

Ngā Whakāwhitinga: Standing at the crossroads. How Māori understand what Western psychiatry calls ‘schizophrenia’.

Abstract

This project explored how Māori understand experiences commonly labelled ‘schizophrenic’ or ‘psychotic’. Semi-structured interviews were conducted with 57 Māori participants who had either personal experiences labelled as ‘psychosis’ or ‘schizophrenia’ or those working with people with such experiences, including tangata whaiora (users of mental health services), tohunga (traditional healers), kaumatua/kuia (elders), Māori clinicians, cultural support workers and students. Kaupapa Māori Theory and Personal Construct Theory guided the research within a qualitative methodology. The research found that participants held multiple explanatory models for experiences commonly labelled ‘psychotic’ or ‘schizophrenic’. The predominant explanations were spiritual and cultural. It seems that cultural beliefs and practices related to mental health within Māori communities remain resilient, despite over a century of contact with mainstream education and health services. Other explanations included psychosocial constructions (interpersonal trauma and drug abuse), historical trauma (colonisation) and biomedical constructions (chemical brain imbalance). Participants (both tangata whaiora and health professionals) reported they were apprehensive about sharing their spiritual/cultural constructions within mainstream mental health settings due to fear of being ignored or pathologised. This study highlights the importance of asking users of mental health services about the meaning they place on their experiences and recognising that individuals can hold multiple explanatory models. Māori may hold both Māori and Pākehā (European) ways of understanding their experiences and meaningful recognition should be afforded to *both* throughout assessment and treatment planning in mental health services. Clinicians need to be aware that personal and cultural

meanings of experiences labelled psychotic may be withheld due to fear of judgement or stigmatisation.

Keywords

Māori, Indigenous, psychosis, schizophrenia, hearing voices, culture, spirituality, traditional healing

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Introduction

This paper is an attempt to weave Māori psychological concepts (Matauranga Māori) with Western within a largely Western forum (a scientific journal). In this vein a traditional Māori introduction is included in the article. It is customary as Māori to introduce ourselves by providing our unique connection to our land and ancestors (pepeha). The purpose of the pepeha within this context is to provide the reader with a deeper sense of connection to the research and researchers. The first author (Melissa Taitimu) has provided her pepeha below:

Ko Whakakoro tōku maunga (my mountain is Whakakoro)

Ko Rotokakahi tōku awa (my river is Rotokakahi)

Ko Morehu tōku marae (My meeting house is Morehu)

Ko Te Uri o Tai tōku hapū (My subtribe is Te Uri o Tai)

Ko Te Rarawa tōku iwi (My tribe is Te Rarawa)

No Pawarenga ahau (I am from Pawarenga)

Ko Melissa Taitimu tōku ingoa (My name is Melissa Taitimu)

Western historical context

Madness has been and remains an elusive thing...it is equally possible to think in terms of the manufacture of madness, that is, the idea that labelling insanity is primarily a social act, a cultural construct (Porter, 1987, p.8).

As the title suggest this research is positioned at the crossroads between two cultures. Māori ways of understanding the range of experiences commonly labelled ‘schizophrenic’ are influenced by the social and political history of western psychiatry. Within western society, various eras have differentially defined behaviours and experiences that would today be

considered 'schizophrenic'. To hear voices and see things others cannot could have led an individual to be considered a prophet, heretic or lunatic depending on which century they were born in (McCarthy-Jones, 2013; Read, 2013). In general, these experiences have been defined as either a problem of the spirit, the mind or the body, or some combination thereof (Alexander & Selesnick, 1996; Kemp, 1985).

Most recently, psychotic experiences are considered a problem of the 'body'. Since the advent of western psychiatry, literature (Kraepelin, 1919; Bleuler, 1913 translated in 1950) regarding assessment and treatment protocols for schizophrenia focus predominantly upon biochemical, neurological and genetic factors as explanations for these experiences (Thara, Sucharitakul, & Mendis, 2001; Carpenter & Buchanan, 1995; Dean, 2000) despite critiques regarding the reliability and validity of this body of research (Joseph, 2004; Bentall, 2004; Read & Dillon, 2013). Furthermore, research has indicated that biomedical constructions can lead to increased levels of social distance, increased rates of discrimination and negative attitudes towards those thought to have a 'mental illness' (Read, Haslam, Sayce & Davies, 2006; Haslam & Kvalle, 2015).

Research indicates that listening to the subjective explanations and experiences of people experiencing psychosis can lead to a deeper understanding of the phenomena. Further to this, the very process of being afforded an opportunity to make sense of one's own experience and offer personal understandings can have a major impact upon the recovery process (Barnett & Lapsley, 2006; Randal, Geekie, Lambrecht & Taitimu, 2008; Lambrecht & Taitimu, 2012). Despite this evidence, first person accounts of psychosis and schizophrenia have emerged within a context that has largely ignored or pathologised personal understandings of the experience (Taitimu & Read, 2006; Geekie & Read, 2009) and not taken into consideration the impact of wider historical, social and cultural factors (Porter, 1987).

Indigenous psychology: historical context

Māori experiences are aligned with indigenous peoples the world over, whereby colonisation has subjected whole cultures to psychiatric theories and practices at both the individual and collective level. A common theme is apparent. Research and clinical practice has predominantly been done *upon* Indigenous peoples *by* non-Indigenous researchers working with ‘universal’ diagnostic systems within a western psychological or psychiatric settings (Bhurga & Littlewood, 2001; Fernando, 1988; McIntosh, 2004). One modern example is the World Health Organisation (WHO) studies that have investigated the manifestation, consequences and course of what Western mental health experts call ‘schizophrenia’ across regions and cultures (World Health Organisation, 1979). A major limitation of the WHO studies is the validity of using a Western construct on diverse cultures. It has been argued that within this colonising context, cultural meanings and experiences may have been over-diagnosed and / or misdiagnosed (Fernando, 1988). The WHO studies revealed, nevertheless, that developing countries (non-western) experience far higher rates of recovery from ‘schizophrenia’ than Western countries. Further research has indicated that this may be a result of the culturally embedded subjective meanings placed upon the experience, and the positive expectations around recovery (Castillo, 2003; Lin & Kleinman, 1988).

