

Does Social Group Status Influence Social Distance in Relation to Depression?

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It is widely assumed that Maori and non-Maori have disparate views of mental health. Using the mental health literacy framework, a survey questionnaire was mailed to a random sample of 500 people selected from both the General and Maori electoral rolls. A total of 205 completed questionnaires were received which included 115 from non-Maori and 90 from Maori. Participants were required to respond to a vignette describing a fictional character experiencing a major depressive disorder. Our findings indicated no significant differences between Maori and non-Maori respondents regarding problem identification, quality of life impacted, social distance judgements, and the relationship between degree of familiarity with mental illness and desired social distance. Implications of these findings are discussed in relation to destigmatisation of mental health campaigns in the public health field.

There has been widespread interest in the social experiences of those with mental illness (Angermeyer & Matschinger, 1996; Holmes & River, 1998; Markowitz, 2001). Much of this interest has centred on the issue of social stigma, and in particular the negative influence of stigmatisation on the life experiences of individuals with a mental disorder (Sartorius, 1999; Ben-Porath, 2002). The main conclusion drawn in the literature is that psychiatric stigma can significantly impair quality of life across a range of social domains for those who experience mental ill health (Roman & Floyd, 1981; Rosenfield, 1997; Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999; Phelan, Link, Stueve & Pescosolido, 2000; Jorm, Angermeyer & Katschnig, 2000). When we consider the adverse life experiences of those with mental illness in the context of the increasing prevalence of psychological disorders then it is necessary that we delineate the attributes mentally ill persons are

believed to possess, which lead them to convey a negative social identity (Major & Crocker, 1993; Hayward & Bright, 1997; Crocker, Major & Steele, 1998; Neugebauer, 1999; Kurzban & Leary, 2001; Haghghat, 2001).

In pursuit of this objective one particularly fertile line of inquiry has been the ongoing investigation of beliefs held by lay members of the public about psychopathology (Rabkin, 1974; Furnham, 1988; Angermeyer, Matschinger & Riedel-Heller, 1999; Jorm, 2000). With reference to psychiatric stigma a more refined focus has been directed at lay evaluative judgements of mentally ill targets as they relate to social distance. Social distance is best understood as a proxy measure for eliciting discriminatory attitudes toward persons with mental illness (Corrigan, Edwards, Green, Diwan, and Penn, 2001). Notwithstanding the different explanatory theories forwarded regarding the function of stigma (see Hayward & Bright, 1997; Crocker et

al. 1998; Haghghat, 2001; Kurzban & Leary, 2001), measures of social distance are assumed to inform on the relationship between attitudes and likely behaviour exhibited toward targets experiencing mental illness. Underlying the measure of social distance is the assumption that behaviours symptomatic of mental illness prompt affective reactions such as rejection, acceptance, and ambivalence from members of the public (Roman and Floyd, 1981; Crocker et al. 1998).

It is important to note that the range of factors believed to influence social distance ought to be differentiated between perceived attributes of the target and those possessed by the perceiver. Of principal interest to the present research is that social group status of perceivers is commonly cited as influencing quality of social distance appraisals (e.g., Littlewood, 1998; Corrigan, Edwards, Green, Diwan & Penn, 2001).

Ethnicity and nation of origin are frequently cited as proxy categorical cultural groupings equivalent to social group status (Fabrega, 1991; Pote & Orrell, 2002; Angermeyer, Buyantugs, Kenzine & Matschinger, 2004). For our purposes, we investigate a possible association between ethnicity and social distance as they relate to psychiatric stigma.

The main claim made within the literature commenting on the relationship between ethnicity and psychiatric stigma is that in comparison to their counterparts, members of minority status groups will be *less inclined* to stigmatise

individuals with mental illness (Pote & Orrell, 2002; Faye, 2005; Grandbois, 2005). We concentrate on two broadly received views that generally underpin much of the research in this field.

The first view is that the mentally ill and individuals of ethnic minority groups share prototypical features, which can lead to a devalued social identity (Crocker et al. 1998; Corrigan, Green, Lundin, Kubiak, & Penn, 2001). These features include: being economically disadvantaged; being the target of negative stereotypes (Townsend, 1992); and, experiencing interpersonal rejection and discrimination (Crocker et al. 1998). Advocates of this position assume that ethnic minority members will display a higher degree of tolerance and empathy toward the mentally ill on the grounds that they too possess features of a devalued social identity.

