multi-dimensional, spirituality), to name a few. Ngā uara are originated from mātauranga (Prentice, 2022) and are descriptions of the value-experiences of tikanga.

The enactment of these values informs and sets a standard of ethical behaviour and practice. Māori ethics is the expression and outcome of tikanga-in-action. To deliberately enact tikanga or Māori values as a practice to ethical behaviour in situations such as; interpersonal exchanges, whānau dynamics, with the environment, in research, or the participation in cultural rituals; is an indication of existing knowledge of mātauranga Māori, the knowledge safe-keep of Māori metaphysical constructs. Māori methodologies and methods should be grounded in mātauranga, exemplified through tikanga and thus will align with Māori ethical considerations and practices – ngā uara (Prentice, 2022).

To ensure the inclusion of literature to be scoped is reliable and valid for the study, the chosen research paradigm and methodology prioritise a Māori ontology. Māori models and frameworks are modern day expressions of pūrākau and mātauranga Māori. The research method ethically enables the identification, gathering and deconstruction of Māori models and frameworks, as literature sources that can contribute Māori constructs to establish themes to answer the research questions.

A scoping review of the literature utilising a PRIMSA-ScR guidelines (Tricco et al., 2018) will be the design protocol for the study and explained in Chapter 3. The use of both Māori methodology, method and a Western design protocol, signals this study is research at the interface.

A combined exercise to extend Māori epistemology through the acquisition of new mātauranga and tikanga Māori for the benefit of hauora Māori.

WĀHANGA 3: SCOPING LITERATURE REVIEW

This dissertation explores the literature to examine the embedded pūrākau in Māori models and frameworks of health to identify common mātauranga towards the development of a Māori therapy and assist in answering the research questions. The exploration of the literature will be conducted through a scoping literature review. A scoping review is a systematic research approach to synthesis knowledge, chart evidence on a topic and identify main concepts, theories, and knowledge gaps for further research and development (Tricco et al., 2018). Chapter 3 outlines the research design protocol used to synthesis and chart the literature to identify constructs within Māori models and frameworks of health, to produce theories and knowledge gaps towards developing a Māori therapy.

Wilson et al. (2021) recently published a literature review that identified key concepts within Māori models of health to determine how they could inform the development of a Māori-centred relational model of care. Wilson et al. (2021) used PRISMA literature review guidelines to disseminate the data and structure their report, as well as being informed by Arksey and O'Malley (2005) scoping review framework. As the data set for this dissertation is to be retrieved from a similar scope of literature to Wilson et al. (2021) it would stand to reason that their study informs this research design protocol, approach and data inclusion.

3.1 Scoping Review Design Protocol

The research design protocol for this scoping review follows the PRISMA guidelines for reporting literature reviews as articulated in the PRISMA-ScR checklist which includes a 27 item literature review checklist of which 5 items are not applicable to a scoping review (Tricco et al., 2018). The *PRISMA 2020 flow diagram for updated systematic reviews which included searches of databases, registers and other sources* (Page et al., 2022) will be utilised to disseminate and synthesis the data (see Table 1).

3.2 Limits of the Scope

Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health (Wilson et al., 2021) identified nine Māori models and frameworks from four database searches which included: CINAHL, PubMed, Scopus, and INDEX New Zealand. Literature from other sources was accessed using the nzsearch.org database (Wilson et al., 2021). The literature review data search identified 414 records

which were screened to 14 articles with four removed based on inclusion criteria, leaving ten articles (Wilson et al., 2021). These ten remaining articles described nine different Māori health models and frameworks, which were deconstructed to establish key constructs, principles and values to include in the development of a Māori-centred relational model of care (Wilson et al., 2021).

The study by Wilson et al. (2021) is the most recent literature review of published and non-published Māori health models and frameworks over the last four decades. The study data search terms were “Māori” AND combined variations of “model”, “framework”, “care” (Wilson et al., 2021). The nine Māori models of health retrieved are not an exhaustive list, but a good cross-section of what Māori models constitute. The identified models and frameworks by Wilson et al. (2021) were found using the same PRISMA literature review protocol and databases as this study, and will be included in the data set for this scoping review.

3.3 Information Sources

This study’s objective is to locate Māori models and frameworks for review of published allied health practitioners and literature from authors in the New Zealand talk therapy professions such as, psychotherapy, counselling and psychology. To establish consistence this study’s dataset will be scoped from the same four databases used in the Wilson et al. (2021) study to retrieve Māori models of health: CINAHL, PubMed, Scopus, and Index New Zealand (INNZ); however will alter the search terms to target literature specific to talk therapy professions. All databases were sourced via the AUT library databases: Psychology & Psychotherapy.

Cumulative Index to Nursing and Allied Health Literature (CINAHL) is widely understood as the industry standard, a premier source of nursing and allied literature offered exclusively on EBSCOhost (McGowan, 2014). CINAHL has five databases of which Wilson et al. (2021) used CINAHL Plus which indexes 5014 titles (McGowan, 2014). This study has chosen the latest database CINAHL Complete which incorporates CINAHL Plus and offers approximately 300 more indexes (McGowan, 2014). CINAHL Complete has been chosen for this study as the database literature is populated by allied health practitioner authors.

Scopus database was launched in 2004 and has over 25,100 titles of which 23,452 are peer-reviewed journals (Elsevier, 2020, January). Scopus provides a global overview of research output in the fields of science, technology, medicine, social science and arts

and humanities (Elsevier, 2020, January). PubMed is a free search engine which comprises 35 million citations and abstracts of biomedical literature primarily from MEDLINE, life science journals and online books (National Library of Medicine, 2023, March 21). INNZ is an online database of articles from New Zealand journals and magazines from 1980 to present day (National Library, n.d.). These databases provide a wide breadth of international and domestic titles from a cross section of fields relevant to this scope.

This scope utilised a different source for retrieving literature than from nzsearch.org database (Wilson et al., 2021), opting instead on literature from New Zealand journals of talk therapy associations: New Zealand Journal of Psychology; Ata: Journal of Psychotherapy Aotearoa New Zealand; and the New Zealand Journal of Counselling. These literature sources for this study are 'peer-reviewed' articles of talk therapy authors with publications relevant to the scoping review objective.