Despite this, the “one size fits all” approach remains. Biological psychiatry is currently seeking to impose, primarily via the ‘Global Mental Health’ movement (Mills, 2014; Read, Haslam & Magliano, 2013), Western ‘medical model’ concepts and treatments on numerous countries including India, Pakistan, Bali, Nigeria and Malawi, and, within the United States, on Afro-Americans and Latinos. Within this movement whole cultures are being labelled as having poor ‘mental health literacy’ (the degree to which one agrees with psychiatry’s belief that one’s distress is a manifestation of a biologically based illness) and

the ongoing use of culturally embedded explanations and recovery pathways is pathologised (Mills, 2014; Read, Haslam & Magliano, 2013). In this unashamed return to colonialism by biological psychiatry (Mills, 2014) local spiritual or social causal beliefs are often characterised as misinformation or ignorance, and a typical conclusion of psychiatry's studies in this field (see Read et al., 2013) is the call for 'interventions aimed at increasing the mental health literacy of traditional healers [which] are [seen as] essential' (Sorsdahl, Fisher, Wilson, & Stein, 2010).

The emergence of Indigenous psychologies and research signposts a step towards 'undiagnosing' Indigenous peoples and recognising what in fact may be social, political and spiritual ills (Nikora, Levy, Masters, & Waitoki, 2004; Taitimu, 2007). Indigenous research is conducted by Indigenous scholars, within Indigenous communities and recognises the critical need to take into consideration cultural constructions of wellbeing (understandings of wellbeing that integrate traditional knowledge systems into current practice) as well as the socio-political and historical response to colonisation as meaningful in understanding Indigenous health status (Duran & Duran, 1995; Durie, 2001). A common finding within this landscape is that Indigenous peoples can hold multiple explanatory models for experiences commonly labelled psychotic that includes *but is not limited to* that which is on offer from biological psychiatry (Allen, 2002). Explanatory models often include cultural constructions and the socio-political landscape specific to an area (Geekie & Read, 2009; Taitimu, 2007). For example, Sadowsky (2004) found that the content of delusions in African patients in Southwest Nigeria was related to their experiences of war and colonisation. The current research was interested in the unique historical, social and political context in which Māori have been diagnosed with psychotic disorders and how Māori themselves make meaning of these experiences.

Māori psychology: historical context

A comprehensive outline of mātauranga Māori (traditional knowledge systems) is impossible to capture within the constraints of an article. Some argue it can only be understood experientially through participation within the Māori community. The extension of this view is that any attempt to intellectualise Māori psychological concepts via research inevitably sacrifices the depth and complexity of the knowledge (Waitoki & Levy, 2016). The difficulty in defining Māori psychology is evident in a comment made by Māori Marsden's son, Taki Marsden, when asked how his father (a well respected elder within the Māori community) would define mātauranga Māori. He replied, "to ask my father what mātauranga Māori is would be like asking a fish what water is. It remains invisible to them," (Royal, 1998). Therefore this section is a very condensed, superficial summary of a complex philosophy that is only fully understood from within (Waitoki & Levy, 2016).

The nucleus of Māori society is the whānau (family). This constitutes not only one's immediate family but also extended networks such as cousins, aunts and uncles. A number of whanau belong to hapū (sub tribes), while a number of hapū belong to an iwi (tribe). Each whanau, hapu and iwi are intimately connected to their whenua (land). The concept of whenua is central to Māori identity as it links them to their ancestral mountains, rivers, seas, tūrangawaewae (a place to stand) and economic base (Walker, 1996). Imbalance, disconnection and illness within one's whanau, hapu, iwi, whenua or turangawaewae can affect the wellbeing of individuals, families and communities.

Tapu plays an integral role in understanding wellbeing from a Māori perspective. Tapu begins with a being's birth and refers to the potential for what it can become (Barlow, 1991). Mana is the fulfilment of that potential. In this vein, Barlow and Shirres (1979) refer to tapu as "being with potentiality for power." The "being" element of this definition refers to the essence that is tapu "potentiality for power" indicates each being has the potential to

relate to another being in a powerful way and the laws of tapu govern this. In terms of these laws of interaction, tapu has been referred to as a Māori legal system consisting of rules around prohibition and protection to ensure society flourished (New Zealand Ministry of Justice, 2001). Tapu could be applied to people, places, animals, food, plants, events and relationships. Sometimes tapu is a permanent state, at others, it is temporarily applied to guide encounters and restore or maintain equilibrium (Durie, 1999). Breaches can occur when the proper respect and discipline is not afforded to tapu (Mihinui, 2002). Mate Māori is a form of Māori illness that can be caused by transgressions of tapu (Lyndon, 1983).

An example of the epistemological differences between Māori ways of understanding illness and wellbeing is evident in the term pōrangi, a form of mate Māori. This understanding was shared by a kaumatua or elder (who preferred to remain anonymous) within this project. Before time, light and space entered our world, Māori creation stories hold that Ranginui (sky father) and Papatūānuku (earth mother) held each other in a tight embrace. This period of creation was called Te Pō (the darkness). The many children of Rangi and Papa, felt cramped and uncomfortable with the darkness cast by their tight embrace. They pushed their father, Rangi, up and their mother, Papa, down. Once this was achieved, time, space and light came into the world. This represented the progression from Te Pō (the darkness) to Te Aō (the light). Pōrangi (literally translated to dark night) has been described as a regression to the state of Te Pō. This is a state of disconnection and darkness. Within the state of Te Pō one loses a sense of self, time and space, becomes very withdrawn, disconnected and can hear and see things that are not physically present. Within this research, participants cautioned that some clients experiencing this form of mate Māori may be misdiagnosed with ‘schizophrenia’. The term Pōrangi is used today as a stigmatising term within Maori communities much like the term “schizo” or “psycho” is utilised in western contexts. Another kaumatua within this research suggested this is likely a result of the

disconnection Māori have from traditional health knowledge systems as a result of colonisation.

The experience of colonisation for Māori resulted in a number of negative experiences and illnesses (Walker, 1990; Durie, 1997). One example is the Tohunga Suppression Act 1909 (Durie, 2001) which effectively prohibited the use of traditional healing methods to address mate Māori (illness attributed to transgressions of tapu) and signalled that health care was to be based on Western constructions and treatments. This strategy, along with others such as rapid urbanisation during the 1960s, contributed to increased rates of utilisation of western mental health services throughout the second half of the 20th century (Durie, 2001). Māori make up more than 25% of all admissions to inpatient units (Ministry of Health New Zealand, 2010) despite representing only 15.4% of the total population. Further investigation has found that 47.9% of Māori admitted to inpatient units have a diagnosis of ‘schizophrenia’ and Māori are significantly more likely than nonh-Maori to be diagnosed with ‘schizophrenia’ or other psychotic disorders (Wheeler, Robinson, & Robinson, 2005).