The second view of the relationship between ethnicity and psychiatric stigma, suggests that the way in which mental illness is conceptualised will influence how it is responded to. A core assumption underpinning this position is that mental illness is a cultural construction and therefore ethnic groups construct from their own local compendium of behavioural norms what is to be considered aberrant compared with appropriate behaviour (Fabrega, 1991; Littlewood, 1998; Smith, 2002). On the basis that ethnic groups may not recognise so-called Western concepts of mental illness or have different concepts of mental illness altogether, it is also surmised that they will stigmatise less in comparison to other groups (Rosen, 2003). Thus it is assumed that stigmatisation is conditional on the ability of members to perceive behaviour as being atypical within the context of their own group's conceptual understanding of what constitutes abnormal behaviour (Corrigan, 2004).

We sought to investigate the association between social group status and social distance in relation to psychiatric stigma. We examined this relationship by comparing depression literacy factors between Maori who hold minority group status in New Zealand and non-Maori who comprise the majority group. Within New Zealand health policy and literature, these two groups 'Maori and non-Maori' are

habitually demarcated on the basis of categorical ethnicity associated with group membership (Marie, Forsyth, & Miles, 2004). In addition, it is widely reported that Maori conceptualise mental health outside of Western nosology (Durie, 1994; Rochford, 2004). The common conception is that Maori view mental illness holistically whereby the health of the collective serves as an index for the health of the individual. A number of metaphoric frameworks representing this conception are in wide circulation and prominent among these is a framework known as *te whare tapa wha*, which translates as the four cornerstones of the house (Durie, 1994).

The idea that Maori perceive mental illness differently is in fact a standard premise underlying New Zealand's health strategies and policies and is also identified as a major consideration informing the nation's destigmatisation of mental illness campaign (Ministry of Health, 2001; Vaughan & Hansen, 2004). Therefore, given the distinction in social group status between Maori and non-Maori and the assumption that respective group members hold different views of mental illness we would anticipate variance in social distance judgements between the groups. In brief, we would expect that Maori would be less discriminatory in their social distance judgements in comparison to participants with majority group status.

This paper examines whether minority ethnic status, as a specific social grouping, influences social distance judgements toward a target exhibiting symptoms associated with a depressive illness. To establish whether members of the minority (and majority) group recognised that a mental illness was present, problem identification and well-being factors were included in the study. These two factors were included in order to seek empirical clarity relative to the claim that Maori conceptualise mental health problems differently from non-Maori. Additionally, we also included familiarity as a factor in this research to determine whether enhanced familiarity serves as a deterrent of psychiatric stigma. Our rationale for selecting a major depressive disorder as the focus of this research is that

independent of ethnic categories, it is the psychological disorder more often experienced (Gaw, 1993; Castillo, 1997; Kazarian & Evans, 1998), it affects all age groups, and has been claimed to not only be the disorder most easily recognised by the lay public, but also the disorder that receives the widest public exposure (Goldberg & Huxley, 1992; Goldberg 2001; Daley & Salloum, 2001; Joseph, 2001). A final reason for selecting depression as the disorder of interest is that it has been used as an exemplar to describe the main features which allegedly distinguish Maori views of mental illness from those held by non-Maori (see Durie, 2001).

Method

The survey questionnaire was mailed to a random sample of 500 people selected from both the General and Maori electoral rolls. A total of 205 usable completed questionnaires were received which included 115 non-Maori and 90 Maori.

Participants

Five hundred surveys were mailed to individuals randomly selected from the General or Maori Electoral Rolls of New Zealand. The 205 usable returns comprised 115 participants from the General Electoral Roll and 90 participants from the Maori Electoral Roll. Five respondents who returned questionnaires were excluded, three who were on the Maori Electoral Roll yet didn't identify as Maori, and two who identified as being Maori, but were on the General Electoral Roll. The return rate was 41% which is comparable to that obtained by an Australian sample which investigated public beliefs about the helpfulness of interventions for depression (Jorm, Medway, Christensen, Korten, Jacomb & Rodgers, 2000).