3.4 Eligibility Criteria

Inclusion and exclusion criteria mirrored Wilson et al. (2021) scoping review but incorporated different search terms. Including Wilson's eligibility criteria provided reliability and validity to the inclusion of the nine Māori models and frameworks (Wilson et al., 2021) retrieved for this study's data set.

Database Search Terms:

Advanced searches with Boolean logic of 'AND/OR' were used for all four databases.

- Māori or Maori model AND Māori or Maori models AND counselling
- Māori or Maori framework AND Māori or Maori frameworks AND counselling
- Māori or Maori model AND Māori or Maori models AND psychotherapy
- Māori or Maori framework AND Māori or Maori frameworks AND psychotherapy
- Māori or Maori model AND Māori or Maori models AND psychology
- Māori or Maori framework AND Māori or Maori frameworks AND psychology
- Māori or Maori model AND Māori or Maori models AND therapy
- Māori or Maori framework AND Māori or Maori frameworks AND therapy

Two spelling of the word Māori were included, with or without a macron. Singular and plural spelling of model and framework were used. To specify talk therapy literature terms "counselling", "psychotherapy", "psychology" and "therapy" were added.

3.5 Inclusion & Exclusion Criteria

- Literature needed to outline a unique Māori model or framework that specifically informed or could support a therapeutic delivery of practice.
- As this study is premised in a Kaupapa Māori Methodology and Pūrākau Method to enable the inclusion of mātuaranga Māori i tuku iho (Māori knowledge passed down over generations) no timeframe was applied.
- The author is not fluent in te reo Māori so only papers written in predominantly English were eligible for inclusion.
- To ensure a wide inclusion of literature both peer-reviewed and non-peer-reviewed papers were included.
- Titles with the search Boolean terms were included.

Literature of Māori models and frameworks that promoted Māori health and informed biomedical studies with Māori cohorts were excluded. Any of the nine Māori models and frameworks retrieved in the literature review by Wilson et al. (2021) were excluded as new data but included in the final study data set for analysis.

Talk Therapy Journal Inclusion & Exclusion

Talk Therapy Journal literature was delineated from the four database searches with Boolean logic, as the three online New Zealand talk therapy journals were manually scoped and reviewed. The journal articles are peer reviewed and the same inclusion and exclusion criteria as the database searches was applied.

3.6 Search

The electronic database search strategy was similar across all four databases, making adjustments to particular software nuisances such as, INNZ letters are case sensitive when using the Boolean logic words AND/OR/NOT. CINAHL Complete, Scopus and INNZ were located through the AUT Library database link <https://aut.ac.nz.libguides.com/c.php?g=205038&p=1352216>. INNZ and PubMed are free databases and do not require paid access. Under the PRISMA ScR guidelines at least one search strategy should be explained as a demonstration of the approach employed across all electronic databases. The approach taken with CINAHL Complete is briefly outlined.

Access to CINAHL Complete database was made through the AUT Library database link. On this page CINAHL Complete can be found under the title 'General health databases and resources'. The eight combination search terms using the 'AND, OR' Boolean phrases were entered and applied. All search results from CINAHL Complete, and similarly search results from the other three databases, were exported into a Microsoft Excel (CSV/XLS) format for screening and eligibility. The same subheadings such as title of articles, authors and publishing details were shared across databases for uniformity and ease of screening and extraction of the data.

3.7 Selection of Sources of Evidence

The Boolean search collated articles that had the research terms found within full text articles, producing a large quantity of data that required a multi-fold duplication removal process.

Utilising a Microsoft Excel spreadsheet, the data from all four databases were exported into four separate spreadsheets and saved under each database title respectively. The Boolean searches produced 8 sets of data per database and were exported into single worksheets respectively. A further worksheet was used to collate together all data retrieved, then duplicates identified by title were removed using the 'remove duplicates' shortcut in the Data tab on the Excel ribbon. The non-duplicate data from all four databases were cut and pasted into a 'master' spreadsheet that was again screened for further duplicates by title, so to remove duplicate articles found across databases.

Sorted by the A-Z Excel function a manual review for duplicate titles of the master data spreadsheet was also conducted as some spelling of the article titles were inconsistent such as " " found at the beginning and end of a title and alternative spelling to words like 'authorisation' or 'authorization'. Removing duplicates by screening titles only was the best approach, as in some cases the same article recorded author's names differently across databases. The retrieved talk therapy journal literature was also included in the duplication removal screening process.

The non-duplicate master dataset was still large. To further refine the number of articles for extraction, within the Excel spreadsheet, the 'titles' were then sorted by the research search terms 'Māori/Maori, Model/s, Framework/s, Counselling, Psychotherapy, Psychology, Therapy'. All titles that did not have these terms were excluded. Duplications were again removed from the remaining 'titles' data set. With a manageable data size all titles were screened if suitable for an abstract review.

Titles that promoted Māori health, informed a biomedical study, and were one of the articles found in the Denise et al (2022) study were excluded. Titles that made reference or inferred a Māori model or framework that supported therapeutic practice or measured wellbeing were included for an abstract review. The abstract review utilised the research inclusion and exclusion criteria. Post the abstract review, articles were selected for a full text analysis, verified again under the same inclusion and exclusion criteria, and added to the final data set extraction. A PRISMA-ScR flow diagram mapped the synthesis of data – Table 1 see Chapter 4.

3.8 Data Charting Process

There is no statistical analysis of the data only qualitative. In a qualitative scoping review a basic content analysis informs how the data is charted (Page et al., 2022). The models and frameworks in the data set will be composed into a table format by the 'models name' and the key core values or constructs. The key Māori constructs were categorised under three sub-headings fashioned in accordance with the study by Wilson et al. (2021) to organise how the results of this research are analysed and reported. The final data set for analysis includes all models and frameworks identified from the study by Wilson et al. (2021) and the models and frameworks extracted from this study's scoping review.

3.9 Data Items

The data items are Māori models and frameworks of health extracted from the literature and their associated Māori constructs or ngā mātāpono me ngā uara Māori.

3.10 Critical Appraisal of Individual Sources of Evidence

Unlike a systematic literature review a critical appraisal of sources of evidence is not required for a scoping review and will not be conducted. To limit bias of data selected in order to answer the research questions, the key components that inform a Māori therapy and their relationship to wairuatanga must possess a whakapapa to a Māori cosmology. Guided by the parameters of a Pūrākau Method all data extracted will be validated by its whakapapa to a Māori ontology and epistemology.