Despite overutilization of mainstream mental health services, Māori spiritual beliefs regarding mental illness remain resilient (Lyndon, 1983; Cherrington, 1994). This is largely a result of the Māori renaissance where Māori have reclaimed their voice in the areas of education, health and media (Walker, 1990). Cherrington (1994) interviewed Māori with a diagnosis of schizophrenia using mental health services and found that 93% of her participants knew about cultural concepts such as tapu and mate Māori and 78% believed that mental illness could be related to these concepts. At the same time, Māori have been found to be apprehensive to discuss their subjective beliefs within mainstream mental health settings because of a fear that these beliefs will be ignored, marginalised or pathologised (Lyndon, 1983; Lapsley et. al. 2002).

In a survey of 247 New Zealand psychiatrists, in 2000, the majority recognised the need to consult with Māori staff when working with Māori clients; but 28 (11%), all male, New Zealand born, and with 10 or more years clinical experience, expressed the view that Māori were particularly biologically or genetically predisposed to mental illness; and several psychiatrists offered other racist comments (Johnstone & Read, 2000):

“Genetically Maori as a culture seem predisposed to mental illness.”

“Stop sending me crap studies like this, about pointless, meaningless, cultural rubbish. Maori only represent about 10 per cent of the population, for God’s sake.”

“Medication is the answer – but they just don’t take their pills – if cannabis was prescribed, I’d bet they’d bloody take that.”

To address these issues, there is increasing demand for services and treatments to align to Māori ways of understanding wellbeing and illness (Durie, 1997). More recently, a number of models of Māori health have been incorporated into mental health policy and practice that incorporate both traditional and contemporary Māori constructions of wellness. One such model is ‘Te Whare Tapa Wha’ (literally translated as ‘the house of four walls’). Originally proposed by Mason Durie (1999), a Māori researcher and psychiatrist, this model posits that all four walls must be strong for the house to stand. If one is weak, the whole house falls down. The four dimensions are wairua (spiritual), hinengaro (mental and emotional), whanau (family) and tinana (physical) indicating that the mental, physical, spiritual and social aspects are inseparable.

Background: Nga Whakāwhitinga

The current research was established after consultation with the community (elders, mental health services, non government organizations [NGOs], mental health service users and policy level advisors) raised great concern about inpatient utilisation rates and statistics for

psychosis and schizophrenia. The overwhelming feedback was that Māori needed access to their own ways of understanding wellbeing when they are labelled ‘schizophrenic.’ In fact a common theme raised during consultation was that ‘schizophrenia’ was a negative term that negatively impacted upon the health of those it was ascribed to. Consultation is a significant first step for many Kaupapa Māori research projects. Within this project many meetings both formal and informal were held to establish the aims and methodology of the research. Nga Whakāwhitinga is the name bestowed upon the research by one of the elders advising the research journey. The term translates to “standing at the crossroads” and represents the space in which this research was conducted, at the juncture between two worlds, te ao Māori (the Māori world) and te ao Pākehā (the western world). In this vein, one of the major aims of the research was to gather Māori constructions of experiences commonly labelled psychotic in order to better understand the manifestation, content, course and outcome of these experiences; and compare these findings to current western psychiatric constructions found within mainstream mental health services.

Theoretical and political frameworks

Kaupapa Māori Theory (Smith, 1997; Pihama, Smith, Taki, & Lee, 2004) and Personal Construct Theory (Kelly, 1991) were utilised to guide the research within a qualitative methodology. Kaupapa Māori Research is conducted from within rather than upon Māori communities. This process centralises Māori ways of understanding and practicing health and is invested in the survival and revival of these practices (Smith, 2003; Pihama, 1993). Kaupapa Māori research also aims to critique social structures that prioritise the ideas and practices of the dominant group over others. Kaupapa Māori research is invested in creating the conditions for transformative change calling for local solutions to local issues (Nikora et al., 2004). The core principles of Kaupapa Māori research proposed by Smith (1997) were

used as the foundation for the current research. Tino rangatiratanga (the ‘self determination’ principle): affords Māori the right and responsibility to determine their own definitions of illness and wellbeing and how this is protected, treated and maintained. Taonga tuku iho (the ‘cultural aspirations principle’): actively aims to validate and legitimise Māori ways of understanding wellbeing. Ako Māori (the ‘culturally preferred pedagogy’ principle): Māori are able to choose their own ways of understanding their experience that may incorporate a combination of Mātauranga Māori and Western knowledge. This integration does not make the knowledge less Māori. Whānau (the ‘extended family structure’ principle): the process of whanaungatanga allows all key stakeholders to define present and future commitments in reference to each other and the kaupapa (direction/aims) of the research. Kaupapa (the ‘collective philosophy’ principle): this research holds at the core of any decision the goal of Māori development (politically, socially, economically and culturally).

In keeping with this framework consultation and the establishment of a Māori advisory group (rangahau whanau) supported the development of the research project.. The advisory group was developed from personal networks and included: Māori clinicians, Māori researchers, tangata whaiora (service users), cultural support workers and two elders (kaumatua) Pio and Chrissy Jacobs. Extensive Māori ethical protocols (see Kaupapa Māori theory principles above) were followed during recruitment and throughout the research process, guided by the rangahau whanau. One example of Māori ethical approval is evident in a dream that one of elders had after the first author (Melissa Taitimu) had been for a visit. Uncle Pio advised our rangahau whanau that he knew we were “on the right path” as Melissa’s grandfather had visited him in his dream.

Personal construct theory (PCT) was included in the research to emulate the title of the project, standing at the crossroads. The aim was to weave a western psychological theory with traditional Māori research methodologies. The central principle of PCT that was utilised

within this project was that words are not independent of reality (Kelly, 1991). More specifically, the constructs we use, such as schizophrenia, can influence the course, content and outcome of experience.

Method

Ethical approval was received from the University of Auckland Human Subjects Committee. Signed informed consent was obtained from all participants.

Recruitment

The project was designed to use qualitative methodology in such a way as to give voice to people who have the experiences in question and to those who work to support them. A convenience sampling approach was employed in order to access people in both groups. Recruitment utilised Māori networks (whakawhanaungatanga), general media and public hui (meetings). The inclusion criteria asked for participation from people who had worked with or experienced psychosis or schizophrenia who also identified as Māori. Non governmental mental health services (NGOs) in the Auckland and Northland regions of New Zealand were also approached. A total of 57 Māori participants attended the semi-structured interviews.