The electoral rolls were sourced as they provided direct access to the self-assigned social group status criterion namely, Maori/non-Maori, which is a focus of this investigation. In terms of collecting participants from the Maori Electoral Roll we used the Te Tai Tonga Electorate (Wellington and the South Island of New Zealand). All those selected to participate were sent a detailed participant information sheet, a questionnaire including a protocol

for its completion, and a consent form that also asked participants to indicate whether they would like a copy of the results of the study along with a postage paid return envelope. On completion of the study, all participants including other nominated recipients of the participants (e.g. marae-based health organizations) were sent a lay summary of the results. Summaries of the results were also disseminated to Maori health research units throughout New Zealand.

Materials

A vignette was constructed describing the case history of a hypothetical character exhibiting the minimum DSM-IV-R criteria (American Psychiatric Association [APA], 1994) required for a clinical diagnosis of a major depressive disorder. Indirect references were included in the vignette describing active symptoms associated with the onset, duration, frequency, course, and severity of the specific behaviours exhibited by the target character. The character's age and sex corresponded to the mean demographic profile for a major depressive disorder as reported in the available New Zealand psychiatric morbidity data (Ellis and Collings, 1997). The language used in the vignette was lay-oriented and free of technical jargon so that participants independent of their respective educational status or background could easily understand it. The fictitious name given to the hypothetical target 'Rita' was selected on the grounds that the ethnic origin of the character remained ambiguous in the context of New Zealand. The vignette read as follows:

Rita is 35 years old. In the last 2 months Rita has been feeling unusually sad and miserable. While Rita used to be an active person who took part in recreational and social groups, lately she hasn't shown any interest in sports and social activities. Although Rita often feels tired, she has trouble sleeping nearly every night. At her job Rita finds it difficult to concentrate on tasks and feels that everything is getting on top of her, and she worries that she may lose her job. Rita often finds it difficult to make decisions, even when it comes to deciding what to wear in the mornings. Some days Rita feels bad that she doesn't contribute more to her job or her local

community, but feels unable to muster the energy to do anything about it. Formerly a healthy and fit person, she doesn't feel like eating much anymore and has noticeably lost weight.

Questionnaire Development

Accompanying the vignette was an extensive questionnaire developed from the main items included in previous mental health literacy investigations (see Jorm, 2000). Specifically, the full range of items included questions regarding problem identification, causal attributions, quality of life, treatment preferences, likely prognosis, social distance, social burden, and familiarity with mental illness generally. However, only items relating to problem identification, wellbeing, social distance, and familiarity are reported here. Questionnaire items included free response questions, Likert scale items, and tick box items.

First, the questionnaire included demographic questions about the participant's age, sex, and highest educational level achieved. Participants were also asked to respond to the question 'Do you identify as Maori?' as a check against their registration on New Zealand's electoral rolls from which their names and addresses had been obtained. Second, in relation to problem identification, respondents were asked to read the vignette and to respond to an open-ended question requiring them to identify what, if anything, was wrong with the character. These responses were assigned to one of three pre-determined categories – correctly identifying depression (all responses including the word 'depression' or 'depressed' were counted as correct, i.e., clinical depression, major depression, 'Rita is depressed'), identifying a mental disorder that was not depression, or not identifying any mental disorder.

Third, participants were also required to indicate on a 7 point Likert scale (1 quality of life unaffected – 7 severely affects quality of life) the degree to which they believed the target's condition would affect her quality of life. Fourth, participants were asked to respond to items regarding social distance. Following Arkar & Eker (1994) and Angermeyer & Matschinger (1996), social distance was

operationalised by asking participants how willing they would be to have certain types of relationship with the target character. Eleven types of relationship, covering varying degrees of intimacy, were assessed. The types of relationship ranged from sitting next to the target on a bus, to having the target as a workmate, to having a long-term romantic relationship with the target. Responses were made on a 7-point Likert scale (1 very unwilling – 7 very willing) and an overall social distance score was calculated for each participant by averaging across the scores from all eleven types of relationship.

Finally, with regards to familiarity, participants were asked to indicate whether they themselves had experienced a mental illness or whether they knew anyone who had experienced a mental illness, and if so, to indicate what kind of relationship(s) they had with these individuals. Fourteen relationship options covering different degrees of intimacy and personal experience, including an 'other – not listed' option, were made available to participants. Following Angermeyer & Matschinger (1996), this information was used to construct an index of differing levels of familiarity with mental illness. Participants reporting that they themselves or someone in their immediate family had experienced mental illness were assigned a high level of familiarity. Participants reporting other experiences such as knowing someone in their social network or a colleague who had experienced mental illness were assigned a moderate level of familiarity, while participants reporting no experience with mental illness were assigned a lower level of familiarity. Participants reporting multiple relationships were assigned to the highest applicable level of familiarity.