3.11 Synthesis of Results Method

The research paradigm – Te Ao Raranga and Pūrākau method will be used to synthesise the data. In summation, the synthesis of data to locate Māori constructs within Māori models and frameworks that can provide key thematic components for a Māori therapy,

will be guided by their ability to whakapapa to a Māori ontology. All identified Māori constructs from the literature data set will be tabled for analysis and verified in conversation with a kaumatua.

WĀHANGA 4 – RESULTS

4.1 Synthesis of the Results

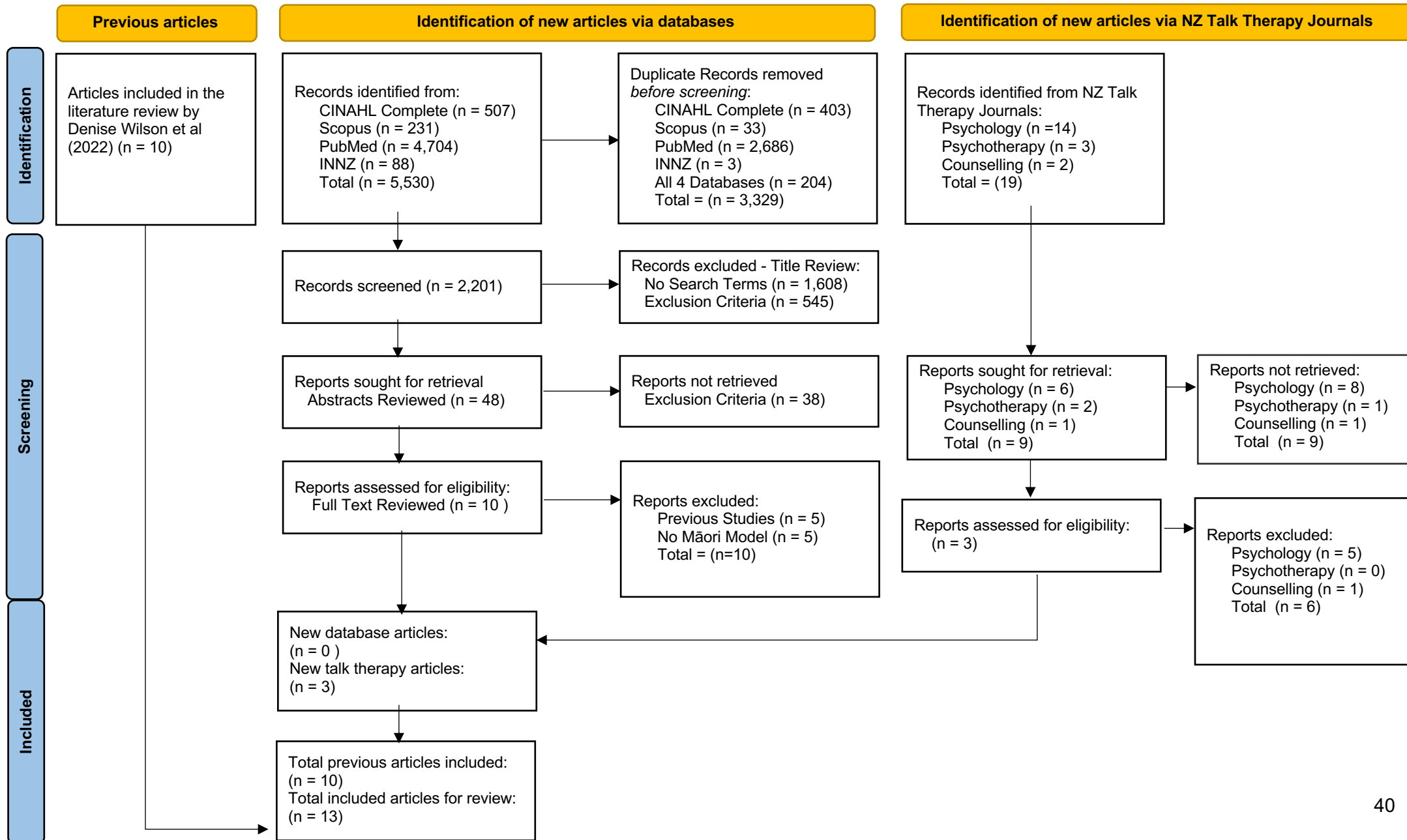
Utilising the study's research paradigm Te Ao Raranga and Pūrākau Method the identification and syntheses of Māori constructs from Māori models and frameworks of health can begin. To be able to offer recommendations of key components for a Māori therapy and their relationship to wairuatanga, the Māori constructs must exhibit a whakapapa to a Māori ontology, namely te pūrākau orokohanga – the Māori story of creation. Chapter 4 will detail the process taken to identify and synthesise the data to answer the research questions.

The ability for the researcher to have a working understanding of how to analyse the whakapapa kōrero of te pūrākau orokohanga Māori is required to effectively use the research method. The author has held wānanga over several years with a kaumatua o te Kāhui Ariki, a Tainui kaumatua of the Māori Royal Household. A kaumatua steeped in Māori lore. At marae and wāhi tapu interpretations have been relayed of first creation constructs such as Io, Te Kore, Te Po and Te Ao Mārama. How the interplay of ngā atua Māori, provide a working narrative of the interplay of relational archetypes that form first principles – ngā mātāpono, like wairua, mana, mauri, tapu; and how these constructs define Māori values of wellbeing – ngā uaara (Jones, 2013; Marsden & Royal, 2003; Prentice, 2022) were discussed. The undertaking of expert guidance is recommended to ensure an accurate and valid pūrākau approach is incorporated, to identify and synthesis the research data.

Alongside stated inclusion and exclusion criteria, articles that described heavily or in English only, models or frameworks on how to work with Māori in health settings were excluded. All kupu Māori (Māori words), have a whakapapa to a Māori ontology. Like pūrākau, they themselves have layered meaning within them. For this reason, key components for a Māori therapy must be informed by kupu Māori.