Interview schedule

Within each semi-structured interview, participants were asked about their understanding of seven experiences that could be considered to be psychotic or labelled schizophrenic, including what they thought caused a person to have such experiences. The experiences presented to the participants were drawn from clinical literature such as the Diagnostic and Statistical Manual, psychotic symptom checklists and other clinical accounts. For example, 'A person hears a voice putting them down or telling them to hurt themselves'. Participants

were then asked what questions they would ask (context, history etc.) to understand more about the experience if someone came to them for help, and what help seeking pathways they would recommend to someone with these experiences. Finally, within each interview, participants were asked their understanding of the terms schizophrenia and psychosis.

Data analysis

All interviews were audio-taped and transcribed by the first author. Transcripts were sent to participants for comment. Fifteen provided feedback, which was mostly minimal, such as a small elaboration on a concept mentioned in the interview. Thematic analysis (Braun & Clarke, 2006) was then conducted on the transcripts. This is a method, commonly used in Psychology research, involving an inductive approach to developing themes directly from the data on the basis of shared meaning. NVivo, a data analysis package, was used to facilitate the thematic analysis, leading to the themes described in the Results section.

Results

Sample characteristics

All 57 participants self identified as Māori and experienced various levels of connection to Te Ao Māori (the Māori world). Participant subgroups included tangata whaiora (TW- people seeking wellness/service users), Kaumatua/Kuia (KAU - elders), Kai mahi (CSW - Cultural support workers), Managers of mental health services (MAN), clinician (CLIN - psychiatrists, nurses and psychologists) and students (STU - undergraduate and post-graduate psychology students). Some participants belonged to more than one subgroup. Demographic data highlighting participant subgroup, gender, number of years contact with mental health services and whether the participant work in a District Health Board or NGO is summarised in Table 1.

-- Table 1 about here --

Preference for cultural and psychosocial understandings but no one Maori way

A central and perhaps unsurprising finding was that there is no *one* Māori way of understanding psychotic experiences. Table 2 shows that participants held numerous and various explanatory models that included biological explanations and traditional Māori spiritual beliefs. In general, however, participants appeared to prefer cultural and psychosocial explanations. Outlined below are some of the comments made by participants regarding their understandings. Participants' comments are purposely and respectfully provided with little interpretation.

-- Table 2 about here --

Common everyday experience

A number of participants reported these experiences could be normal and do not need to be pathologised:

For me hearing voices is like saying hello to your whanau in the morning it is nothing unusual. CSW

My understanding of that is that I absolutely accept that if someone tells me that they see someone standing in the room that I can't see that there actually is. They actually can see it. I understand that. KAU/MAN

Whakapapa/ tupuna (ancestors)

Participants referred psychotic experiences possibly being indicative of one's ancestors trying to contact them for particular reasons:

They come to me when things are about to get bad...they sometimes tell me what to do and if I do it then I get through. I used to think them coming meant I was going crazy again but now I realise that when times were tough, they were there to help me through. TW

Yep a lot of them have something that needs to be done. You will know when you're supposed to do it, they're not subtle, they will show you what you need to do and they won't stop until you do it. TW

Other participants referred to events and significant persons in their family history (whakapapa), sometimes many generations removed, as explanation for psychotic experiences:

In my family we had to go back a fair way to get an understanding why all of this was happening now [diagnosis of schizophrenia in family]. We had to visit the place where it started and get some of our kaumatua [elders] to talk to them to find out what really went on and then how we could go about finding some sort of resolution or utu [balance]. KAU

Matakite (gifted)

Psychotic experiences were also understood at times as a sign of giftedness (Matakite, Tohunga). This is a spiritual gift and includes the role of seer (of future events) and

awareness of activities and actions in other places. Having this gift was discussed as being passed on through generations:

And there was families who were like that. That's when that korero [saying] used to come 'he momo tangata he wena' [they are a different type of person], and they were known for that sort of thing and the rest of the whanau accepted they're like that. They come down from a line of tohunga and it's being able to understand those people and still accepting them for what they are and supporting them. KAU

Others referred to the initial fear of being matakite (having the gift):

I never wanted to accept it, I said no it isn't, it isn't [matakite] but it wouldn't stop and in truth I knew what I had to do, help my people, I didn't want the responsibility but here I am. They helped me understand it and told me what to do with it. KAU

Mate Māori (Māori Illness)

Psychotic experiences were not always considered within a normative or positive cultural lens. Mate Māori was described as term loosely translated as Māori illness. A number of participants referred to various illness states that could be understood as mate Māori.

You know when hearing a voice in Māoritanga there is only two things with mental health, there was only pōrangi [literal translation dark night] and wairangi [literal translation water / sky] but now they've got another one, haurangi [under the influence of alcohol or drugs] ...There wasn't any such thing as bipolar, schizophrenia, we didn't lock ours up and throw away the key, that's it. KAU
Pōrangi [a form of Mate Māori] is that the poor person is in darkness, his mind is in darkness. If we go back to rangi and papa [sky father and earth mother] and his

mind is in darkness, he doesn't see any light at all, his world is in darkness.

KAU/CSW

When the wairua goes wandering that is wairangi [a form of Mate Māori]. People are not their whole selves. They do not have the ability to communicate or fully function. KAU

One woman reflected on the experience of her wairua (spirit) being disconnected from her physical self:

The main person that was behind me was my father. He passed away in 1998, so he was pushing and I was being dragged through, there were familiar faces and not so familiar faces, and some faces that had been long gone, and getting through that, it actually terrified me, I had all these body sensations. I knew where I was but I felt as though I was somewhere else and that somewhere else was actually in [home town]. I actually found myself standing in [my home town] and I was standing in the cemetery and as fast as I tried to get back, if you can call it get back from there, I was held there, my wairua couldn't get back to my body. TW/CSW

Tapu

Others referred to the important role of tapu and noa in Māori society and the illness that will result of this balance is not restored.