Internal Validity

Three internal validity checks were undertaken of both the vignette and the questionnaire (Gould, 1996). First, the vignette and the questionnaire were distributed to colleagues of the researchers for peer comment. From the feedback of peers a number of alterations to the vignette and the questionnaire were made. Secondly,

the vignette and questionnaire were distributed to five clinical psychologists who were asked to make a blind diagnosis of the behaviour exhibited by the fictional character, to respond to the questionnaire items, and to provide feedback on the questionnaire's general construction and comprehensiveness. All five clinicians correctly identified that the character was experiencing symptoms consistent with a major depressive disorder. Minor revisions were made to the questionnaire based on comments received by the clinicians. Lastly, a pilot study was performed prior to the distribution of the materials to members of the lay public. Sixty randomly selected students from the University of Canterbury were administered a prototype questionnaire along with a protocol for its completion and consent form. The results of this preliminary data indicated that participants found the questionnaire items comprehensible, the instructions easy to follow, and most identified that the target was experiencing a mental disorder of some kind. Minor revisions of the questionnaire were made based on the analysis of this initial data and feedback from the pilot sample. All materials were then submitted to the Canterbury Ethics Committee from whom ethical approval for this research was obtained.

Sample characteristics

The demographic profile of our sample showing age, sex, ethnicity, and highest educational achievement of participants is shown in Table 1.

As can be seen, female participants were over-represented, however, the size of the over representation was similar for Maori and non-Maori. The Maori respondents comprised a slightly younger age group, which may reflect the younger national demographic profile of Maori when compared with the non-Maori group (Statistics New Zealand, 2002).

Results

A summary of the main findings from each of the three areas of investigation is shown in Table 2. As can be seen, Maori and non-Maori participants displayed similar frequencies of depression identification, similar evaluations regarding the target's well-being, and similar evaluations of desired social distance. These findings are examined in greater detail below.

Problem identification

In order to establish that participants recognised that the target character was exhibiting cues symptomatic of depression, participants were asked to identify what, if anything was wrong with the target. Seventy-two percent of Maori and 80% of non-Maori participants correctly identified the character as suffering from depression. A further 1% of Maori and 3.5% of non-Maori identified a mental illness other than depression, while the remaining 27% of Maori and 16.5% of non-Maori did not identify any mental illness. To examine problem identification further, a chi-square test of independence was conducted to compare the relative

frequency with which Maori and non-Maori participants correctly and incorrectly identified the disorder that the target was suffering from. Due to their low observed frequencies, responses that fell into the 'incorrect mental illness' category were included in the 'no mental illness identified' category. The distribution of correct and incorrect problem identification was not significantly related to social groups status of respondents, $\chi^2(1, 205) = 1.70, p = 0.19$. The majority of participants, both Maori and non-Maori alike, made explicit reference to the label 'depression' in describing what they believed was wrong with the target character. This suggests that independent of social group status, the majority of participants recognised that the target character described in the vignette was experiencing a serious psychological disorder.

Well-being

Participants were asked to rate the degree to which they believed that the behaviour of the target character would affect her quality of life and wellbeing (1 quality of life unaffected – 7 severely affects quality of life). The mean rating for all participants (M = 6.2, SD = 0.82) indicates that in general, participants believed that the target's condition would have a significant impact on her general wellbeing. To examine for differences between Maori and non-Maori participants a *t*-test for independent means was conducted. There was no significant difference ($t[203] = 1.87, p = 0.06$) between Maori (M = 6.1, SD = 0.81) and non-Maori (6.3, SD = 0.82) participants regarding their judgments about the extent to which the target character's behaviour would affect her quality of life. On the whole, participants recognised that the symptoms exhibited by the character in the vignette would negatively influence her wellbeing and quality of life.