Table 1 is a flow diagram of the process undertaken to synthesis a wide breadth of literature to establish a final data set of articles for analysis.

Table 1 – Flow Diagram – Synthesis of Scoped Literature of Māori Models and Frameworks of Health & Wellbeing



4.1.1 Previous articles

All ten articles from the literature review by Wilson et al. (2021) were included in the final data set (Barton & Wilson, 2008; Durie, 1985; Lacey et al., 2011; Love, 2004; Mark & Lyons, 2010; Murray, 2010; Pere, 1991; Pitama et al., 2007; Robinson et al., 2020; Stevenson et al., 2020). Two articles discussed the model Te Wheke (Love, 2004; Pere, 1991), leaving a total of nine Māori models or frameworks for inclusion.

4.1.2 Identification of new articles via databases

The database Boolean search collated 5,530 studies from 4 databases, CINAHL Complete, Scopus, PubMed and INNZ. Duplicates removed totalled 3,329, leaving still a large number of articles – 2,201 for further screening. After a 'title' search using the same Boolean search terms and exclusion criteria, 1,608 and 545 studies respectively, were removed.

Articles retrieved for abstract review totalled 48 studies of which 38 were excluded. Ten studies were eligible for a full text review; five studies were excluded as they referenced a model or framework from 'previous articles' and the remaining five articles were assessed as unsuitable as to the exclusion criteria. No new studies were found through the Boolean database search.

4.1.3 Identification of new studies via talk therapy journals

A manual title review of three New Zealand talk therapy journals on respective association websites found 18 new articles - Psychology n=14, Psychotherapy n=2 and Counselling n=2. Inclusion and exclusion criteria applied was similar to the database search. After abstract reviews and subsequent review of articles suitable for full text assessment, three articles – Psychology n=1 (Palmer, 2004), Psychotherapy n=2 (Gray, 2003; Morice, 2003) were included as new studies. Studies on all three journals are peer-reviewed.

4.2 Characteristics of Sources of Evidence

A detailed written summary of each of the 13 articles and their related Māori model or framework will not be provided, as the main focus for this study is to collate Māori constructs within Māori models and frameworks to formulate thematic recommendations or key components for a Māori therapy. The characteristics of the evidence lies in the Māori constructs and are presented in two tables. Tables 2 & 3 present twelve Māori Models and Frameworks - the study data set, and associated Māori constructs for

analysis. Implementing a pūrākau method, a whakapapa analysis of the models and frameworks suitability to provide valid and reliable Māori constructs for review was conducted.

Table 2 is a reconstruction of data presented by Wilson et al. (2021) who used four subheadings to chart key considerations for a Māori model of care. The fourth subsection 'Socio-political Health Context' (Wilson et al., 2021) has been omitted for this study as the considerations under this subsection - colonisation, migration, racism, marginalisation, are not Māori constructs that is, kupu Māori with inherent whakapapa. Table 3 charts new sources of evidence from this study scoping review; namely, three articles, their respective model or framework and associated Māori constructs.

The identification of kupu Māori constructs from each of these evidence sources, Table 2 & 3, are organised under three subheadings 'Dimensions of health and wellbeing', 'Whanaungatanga (Connections)' and 'Whakawhanaungatanga (Building relationships)', as designated in the literature review by Wilson et al. (2021).

4.2.1 Dimensions of health and wellbeing

The largest concentration of identified constructs across the twelve Māori Models & Frameworks are dimensions of health and wellbeing – wairua – spirituality, hinengaro – mind & emotion, tinana – physiology and the systemic consideration of whānau ora. Whatumanawa and panapana were mentioned in two models to specifically delineate emotional health. These dimensions are cornerstone constructs in seminal Māori models Te Whare Tapa Wha and Te Wheke, which have set a precedence for all other models to follow (Durie, 1985; Pere, 1991). As they were the first models to establish a holistic consideration of Māori health and wellbeing it stands to reason these Māori dimensions of health and wellbeing are heavily represented over the dataset.

4.2.2 Whanaungatanga (Connections)

The four Māori constructs – whakapapa, whenua, whānau and whanaungatanga are intimately related. Whanaungatanga is represented in 10 of the 12 models and frameworks. Although the other three constructs aren't as widely represented across the data, they are inherently included in the concept of whanaungatanga which is to have a healthy relationship with whānau and whenua through the connection of whakapapa.

Table 2 – Previous Study Sources of Evidence – Māori Models & Frameworks

| | Hui Process ¹ | Kapakapa Manawa Framework ² | Meihana Model ³ | Te Hā o Whānau ⁴ | Te Kapunga Putohe ⁵ | Te Punga Oranga ⁶ | Te Whare Tapa Wha ⁷ | Te Wheke ^{8,9} | Te Whetu ¹⁰ |
|--|--------------------------|--|----------------------------|-----------------------------|--------------------------------|------------------------------|--------------------------------|-------------------------|------------------------|
| <i>Dimensions of health and wellbeing</i> | | | | | | | | | |
| • Wairua | | | ★ | | ★ | ★ | ★ | ★ | ★ |
| • Whānau | ★ | | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| • Hinengaro | | | ★ | | | ★ | ★ | ★ | |
| • Tinana | | | ★ | | | ★ | ★ | ★ | ★ |
| <i>Whanaungatanga (Connections)</i> | | | | | | | | | |
| • Whakapapa | ★ | | | | | | | ★ | ★ |
| • Whānau | | | ★ | | | | | | ★ |
| • Whenua | | | ★ | | | | | | ★ |
| • Whanaungatanga | ★ | ★ | ★ | ★ | ★ | | | ★ | ★ |
| <i>Whakawhanaungatanga (Building relationships)</i> | | | | | | | | | |
| • Tikanga | | | ★ | | ★ | | | | |
| • Aroha | | ★ | | | ★ | | | | |
| • Manaakitanga | | ★ | | ★ | ★ | | | | |
| • Mana | | | | ★ | ★ | | | ★ | |
| • Mauri | | | | | ★ | | | ★ | |
| • Pono | | | | | ★ | | | | |
| • Tiakitanga | | | | | ★ | | | | |
| <p><i>Note: ¹Lacey et al., (2011); ²Robinson et al., (2020); ³Pitama et al., (2007); ⁴Stevenson (2018); ⁵Barton and Wilson (2008); ⁶Murray (2010); ⁷Durie (1998); ⁸Pere (1991), ⁹Love (2004); ¹⁰Mark and Lyons (2010).</i></p> | | | | | | | | | |