Tapu (sacred) does not mean don't touch, it is a mark of respect, you respect it...you're gonna get hurt or sick or something if you don't respect it. KAU

Trauma

A number of participants referred to the effects of trauma on experiences of psychosis especially hearing voices and delusions:

Is that mum in the background? Is that the abusive parent? Is that mum always putting them down or is it in relation to some sort of trauma when they were growing up? I think quite often things can be explained by people's nurture and how they got to that point prior to seeing you. That is why the context is so important in relation to how they got there. CLIN

Others referred to the trauma associated with fear of the experience itself:

It is really scary when you start to hear people who aren't physically present, you freak out at first. Especially when everyone around you doesn't want anything to do with you, you feel so alone, it is one of the scariest things I have ever had to go through. TW"

Some participants believed that it is through trauma they were exposed or connected to a negative spiritual experience because of a breach in relation to tapu and noa:

I think with trauma it's almost like you've opened up to something, you've opened up a side to you. Our belief is that our people are spiritual and it's very very spiritual and that's who we are and something comes in and there's a breach that shocks you personally, the breach of tapu is there and so you are open to all negative spiritual things. KAU/CSW

Others referred to historical trauma associated with colonisation as an explanation for these experiences:

A lot of them just don't know who they are because they have been brought up away from their whanau, hapu, iwi... In my books the major ill is loss of identity not schizophrenia. CLIN

They are most likely second or third generation living in state housing in towns, benefit families. I am not surprised that it is higher [Māori admission rates] because Māori have got all of these social issues going on. STU

Substance use and abuse

A number of participants referred to the increasing levels of drug and alcohol abuse within Māori communities as explanation for psychotic experiences:

The issue for me is I think too many of our whanau are getting sick due to the use of drugs. ...Because what you are doing, when our young people become mentally unwell because of drugs it is a European drug that has caused it. I think that is where we get a lot of our paranoia from. KAU/CSW

Rejection of the diagnosis schizophrenia

All participants were asked in the latter part of the interview what the term 'schizophrenia' meant to them. Most tangata whaiora appeared confused about the term.

Like you are not all there or something. Like so stressed out... I suppose a part of that person has been taken away. They are not their full selves or something. I have never had the term explained to me...Psychotic, schizophrenic. TW

Learning a lot I suppose. Being a schizophrenic. Learning new things that you've never really believed in. That is something new. Oh, I don't know...TW

Many participants expressed views regarding the limited utility of the diagnosis of schizophrenia for facilitating understandings of theirs or others experiences. This construct was believed to be developed within a particular cultural context that may not be applicable to Māori. It may even be considered alien to Māori. The diagnosis is rarely explained and seems imposed (both as a concept and upon the soul/body). It ‘happens’ outside of themselves. It is a stranger because it is not defined or explained; it remains unknowable.

It's about another perspective making a judgment on another based on their own cultural norms of what hearing seeing and believing is and labelling that as schizophrenia when in fact that may not be. CSW/MAN

I really believe that schizophrenia does not exist as a diagnosis. And we need to identify the symptoms from the field of psychosis. So when people say to me oh he is schizophrenic, that means nothing to me. But when we talk of it in terms of he is hearing voices or whatever, then I have something to work with. KAU/MAN

Silence: withholding personal meaning

A number of participants discussed their experience of adhering to psychiatric ways of understanding their experiences and strategically withholding their subjective understandings due to fear of being judged or pathologised:

When they asked me, they didn't ask me what I saw. I was like, okay, I want to get out of here so I had better start talking their talk. You don't tell the shrink because you want to get out so you just try and make up stuff that they want to hear so you can get better or so that you can get out of there. TW

One participant provided an explanation for why he remains silent about his own understanding of his experiences:

If you fight against being a psychiatric you're going to go down, you're going to get locked up you're going to get hurt. I've done lake Alice, that's a highly psychiatric prison, I've been to Lake Alice and you've just got to face it, the truth is psychiatric, you're getting punished by god. TW

Much of the treatment at Lake Alice hospital in the 1960s and 1970s, particularly for young children and youth, were punishments. The average age was 11 and Māori were over-represented. Dr Selwyn Leeks, the psychiatrist responsible, thought it important that the young people being subjected to electroconvulsive therapy were actually told that they were being punished (Johnston, 2004).

Boundaries between Māori illness and Psychosis/schizophrenia

In general participants understood psychotic experiences to be indicative of either a Māori illness (Mate Māori), a gift (Matakite) or a Pākehā illness (Western psychiatric condition). The boundaries placed between these experiences generally referred to the content, control and context of the experience however boundaries placed by one person were not necessarily by the other. Some comments are outlined below:

Content

Some participants believed if the content of the experience was not Māori (specifically referring to Māori people, language or experiences) it was likely a “Pākehā illness” and not culturally embedded:

Just again if they know who it is or if they can recognise any links between the voices and anyone that they know. You know if they said they were hearing Pocahontas or something I'd be a bit suspect of that you know I'd kind of thinking well why's Pocahontas trying to talk to you sort of thing. STU

Others found connections after further investigation into the symbolism of the voices:

One of mine believes she's royalty. At first I thought it was funny, we thought oh this one thinks she belongs to the British royal family. But as time moved along for me, I thought it's not about British royalty, it's about Māori royalty. It took me a long time, to work it out. That opened my eyes. I thought, you know she's not as crazy as what people think she is, she's actually connecting to her Māori royalty, now it's not such a big thing to me. It's just that she's used the British royalty names. CSW

Control

Some participants believed that being out of control with the experience was more indicative of an illness state:

One [Pākehā illness state] is very controlling, it consumes them actually and they can't function. The other one [matakite] is fully operating as a person they can tell you about what is happening and they say it in a very authoritative way because they are in control. CSW

Others however referred to feeling out of control initially and learning to integrate the experience along their recovery pathway while still interpreting the experience as culturally embedded:

I used to be so scared of the voices, they were terrifying...now I know what they are trying to say and who they are, I can also control it and tell them not now, it's a choice for me now. TW

Context

Some participants discussed that if the individual could hear voices from a young age it would mean they had a spiritual gift or ability rather than an illness.