Social Distance

Each participant was asked to rate his or her willingness (1 very unwilling – 7 very willing) to engage in eleven types of relationship with someone who behaved like the target character. Overall, participants were largely neutral in their willingness to engage in a relationship (M = 4.0, SD = 1.13). To

Table 1: Demographic Profile of Participants

	Maori (n=90)	Non-Maori (n=115)	Total (n=205)
<i>Gender</i>			
Female	58 (64%)	76 (66%)	134 (65%)
Male	32 (36%)	39 (34%)	71 (35%)
<i>Age (years)</i>			
Mean (S.D.)	35.9 (12.0)	44.7 (13.5)	41 (13.5)
Range	18-67	18-81	18-81
<i>Education</i>			
Advanced degree	8 (9%)	6 (5%)	14 (7%)
University degree/diploma	8 (9%)	15 (13%)	23 (11%)
Non-university degree/diploma	24 (27%)	48 (42%)	72 (35%)
Secondary school qualification	29 (32%)	35 (30%)	64 (31%)
No formal education	21 (23%)	11 (10%)	32 (16%)

investigate possible differences between Maori and non-Maori respondents the ratings for the 11 social distance items were ranked on the basis of the mean rating for each type of relationship. Maori and non-Maori rankings were then compared using Kendall's Tau rank-order correlation. A strong positive correlation between ethnicity and social distance was revealed ($T = 0.77$, $p < 0.01$), indicating that Maori and non-Maori social distance appraisals were concordant.

Supplementary analyses were conducted to further examine the influence of social group status on social distance evaluations and to determine whether enhanced familiarity serves as a deterrent of psychiatric stigma. As described in the methods section, on the basis of their personal experience, participants were characterised as having either high, moderate, or low familiarity with mental illness. Overall social distance scores, averaged across all eleven types of relationship, were then examined by means of a 2 (Ethnicity: Maori / Non-Maori) X 3 (Familiarity: High familiarity / Moderate familiarity / Low familiarity) analysis of variance. This revealed a significant main effect for familiarity, $F(2, 199) = 3.36$, $p < 0.05$. Planned comparisons revealed that participants who were highly familiar with someone who had a mental illness ($M = 4.10$, $SD = 1.16$) were significantly more willing to engage in a relationship with someone like the target than were participants that did not know anyone with a mental illness ($M = 3.65$, $SD = 1.20$), $F(1, 199) = 5.6$, $p < 0.02$. No significant differences were found between participants who were highly familiar with someone that had

a mental illness and participants who were moderately familiar ($M = 3.86$, $SD = 0.96$), nor between participants who were moderately familiar and participants who were not familiar. No main effect for ethnicity was found $F(1, 199) = 1.95$, $p = 0.16$, nor was the interaction between ethnicity and familiarity found to be significant $F(2, 199) = 1.52$, $p = 0.22$.

Discussion

The main purpose of this study was to investigate whether social group status influences social distance—a recognised proxy measure of psychiatric stigma. The results of the present research provide no support for the claim that members with minority group status are less (or more) prone to stigmatise mentally ill persons in comparison to individuals with dominant group status. Of interest, is that no significant differences were found between Maori and non-Maori participants regarding problem identification, judgements of wellbeing, social distance appraisals, and the relationship between familiarity with mental illness and desired social distance. Irrespective of group status, participants viewed the fictional target in similar ways. Consistent with other research, this finding provides further reason to question the view that minority ethnic group status, or social group status more generally, is a reliable predictor of psychiatric stigma (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley & Kola, 2005).

Although it is widely held that Maori and non-Maori have disparate concepts of mental illness, our findings provide evidence to the contrary, consistent with previous research (Marie, Forsyth, & Miles,

2004). That is, the pervasive notion underpinning a wide range of New Zealand health policy and literature is that Maori perceive mental health issues holistically while non-Maori are presumed to hold more individualistic views of mental health phenomena (Ministry of Health, 2000, 2001a, 2001b, 2002a). Given the ubiquity with which this view is perpetuated we would have anticipated such a conceptual divergence to be reflected in participants' responses.