Table 3 – New Sources of Evidence – Māori Models & Frameworks

| | Hōmai te Waiora ki Ahau ¹ | Whakapapa and Whanaukataka ² | Towards a Māori Psychotherapy ³ |
|---|---|---|--|
| <i>Dimensions of health and wellbeing</i> | | | |
| • Wairua | ★ | ★ | ★ |
| • Whānau | ★ | | ★ |
| • Hinengaro | ★ | ★ | ★ |
| • Tinana | ★ | ★ | ★ |
| • Whatumanawa Panapana | ★ | ★ | |
| <i>Whanaungatanga (Connections)</i> | | | |
| • Whakapapa | | ★ | ★ |
| • Whānau | | ★ | ★ |
| • Whenua | ★ | | |
| • Whanaungatanga | ★ | ★ | ★ |
| <i>Whakawhanaungatanga (Building relationships)</i> | | | |
| • Tikanga | ★ | | |
| • Aroha | | | ★ |
| • Manaakitanga | | | ★ |
| • Mana | ★ | | ★ |
| • Mauri | ★ | ★ | ★ |
| • Pono | | | ★ |
| • Tiakitanga | | | |
| • Kotahitanga | | | ★ |
| • Rangatiratanga | | | ★ |
| • Kaitiakitanga | | | ★ |

Note: ¹Palmer (2004); ²Gray (2003); ³Morice (2007).

4.2.3 Whakawhanaungatanga (Building relationships)

A simple tally of what is the strongest represented Māori constructs will not suffice as a useful interpretation of the results gathered under - whakawhanaungatanga. In any language, complexity arises when articulating the act of relationship building. The use of multiple descriptors is necessary to capture the width of activity and experience that occurs within the act of relationship building – whakawhanaungatanga. Hence there are a larger number of constructs under this subheading. A birds-eye-view is more suitable to assess and organise this data.

The data set as a whole can be grouped under Models of Health & Wellbeing and Frameworks of Engagement (Wilson et al., 2021). Models of Health & Wellbeing include: Te Punga Oranga, Te Whare Tapa Wha, Te Wheke, Te Whetu, and Whakapapa Whanaukataka (Durie, 1985; Gray, 2003; Mark & Lyons, 2010; Murray, 2010; Pere, 1991). Frameworks of Engagement include: Hui Process, Kapakapa Manawa Framework, Meihana Model, Te Hā o Whānau, Te Kapunga Putohe, Hōmai te Waiora ki Ahau, and Towards a Māori Psychotherapy (Barton & Wilson, 2008; Lacey et al., 2011; Morice, 2003; Palmer, 2004; Pitama et al., 2007; Robinson et al., 2020; Stevenson et al., 2020).

Although not a perfect delineation, Māori models are well represented in Māori constructs that denominate dimensions of health and wellbeing, whilst Māori frameworks are well populated with Māori constructs across whanaungatanga and whakawhanaungatanga, that is, the act of engaging in relationship building.

4.3 Results of Sources of Evidence

The dissertation *Towards a Māori Psychotherapy* written by Morice (2003) is the single article found in the study that attempts to use Māori constructs found in both Māori models and frameworks to provide an organised structure for a Māori psychotherapy. Table 3 shows that Morice's therapeutic model is across all three subheadings 'Dimensions of health and wellbeing', 'Whanaungatanga (Connections)', 'Whakawhanaungatanga (Building relationships)' and also strongly represented with Māori constructs under each subheading. This offers a way forward to organise the results to answer the first research question:

1. What are the key components for a Māori therapy?

Māori Dimensions of Health – Ngā Ahunga Waiora Māori

A consensus is present across all Māori models and frameworks to include holistic health dimensions – tinana, hinengaro, whānau and wairua. Māori holistic dimensions of health are recommended as a key component for a Māori therapy.

Māori Ontology of Whanaungatanga - Whakawhanaungatanga

A consensus is present across Māori models and frameworks as to the ontological importance of whanaungatanga towards whānau and whenua through the connection of whakapapa. An ontology of whanaungatanga is recommended as a key component for a Māori therapy.

Māori Engagement Process – Mātauranga me Tikanga Māori

A consensus is present across all Māori engagement frameworks that they embody whanaungatanga and Māori constructs that correlate with whakawhanaungatanga. The variation of Māori constructs charted under these subheadings in Table 2 & 3, are best interpreted and organised under ngā mātāpono and ngā uara.

- **Ngā Mātāpono** – wairua, mana, mauri, tapu
- **Ngā Uara** – aroha, manaakitanga, whanaungatanga, pono, tiakitanga, kotahitanga, rangatiratanga, kaitiakitanga.

When grouped as such, a key component for recommendation is that a Māori therapeutic engagement process should be informed and have present in its application ngā mātāpono me ngā uara Māori. In doing so, mātauranga me tikanga Māori are present.

4.4 Synthesis of Results

The final synthesis of the results requires that the key components for a Māori therapy be translated into whakaaro Māori, this will enable the answering of the second research question:

2. What is the relationship between a Māori-centred therapy and wairuatanga?

Te Ao Raranga provides a working schema to understand the relationship between mātauranga and tikanga Māori. Ngā uara are the experiences reproduced by following protocols of Tikanga and are practical extensions of Mātauranga Māori. Māori epistemologies include an array of cultural practices that are sources of Mātauranga Māori. The organisation of Mātauranga Māori is through whakapapa. Mātauranga and

whakapapa provide the flesh and bones to a Māori ontology. A reality that honours and personifies ngā mātāpono Māori.

This research has identified that key components for a Māori therapy include: Ahunga Waiora Māori, Whakawhanaungatanga, Mātauranga me Tikanga Māori, and their expressions Ngā Mātāpono me Ngā Uara. These components were derived from identifying and analysing kupu Māori constructs within Māori models and frameworks of health. Kupu Māori have whakapapa to Māori epistemology and a Māori ontology, and by their whakapapa, are pregnant with metaphysical constructs such as wairua, mana and mauri. Rather than wairuatanga interpreted as an adjunct construct, a therapy centred with these key components would embody wairuatanga, as naturally as the earth embraces the sun.