When you ask them how long they have been hearing voices, this can give you a pretty good idea if it is matakite. They hear these things usually from a really young age unless it has been suppressed in them. KAU

Others suggested that with appropriate cultural support and guidance some illness states could have been avoided. Labels and subsequent treatments within Western psychiatric settings were criticised for creating or worsening illness states:

She died in XXXX hospital, when my grandfather passed away he couldn't look after her anymore. Our family knew that she wasn't schizophrenic, she didn't have a mental illness we were quite clear that she was a tohunga however her immediate family believed that she had schizophrenia and she was in hospital when she died. She wouldn't have been schizophrenic if she was allowed to just come with us. KAU

For me, one of the most significant distinctions is who is around you at the time? Do they think you are crazy, because if they do, then you probably will be. It is easy to become what others think you are. Us Māori have been doing that for ages, taking on these things that the Pākehā put on us. But if we are around our own, they may not be told it is crazy to hear things and see things, and guess what? Maybe we won't be crazy just by virtue of being understood and told this experience actually has a perfectly plausible explanation. CLIN

Discussion

The findings of this research support the current literature from both Indigenous and service user literature indicating that individuals can hold multiple, and what may appear to be competing, explanatory models for psychotic experiences including spiritual, psychosocial and biological explanations. This finding indicates Māori will likely benefit from *both* clinical *and* cultural interventions. Further to this, the current findings draw attention to a potential barrier to this aspiration where Māori service users and clinicians have found spiritual and cultural constructions to be marginalised and/or pathologised within mainstream settings resulting in a survival coping strategy of silence.

Incorporating both cultural and clinical understandings of psychotic experiences into assessment and treatment is necessary if one considers the additional finding that the boundaries between Māori giftedness (Matakite), everyday / normal experiences for Māori, Māori illness (Mate Māori) and Pākehā illness (schizophrenia / psychosis) are blurred and can be misinterpreted within both Māori and Pākehā contexts. Some participants stated that an individual could experience both mate Māori and psychosis and would recommend seeking help from both pathways. Others commented upon the higher levels of tolerance / acceptance of psychotic experiences within Māori whanau (family) resulting in some individuals presenting at health services at acute stage of their illness, a trend that is often cited within Māori health literature (Mental Health Commission New Zealand, 2001). At the same time, participants commented upon circumstances where protective voices or visions within a cultural context may be pathologised by health practitioners and treated with a view towards symptom reduction. This highlights a significant issue for Māori during their recovery where aspects of their experience that may represent a site of resilience are ignored or considered part of the illness process. It is doubtful that the boundaries will ever be clear

between what experiences are considered matakite, Mate Māori or schizophrenia/psychosis. Therefore, understanding personal meanings and cultural context will continue to play a pivotal play in determining the appropriate pathways for recovery on a case by case basis.

Overall, the current findings are consistent with previous research that has identified the resilience of Māori spiritual beliefs relevant to the diagnosis and understanding of mental illness (Beaglehole & Beaglehole, 1946; Cherrington, 1994; Lyndon, 1983). Lyndon (1983) predicted, almost twenty years ago, that Māori constructions regarding tapu and mate Māori would continue to be used to understand what Pākehā call ‘mental illness’ in the future as she observed these beliefs were already being passed on to the next generation of young Māori. Lyndon also believed that increased acceptance of Māori constructions through the period of Māori development in health would serve to strengthen these beliefs (Durie, 1997). The current research has found support for this prediction as many of the participants interviewed, who had been in contact with mental health services for long periods of time, still retained strong cultural/spiritual constructions of their experiences and work. However, it was also apparent that many participants had their constructions ignored, marginalised or pathologised within mainstream settings. This indicates that in some instances, there has not been a significant shift in the system in terms of acceptance of Māori constructions. This may be especially the case for the diagnosis of schizophrenia, as it remains the most medicalised mental disorder.

To broaden the language around Māori constructions of psychotic experiences this research makes a unique contribution to understanding of culturally embedded concepts such as porangi and wairangi in terms of their manifestations and underlying mechanisms that may impact upon the health of Māori. To the knowledge of the researcher, aside from early anthropological and medical writings these cultural experiences have not been well documented or understood. Indeed, due to limited access to this knowledge many in the

Māori community do not understand these concepts or know who they could seek help from (Durie, 2001). Further research is required to understand the various manifestations and current ways of working with *matakite* and *mate* Māori within Māori communities and how this can inform mainstream mental health practices to not only reduce the likelihood of misdiagnosis but also broaden the pathways Māori are able to access during recovery.

While participants were able to develop a dialogue about experiences such as hearing voices, or delusional beliefs, the term schizophrenia held little utility or relevance for many Māori participants even those who have been labelled with, and work with, the diagnosis. This finding supports the literature that advocates for a focus on symptom clusters as opposed to broad based syndromes such as schizophrenia (Bentall, 2004). In addition, participants commented upon the stigmatising impact the word schizophrenia has upon their recovery not only in terms of how they perceived themselves but also how their whanau and community responds to them. This finding is consistent with service user perspectives cited in recovery literature (Lapsley et. al. 2002).

Finally, this research has implications regarding access to mental health services for Māori with psychotic experiences by advocating for research and interventions that address barriers and facilitate pathways between communities and services. This project asked Māori about their recommendations for pathways of healing (Taitimu, 2007) however the discussion is outside of the scope of this article that primarily focuses on meaning of the experience. One recommendations from the research was for the development / enhancement of bicultural services that deliver both cultural *and* clinical assessment protocols that are not independent but meaningfully acknowledge and inform each other. To achieve this shift within services future research and initiatives should target the development of the Māori mental health workforce *and* culturally competent non-Māori clinicians. In the words of one

of our most influential Māori leaders, Sir Āpirana Ngata (1874-1950) an integrated approach would ideally weave the strengths of both pathways:

E tipu e rea mō ngā rā o tō ao

Ko tō ringa ki ngā rākau a te Pākehā

Hei ora mō te tinana

Ko tō ngākau ki ngā tāonga a ō tīpuna Māori

Hei tikitiki mō tō māhuna Ko tō wairua ki tō atua, Nānā nei ngā mea katoa

Grow and branch forth for the days destined to you

Your hands to the tools of the Pākehā for the welfare of your body

Your heart to the treasures of your ancestors as adornments for your brow

Your spirit to god, who made all things

Limitations

Despite being the largest number of qualitative interviews in this field to date, 57 is too small to have confidence in any generalisations to the Māori community as a whole, or to make comparisons between participant sub groups. Larger studies would be desirable in the future.

As is the case with all qualitative forms of enquiry, in particular Kaupapa Māori research, a limitation could be the inherent subjectivity in conducting and interpreting the interviews. However, Kaupapa Māori theory posits that subjectivity is not only a strength, but an integral part of Indigenous research. The primary researcher (MT) being a Māori researcher and sharing to some extent identity, values and beliefs with participants may have allowed for personal meaning and understanding to be shared especially given the finding that many Māori are cautious of sharing their beliefs about their experiences lest they be judged or pathologised. On the other hand, being a younger Māori female may have

influenced *what* information was shared, for example, kaumatua (elders) may have withheld some information due to their belief that the interviewer was too young, did not speak Māori fluently, and it was not her time or role to know such things within our community.