Whatungarongaro te tangata, toitū te whenua.

WĀHANGA 5 – DISCUSSION

The study objective is to scope literature of Māori health models and frameworks to bring to light key components towards a Māori-centred therapy. Literature from varied sources were reviewed, synthesised and recommendations of key components to include in a Māori therapy and their relationship to wairuatanga have been achieved. Chapter 5 will discuss how these findings can contribute to a Māori therapeutic solution that can enable a work force to provide culturally competent services and benefit Māori autonomy over the design and implementation of therapeutic best practice for *hauora* Māori.

5.1 Summary of Evidence

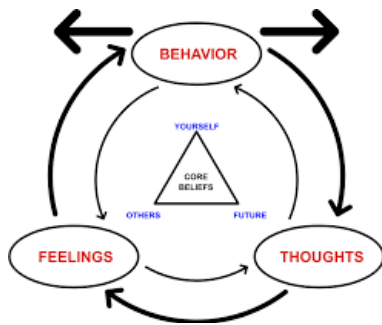
To summarise the results, the study's recommendations are best discussed within a generic therapy schema. Typically Western evidence-based therapies have an overarching macro model to summarise the therapy's theory, which informs and organises a client engagement framework. The framework decompartmentalises a treatment pathway with therapeutic markers that guide therapist inquiry and timing of the application of counselling micro-skills.

The CBT macro model is premised on cognitive and behavioural theory (Beck, 1970). A cyclical process whereby thoughts (cognition) impart feelings or mood (emotion) which motivates a propensity to act (behaviour), equating in a post cognitive interpretation or reflection about the interpersonal event or action taken (Figure 2) (Fenn & Byrne, 2013). An interrelated cycle of thoughts and feelings that reinforces core beliefs, supporting adaptive or maladaptive behaviours (Fenn & Byrne, 2013).

Acceptance Commitment Therapy (ACT) Hexaflex model (Figure 3) infuses the underpinning of cognitive and behavioural theory with Buddhist principles of acceptance and how to remain present to fixated negative thinking (cognition), past or future (Fung, 2015; Hayes & Spencer, 2005). An inflexible psychological state that is hindering access to core values that can support committed action (behaviour) for a positive life lived with self and others (Hayes & Spencer, 2005). Psychological flexibility is a core tenet where acceptance of happy and unhappy states are considered normal human conditions (Hayes & Spencer, 2005).

Figure 2:

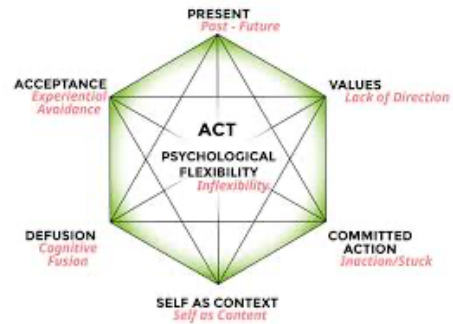
CBT Macro Model



Note. CBT Model
(Cognitive Behavioral Therapy, 2023)

Figure 3:

ACT Macro Model



Note. The ACT Hexaflex Diagram (Li, 2018)

CBT and ACT have engagement frameworks that are extensions of their respective macro models. CBT has the scientist-practitioner model which encourages clinicians to integrate empirical research with applied practice, generating further scientific research (Jones & Mehr, 2007). Based on this model and theory, CBT client engagement and treatment pathways adopt a measurable process of formal assessment, treatment planning, case notes and exit reporting (Dobson & Dobson, 2017). ACT uses an acronym of its name to outline its engagement framework. A – Accept your reactions and be present – cognition, C – Choose a valued direction – emotion, T – Take action – behaviour (Hayes & Spencer, 2005).

CBT counselling micro-skills employ strategies based on the CBT macro theory and scientist-practitioner model. Strategies such as empathetic listening, discussing the pros and cons of limiting behaviour, assisting written goal setting, identifying past strengths to support goal achievement are employed (Dobson & Dobson, 2017). It is a practical approach where a client can locate and change negative thought patterns and associated behaviours that reinforce distorted thinking (Fenn & Byrne, 2013).

Equally, an ACT practitioner employs therapeutic micro-skills informed by the ACT Hexaflex model and ACT acronym. ACT talk therapy includes psycho-education exercises and mindfulness practices to accept painful feelings and situations as regular occurrences to be experienced alongside happy and enjoyable states (Hayes & Spencer, 2005). Non-acceptance precedes avoidant and maladaptive behaviour, a departure from a present state. Cognitive defusion techniques enable psychological flexibility, a sense

of presence or space from negative thinking, time to re-engage with self and create a positive-values informed action plan (Hayes & Spencer, 2005).

5.1.1 Formulating a Māori Therapy

Applying the key components recommended from this study for a Māori therapy into a generic therapy schema, highlights that the key components identified from this research contribute part way to a therapy and that a gap in the literature exists.

Ngā Ahunga Wairoa Māori – A Macro Model

The literature showed that Māori dimensions of health are presented as macro models that inform engagement and practice approaches with tangata whai i te ora. They are universally associated with a metaphor that visually illustrates the holistic importance of working Māori dimensions of health in unison, to achieve service and outcome success with Māori. A metaphor of ngā ahunga wairoa Māori should inform the macro-model of a Māori therapy.

Mātauranga me tikanga Māori as articulated by Prentice (2022) should underpin the therapy's theory, providing a reciprocal pathway between a Māori therapy's macro model and engagement framework.

Whakawhanaungatanga – A Therapy Engagement Framework

Whakawhanaungatanga or an ontology of whanaungatanga is recommended as a key component for a Māori therapy and should be present in the development of its therapeutic engagement framework. Ngā mātāpono me ngā uara Māori should also be present and inform an associated treatment pathway process, provide therapy markers for consideration that can inform practice application.

5.1.2 Paucity of Māori Therapeutic Models & Frameworks

Notwithstanding that all models and frameworks in the data set could be adapted to a therapeutic setting, only one model (Gray, 2003) and three frameworks (Morice, 2003; Palmer, 2004; Pitama et al., 2007) specifically applied either to a clinical assessment and psychometric or informed a therapeutic approach and practice. That across over 2,200 articles only four articles were found under the study's inclusion and exclusion criteria, that related to a Māori therapeutic model or framework, would indicate a paucity in Māori therapeutic literature. However, what do these four articles offer towards a Māori therapy and the development of associated counselling micro-skills.

5.1.3 Pieces of the Puzzle

All four articles detailed Māori approaches to a particular part of a generic therapy schema. They uniformly referenced or inferred Te Whare Tapa as a model that overarched their therapeutic approach.

Macro Model & Theory

Whakapapa and Whanaukataka: relationships in the context of traditional Māori conceptual thought (Gray, 2003), overlaid the pūrākau atua Māori, namely the demi-god Maui-Tikitiki-a-Taranga, to insist on the indivisible connections between all life, human, environment, or celestial. A Māori ontological understanding of whakapapa and whanaungatanga that Māori dimensions of health – wairua, hinengaro, panapana and tinana are microcosms of a cosmic elemental macrocosm (Gray, 2003). That this dynamic interconnection of all life, passed to Māori from atua, is collectively related – a whānau. This macro model of health is infused with pūrākau, mātauranga Māori from atua Māori. By doing so, Gray (2003) premises the embodiment of wairuatanga into therapeutic theory and potential application in psychotherapeutic practice with Māori.

Assessment

Meihana Model: A Clinical Assessment Framework (Pitama et al., 2007) extends on Te Whare Tapa dimensions – wairua, hinengaro, tinana and whānau, with two added dimensions - te taiao and iwi katoa. These dimensions are therapeutic assessment markers that invite a therapist to subjectively validate and inquire Māori beliefs, values and experiences (Pitama et al., 2007). The assessment framework is not only used to assess a client but also measure the systemic support structures required, are present at the place of service delivery (Pitama et al., 2007). This assessment framework's function is to ensure that a clinical assessment with whānau Māori is applied in an environment culturally conducive to the inquiry of a client's experience of being Māori.

Psychometric Measure of Wellbeing

Hōmai te Waiora ki Ahau: A tool for the measurement of wellbeing among Māori – the evidence of construct validity (Palmer, 2004) challenges universally applied Western psychometric testing by fostering psychological constructs and concepts which are relevant measures of wellbeing for Māori. Such as: wairua, hinengaro, whānau/whanaungatanga, mauri, mana, whenua, tikanga. A culturally responsive and specific tool for the measurement of Māori wellbeing – waiora (Palmer, 2004).

A Therapeutic Approach

Towards a Māori Psychotherapy: The Therapeutic Relationship and Māori Concepts of Relationship (Morice, 2003) is a dissertation towards a Māori psychotherapy. A psychotherapy premised on a Māori relational psyche of meaning making, where the human condition is a microcosm of the greater universe (Morice, 2003). A holistic world-view where an individual's psyche is a centrifugal summary of the connection and interplay of physical, social, spiritual and cosmic worlds (Morice, 2003). Worlds inseparably from ngā atua Māori, Morice (2003):

We are inseparably and inescapably a manifestation of the greater whole, formed of the living body of Papatuanuku (sic), Mother Earth, infused with the breath of Tane Mahuta (sic), the God of humankind. (p 1)

Morice (2003) structures her therapy theory with three macro models – Te Whare Tapa Wha, Te Wheke and Ngā Pou Mana to establish holistic dimensions of the Māori human condition. Through principals - ngā mātāpono, such as whakapapa, mana, mauri, hā ora, aroha she sets up her framework with six relational values – ngā uara; manaakitanga, whanaungatanga, kaitiakitanga, kotahitanga, rangatiratanga, wairuatanga (Morice, 2003). These six values are indepthly explained to inform a psychotherapeutic approach and client inquiry that is Māori-centric.

5.1.4 A Gap - Māori Therapeutic Micro-skills

The four Māori models and frameworks discussed are rich with conceptual explanations of holistic dimensions of health and the importance of ontological first principals, that premise Māori values as health markers for assessment, psychometric measurement and therapeutic conversations. They also collectively demonstrate that Māori therapeutic theory, teneted in wairuatanga, can inform the creation of Māori-centred aspects of a therapy schema. These and other Māori models and frameworks have admirably paved the way, challenging the dominance of Western best practice in health settings. By design their function is to inform existing Western health, care or therapy practices to be conducted in a more Māori way.

The objective of this research is to contribute to the development of a stand alone Māori therapy, embodied in it's own philosophical construct, that can enable a work force to provide culturally competent services and benefit Māori autonomy over the design and implementation of therapeutic best practice for hauora Māori. A gap in the literature is a complete Māori therapy with associated counselling micro-skills to safely practice and

implement Māori therapy theory and associated frameworks devoid of Western psychological or psychotherapeutic influence.

This research posits and recommends, that to authentically practice ngā mātāpono me ngā uara and develop accompanying counselling micro-skills, they must be centred in a Māori therapy that has its own macro model informed by pūrākau atua Māori, the source of wairuatanga. Have a resultant theory that privileges mātauranga me tikanga Māori through an ontology of whakapapa and whanaungatanga with no other external theoretical influence. To do so would enable autonomy for Māori to craft with these key components identified in this study, a Māori therapy that naturalises a relationship with wairuatanga. A therapy designed and taught in its own philosophical underpinnings to ensure culturally safe services and competent practice.

5.2 Limitations

The limitation of this study's scoping review is the size of this dissertation and that it required a single researcher. A 45 point dissertation has a word count and recommended hour allotment that contained the research scope size and written analysis of the literature. Answering the research questions of this study could include a deeper dive into the literature to mine and assess current Māori counselling micro-skills specifically aligned to wairua, as key components to a Māori therapy. However, it is recommended that this research should be conducted separately to allow space for a realigned and unique breadth of literature analysis, with a relevant set of research terms and the possibility of assistant researcher support.

A limitation of the study's search terms, which by design were to identify literature that specifically outlined a Māori model or framework of health, did not allow under the inclusion and exclusion criteria, extensive inquiry into other philosophical thinking that would be relevant to Māori micro-counselling skills.