As is the case with most research conducted in Māori health, a balance must be sought between generating and sharing knowledge that is going to help whanau [family, community] who use mental health services, and risking the exploitation, misuse and/or misinterpretation of cultural intellectual property. With the guidance of the rangahau whanau, this research used the benchmark of positive Māori development to make moral, ethical and academic decisions throughout the research process (International Research Institute for Maori and Indigenous Education, 2002).

References

- Alexander, F., & Selesnick, S. (1996). *The history of psychiatric thought and practice from prehistoric times to the present*. New York: Harper & Row.
- Allen, M. (2002). *Identity and resistance in Okinawa*. New York: Rowman & Littlefield.
- Barnett, H., & Lapsley, H. (2006). *Journeys of despair, journeys of hope: Young adults talk about severe mental distress, mental health services and recovery*. Wellington: New Zealand Mental Health Commission.
- Beaglehole, E., & Beaglehole, P. (1946). *Some Modern Māoris*. Wellington, NZ: New Zealand Council for Educational Research.
- Bentall, R. (2004). *Madness Explained: Psychosis and human nature*. London: Allen Lane.
- Bhurga, D., & Littlewood, R. (2001). *Colonialism and psychiatry*. New Dehli: Oxford University Press.
- Bleuler, E. (1913/1950). *Dementia Praecox: The group of schizophrenias*. New York:

International University Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Carpenter, W., & Buchanan, R. (1995). Schizophrenia: Introduction and overview. In H. Kaplan & B. Saddock (Eds.), *Comprehensive textbook of psychiatry*. Maryland: Williams and Wilkins.

Castillo, R. (2003). Trance, functional psychosis and culture. *Psychiatry, 66*, 9-21.

Cherrington, L. (1994). *A Comparison study of the presenting symptoms between Māori and Pākehā patients diagnosed with schizophrenia*. Massey University, Palmerston North.

Dean, B. (2000). Signal transmission, rather than reception is the underlying neurochemical abnormality in schizophrenia. *Australian and New Zealand Journal of Psychiatry, 34*, 560-569.

Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. Albany: State University of New York.

Durie, M. (1997). Māori cultural identity and its implications for mental health services. *International Journal of Mental Health, 26*, 23-35.

Durie, M. (2001). *Mauri Ora: The Dynamics of Mental Health*. Oxford: Oxford University Press.

Fernando, S. (1988). *Race and culture in psychiatry*. Great Britain: Billing & Sons Ltd.

Gavala, J., & Taitimu, M. (2007). Training and supporting a Māori workforce. In I. Evans, J. Rucklidge, M. O'Driscoll (Eds.), *Professional practice of psychology in Aotearoa New Zealand* (pp. 229–244). Wellington, New Zealand: The New Zealand Psychological Society.

Geekie, J., & Read, J. (2009). *Making sense of madness: Contesting the meaning of schizophrenia*. London: Routledge.

- Gluckman, L. K. (1962). *Makutu: A study in the ethno-psychiatry of the Māori, past and present*. Unpublished M.D, University of Otago, New Zealand.
- Goldie, W. H. (1904). *Māori medical lore: notes on the causes and treatment of the sick among the Māori people of New Zealand, as believed and practiced in former times, together with some account of various ancient rites connected with the same*. Wellington: Transactions and Proceedings of the New Zealand Institute.
- Haslam, N. & Kvaale, E. (2015). Biogenetic explanations of mental disorder The mixed-blessings model. *Current Directions in Psychological Science*, 24, 399-404.
- International Research Institute for Maori and Indigenous Education. (2002). *Iwi and Māori provider success. A research report of interviews with successful iwi and Māori providers and governmental agencies*. Wellington, NZ: Te Puni Kokiri.
- Johnston, M. (2004). Former Lake Alice patients win \$4.2m payout. *New Zealand Herald*, July 31. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=3581489
- Johnstone, K., & Read, J. (2000). Psychiatrists' recommendations for improving bicultural training and Māori mental health services: A New Zealand survey. *Australian and New Zealand Journal of Psychiatry*, 34, 135-145.
- Kelly, G. (1991). *The psychology of personal constructs. Volume One: Theory and Personality*. London: Routledge.
- Kemp, S. (1985). Modern myth and medieval madness: Views of mental illness in the European middle ages and renaissance. *New Zealand Journal of Psychology*, 14, 1-8.
- Kraepelin, E. (1919). *Dementia Praecox and Paraphrenia*. Edinburgh: E & S Livingstone.
- Lambrecht, I., & Taitimu, M. (2012). Exploring culture, subjectivity and psychosis. In J. Geekie, J., P. Randal, D. Lampshire, J. Read (Eds.) *Experiencing psychosis first person and research perspectives* (p. 44-55). London: Routledge.

- Lapsley, H., Nikora, L., & Black, R. (2002). *“Kia Mauri Tau!” Narratives of recovery from disabling mental health problems*. Wellington: New Zealand Mental Health Commission
- Levy, M. (2002). *Barriers and incentives to Māori participation in the profession of psychology. A report for the New Zealand Psychologists Board*. Hamilton, NZ: Māori and Psychology Research Unit.
- Lin, K. & Kleinman, A. (1988). Psychopathology and clinical course of schizophrenia: A cross cultural perspective. *Schizophrenia Bulletin*, 14, 555-567.
- Lyndon, C. (1983). *Beliefs in tapu, mate Māori and makutu and the relevance of these beliefs to the diagnosis of mental illness amongst the Māori*. Unpublished Masters, University of Auckland, New Zealand, Auckland.
- Marsden, M. (2003). *The woven universe: Selected writings of Rev. Māori Marsden*. Otaki, NZ: Estate of Rev. Māori Marsden.
- McCarthy-Jones, S. (2013). *Hearing voices: The histories, causes and meanings of auditory verbal hallucinations*. Cambridge: Cambridge University Press.
- Mental Health Commission. (2001). *Cultural assessment process for Māori: Guidance for Mainstream Mental Health Services*. Wellington: Mental Health Commission.
- McIntosh, T. (2004). *Theorising marginality and the process of marginalisation*. Paper presented at the Ngā Pae o te Māramatanga demonstration projects on "protocols for research with vulnerable and marginalised Māori", Waipapa Marae, Auckland.
- Mills, C. (2014) *Decolonizing global mental health; The Psychiatrization of the majority world*. London: Routledge.
- Ministry of Health. (2005). *Raranga Tupuake: Māori Health Workforce Development Plan: Discussion document*. Wellington: Ministry of Health.
- Ngata, A. (?) <http://teahou.natlib.govt.nz/journals/teahou/issue/Mao24TeA/c39.html>