Āta: Growing Respectful Relationships (Pohatu, 2013) eloquently outlines a discussion of applied principles – ngā takepū, based on the concept of āta, to enlighten respectful and transformative approaches to “enter, engage, and exit relationships” (p. 16), so to support and maintain wellbeing. *Towards Some Foundations of a Systematic Māori Theology* (Tate, 2010), describes and deciphers the interconnection of ngā mātāpono – tapu and mana and the application of ngā uara - pono, tika and aroha, to bring about

states of houhou rongu, that is, to reinstate peace. These two comprehensive works offer insight into the application of ngā mātāpono me ngā uara to generate outcomes of peace and wellbeing. Their ability to detail the application of Māori principles and values to achieve hauora would warrant them as important bodies of work to elucidate new research and the future design of Māori counselling micro-skills.

5.3 Funding

No funding was required for this study.

WĀHANGA 6 – CONCLUSION

Chapter 6 concludes the study with a summary interpretation of the results with respect to the review questions and objectives, as well as potential implications and next steps.

6.1 Interpretation and Summary of the Results

The endeavour to create a Māori therapy is a modern development in therapeutic provision, specific to Aotearoa. By design it requires attributes that constitute a therapy: a macro-model-theory, that guides a therapy framework, which informs associated counselling micro-skills. For the therapy to be Māori, these attributes should be the only external influence to its construction.

The research has identified that for a Māori therapy to be tika, the therapy's macro-model and theory should be premised in mātauranga Māori, the safe-keep of Māori ontology and epistemology. Once established, ngā mātāpono me nga uara Māori can embody tikanga-informed therapeutic frameworks and counselling micro-skills. Together, these key components will produce he haumanu Māori that can be taught and practiced with cultural accuracy and safety.

Demonstrated in Māori models and frameworks of health, a universal foundation within te ao Māori is wairuatanga. Not to be assimilated or scaled to a Western understanding of religion, the Māori concept of spirituality broadly embodies relational considerations that inform psychological, emotional and physical encounters with people - alive and deceased, environment, cosmos both tangible and non-tangible.

Possessing a healthy wairua is conceptually linked to a holistic approach to wellbeing or hauora for Māori. It incorporates the importance of health factors such as a safe home and neighbourhood, access to healthy food, opportunity, care, nature and freedom to participate in Māori culture with people and place. Māori health factors that Manatū Hauora are attempting to improve.

A misconception in Western therapy is to interpret ahunga waiora wairua as an adjunct for separate religious or spiritual inquiry. The effect of this approach is to colonise the actual meaning of wairuatanga and limit the extent of therapeutic discovery for client and therapist. The Western world separates science from spirituality as two opposing worlds, real and unreal. Not to be reduced to superstition and the paranormal, wairuatanga is

both science and spirituality; indivisible, multidimensional and conscious. The therapeutic relationship to wairuatanga is not an add on requirement. Rather by the nature of a centrifugal therapy that is theorised, practiced and applied with mātauranga me tikanga Māori, wairuatanga is already naturally present and inherent.

This study has taken care to articulate a research paradigm, methodology and method that extends beyond their application to the research conducted. But to offer a fundamental explanation of the cosmological relational foundation of meaning making for Māori, so to invite conceptual understanding of pūrākau Māori and its latent potential to articulate an ontology of whanaungatanga. Crucial knowledge to the formulation of a Māori therapy theory.

To demote pūrākau Māori as primitive or mythological is to prioritise a dominant hegemony. Appointed as native and primitive is to locate Māori into Western classifications of natural and super-natural, worlds side-lined outside the civilized world. Disenfranchisement that has created dis-ease for tangata whai i te ora. It paralyses the method of meaning making for Māori to a quaint antiquity, unable to evolve and stretch unto its own autonomous inquiry, gathering and assimilation of new knowledge. The consequence is to devalue and disadvantage the opportunity to express an unique construct of reality that locates Māoritanga (Māori reality, beliefs, and practices) accurately within its own world paradigm and knowledge base, in order to problem solve in a modern environment. A critical requirement for a modern therapy centred in Māoritanga.

6.2 Implications and Next Steps

The aim of this research is to consider what constitutes a Māori therapeutic solution for Māori dis-ease and tangata whai i te ora, to address intergenerational predisposing factors to mental unwellness for Māori. The research outcome has contributed key concepts towards an Indigenous informed therapy, a Māori therapeutic approach that is holistic and able to express its ontological relationship to wairuatanga.

The dis-ease to heal is the obstruction for ngā Iwi Māori to autonomously cultivate mauri, mana and wairua. This study has shown that a departure from a biopsychosocial importance as a universal provision of therapeutic care for Māori in favour of he haumanu Māori is not only possible, but necessary to adequately heal the entrenched dis-ease experienced

by tangata whai i te ora. Only a therapy actualised with mauri, mana and wairua can do so.

To implement a working Māori therapy requires further research and development. This study is a step on the road to achieving this opportunity. Recommendations for further research would be to illuminate what are Māori counselling micro-skills. To answer, how do you technically and in their purity practice ngā mātāpono me ngā uara such as aroha, manaakitanga, mauri, mana, wairua in therapy?

The variety of Māori principals and values available for synthesis into micro-skills offers a complexity worthy of independent research. To help choose, the next step would be to originate a macro-model rich in pūrākau atua Māori, a theory capable of sourcing mātauranga that guides a tikanga-informed therapy framework and populates corresponding Māori therapeutic micro-skills. A worth body of additional research in its own right.

Ka noho ahau ki ngā waewae o ōku tupuna, he mokopuna a Ranginui rāua ko Papatūānuku. He kākano o Io. Io-nui, Io-roa, Io-matua, Io-matua-te-kore, Io-taketake, Io-te-pūkenga, Io-te-wānanga.

HE KARAKIA WHAKAKAPI

Tukua atu te hirihiringa o te mātauranga.

Whakahokia ki te hononga o ngā wairua o ngā mea katoa.

Ki te Tiritiri-o-nga-rangi.

Ki te Tihi-o-nga-rangitūhāhā.

Mā Te Aratiatia.

Mā Te Pūmotomoto-o-Tāwhirirangi.

Purea ki te Wai-o-Rongomai.

Kia kawea ki roto o Matangireia.

Ki mua i Te Aroaro o Te Kaihanga o ngā mea katoa.

Haumie!

Hui e!

Tāiki e!

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