- Nikora, L., Levy, M., Masters, B., & Waitoki, M. (2004). *Indigenous psychologies globally-A perspective from Aotearoa/New Zealand*. Retrieved 22 April 2007, from <http://psychology.waikato.ac.nz/mpru/pubs/paps-sums/2004indpsyc.pdf>
- Pihama, L., Smith, K., Taki, M., & Lee, J. (2004). *A literature review on Kaupapa Māori and Māori education pedagogy*. Auckland: International Research Institute for Māori and Indigenous Education (IRI).
- Porter, R. (1987). *A social history of madness: The world through the eyes of the insane*. New York: Wiedenfeld and Nicholson.
- Randal, P., Geekie, J., Lambrecht, I., & Taitimu, M. (2008). Dissociation, psychosis and spirituality: Whose voices are we hearing? In A. Moskowitz, I. Schafer, M. Dorahy, (eds.) *Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology* (p 333-345). London: John Wiley and Sons.
- Read, J. (2013). A history of madness. In J Read & J Dillon (eds.). *Models of Madness* (2nd edition), pp 9-19. London: Routledge.
- Read, J. & Dillon, J. (eds.) (2013). *Models of Madness. (2nd edition)*. London: Routledge.
- Read, J., Haslam, N., & Magliano, L. (2013). Prejudice, stigma and 'schizophrenia': The role of bio-genetic ideology. In J Read, J Dillon (eds.). *Models of Madness* (2nd edition), pp . 157-177. London: Routledge.
- Read, J., Haslam, N., Sayce, L., & Davies, E. (2006). Prejudice and schizophrenia: A review of the 'Mental illness is an illness like any other' approach. *Acta Psychiatrica Scandinavica*, 114, 303-318.
- Smith, L. (2003). *Decolonising methodologies*. Dunedin: University of Otago Press.
- Smith, G. (1997). *The development of kaupapa Māori: Theory and praxis*. Unpublished Doctor of Philosophy, University of Auckland, Auckland.
- Taitimu, M. (2007). *Māori ways of understanding extra-ordinary experiences and*

- schizophrenia*. PhD Thesis: University of Auckland, New Zealand.
- Taitimu, M., & Read, J. (2006). Explanatory models of schizophrenia. *British Journal of Psychiatry*, 189, 284.
- Thara, R., Sucharitakul, D., & Mendis, N. (2001). *Schizophrenia: Youth's greatest disabler*. Geneva: World Health Organisation.
- Waitoki, W., & Levy, M. (2016). *Te Manu Kai i Te Matauranga: Indigenous Psychology in Aotearoa/New Zealand*. Wellington: New Zealand Psychological Society.
- Walker, R. (1990). *Ka Whawhai tonu matou: Struggle without end*. Auckland: Penguin.
- Wharewera-Mika, J. (2012). 'Ahakoa te momo mate, whakanuia tāngata', mental health inpatient services: Māori needs when extremely distressed. Unpublished DCLinPsy Thesis. University of Auckland. New Zealand.
- Wheeler, A., Robinson, E., & Robinson, G. (2005). Admissions to acute psychiatric inpatient services in Auckland, New Zealand: a demographic and diagnostic review. *New Zealand Medical Journal*, 118, 1-9.
- World Health Organisation. (1979). *Schizophrenia: An international follow up study*. London: Wiley.

Table 1: Demographic frequencies and percentages of interview participants

GENDER	Male (37%)	Female 6 (63%)
<p>AGE</p> <p>20-29 30-39 40-49 50-59 60-69 70-79</p> <p>AGE RANGE</p>	<p>10 (17.5%) 9 (15.8%) 15 (26.3%) 12 (21.1%) 9 (15.8%) 2 (3.5%)</p> <p>20 - 78</p>	
<p>PARTICIPANT SUBGROUPS</p> <p>Tangata Whaiora (TW)</p> <p>Kaumatua/Kuia (KAU) Current place of work</p> <p>Cultural support workers (CSW) Current place of work</p> <p>Clinicians (CLIN) Current place of work</p> <p>Psychiatrists Psychologists Nurses</p> <p>Managers (MAN) Current place of work</p> <p>Students (STU)</p>	<p>TOTAL*</p> <p>16</p> <p>14 7 NGO 2 DHB 5 Community</p> <p>20 13 NGO 7 DHB</p> <p>11 11 DHB</p> <p>3 (2 Pākehā) 4 (2 Pākehā) 4 (1 Pākehā)</p> <p>7 6 NGO 1 DHB</p> <p>11 3 DHB**</p>	<p>YEARS OF CONTACT WITH MENTAL HEALTH SERVICES</p> <p><10: 4 (25%) 10-20: 5 (31%) > 20: 7 (44%)</p> <p><10: 2 (22%) 10-20: 2 (22%) > 20: 5 (56%)</p> <p><10: 3 (15%) 10-20: 7 (35%) > 20: 10 (50%)</p> <p><10: 3 (28%) 10-20: 4 (36%) > 20: 4 (36%)</p> <p><10: 0 10-20: 2 (29%) > 20: 5 (71%)</p> <p><10: 3 (27%)</p>

* some participants belonged to more than one subgroup

***Three students were also cultural support workers or trainee clinicians within a DHB (District Health Board)*

Table 2: Themes for making sense of the experience including number of participants

Theme	Sub- themes	Number of participants coded
Common/Everyday experiences	Acceptance Recognition/Validation	12
Whakapapa / Tupuna	Narratives of descent Help during difficult times Instructions for tasks Transfer of knowledge kaitiaki	14
Gift	Mate kite Silence Responsibilities of mate kite	19
Māori Illnesses/ Mate Māori	Porangi Wairangi Makutu	41
Trauma Drugs	Trauma and hearing voices Trauma and spirituality Haurangi Drugs and spirituality	21
Boundaries: Cultural experience vs Pākeha illness	Content Control Context	57*
Understanding schizophrenia	Diagnostic constructions Biomedical constructions Rejection of the diagnosis	57*
Silence	Withholding ones understanding from Pākeha	15

** All participants were asked about this theme and therefore 57 participants were coded*