Clearly, health promotion and intervention efforts in the field of mental health need to target vulnerable and hard-to-reach populations (Corrigan et al. 1999). Often it is the case that minority status groups are unduly over-represented in these populations and, concomitantly, members also frequently experience an unacceptable level of burden related to psychological disorders and disease. In New Zealand, Maori represent such a group. Currently, Maori comprise just 15% of the New Zealand population and yet are over-represented in mental health and disability indices and experience a disproportionate burden of disease when compared with other New Zealanders (Statistics New Zealand, 2002; Ministry of Health, 2002b). With specific regard to depression, a recent study involving randomly selected patients attending New Zealand general practitioners found that Maori are three times more likely to be experiencing a diagnosable depressive disorder when compared with non-Maori. (The MaGPIe Research Group, 2005). Another study that involved surveying mental health consumers' experiences of stigma and discrimination reported that Maori experienced discrimination in all areas and from a wide range of people, but more commonly from their families and friends (Mental Health Foundation, 2004).

For mental health interventions to be effective it is therefore necessary that programmes are informed by reliable evidence about the populations to which they refer and are directed toward (Sarbin & Mancuso, 1970; Day, Pennebaker, & Anderson, 2001; Pill, Prior & Wood, 2001). In view of this requirement and in the context of the results presented, the question

Table 2: Summary of main findings from the three dependent measures

	Maori (n=90)	Non-Maori (n=115)	Total (n=205)
<i>Problem Identification</i> (frequency)			
Identification of depression	65 (72%)	92 (80%)	157 (77%)
No identification of depression	25 (28%)	23 (20%)	48 (23%)
<i>Wellbeing</i> (mean score)	6.33	6.11	6.23
<i>Social distance</i> (mean score)*	3.99	4.00	3.99

*The social distance score is the mean score of all eleven relationships

can be raised as to whether the current received formulation of disparate views being held by Maori and non-Maori with respect to mental illness and stigma is realistic relative to meeting the needs of Maori. This question becomes particularly pertinent when set against the over-representation of Maori with depression.

There are a number of limitations to this study. First, our research employed a survey methodology to elicit data from participants. The limitations of survey methodology have been widely reported within the psychological and health sciences literature (Fihn, 2000; Wilson & While, 1998). Of major concern is the quality of data procured through self report, a method that is potentially open to confounding influences, of which the investigators have no control. While we acknowledge this limitation, we suggest that this method serves as a useful tool to extract lay understandings of mental health phenomena, the findings of, which, can be used to test current theories and conceptions. This limitation could be best addressed by undertaking research using alternative methods that do not rely on self report or conducting studies using multiple methods from which more detailed analyses could be undertaken.

A second possible criticism of this study involves our use of New Zealand's electoral rolls to recruit participants. It could be argued that New Zealand's electoral rolls do not generally reflect the diversity among Maori and that our sample might exhibit some form of bias. However, in the context of our research it is important to consider in which direction this possible form of bias might be expressed. If it is believed that individuals enrolled on the Maori electoral roll are more strongly affiliated to Maori culture and therefore less influenced by mainstream values and social norms including a so-called Western view of mental health, then we would have anticipated that any bias expressed would have gone in the opposite direction of the results reported here. It should be noted that we know of no empirical evidence that identifies specific characteristics of individual Maori who enrol on either the Maori or General electoral roll. In fact, there is consistent and considerable interchange

between rolls every six years when Maori are given the opportunity to switch rolls. Furthermore, we know of no compelling evidence that clearly identifies the reasons why individual Maori change rolls and can only assume that individuals do so for a myriad of personal and political reasons, none of which were the focus of this research. Although some might argue that our findings support the notion that Maori have become increasingly acculturated or assimilated into the dominant status group's views of health, such a perspective at this point remains purely speculative and awaits further research. By randomly selecting our participants from both electoral rolls and including a screening question at recruitment about their ethnic identification, we are confident that our sample was free of any systematic bias.

A third limitation of this study is that our response rate while comparable to a related study (*see* Jorm et al. 2000) was still reasonably low. Although improved response rates in future investigations on this subject would be commended, an important caveat regarding this limitation requires explication. Ethnicity is the principal construct upon which the received view of Maori and non-Maori holding divergent conceptions of mental health is hinged. Even though this received view can be regarded as a population or group level claim, it is through its dependence on the construct of ethnicity, also a claim directed at the level of the individual. Given that this is the case, it should not matter which individual members of each respective population are sampled or how many, as any member should reflect the view of health proscribed to that group. It should also be noted that we intentionally over sampled Maori participants for this research. Future research in this field however, would ideally involve broadening the geographic regions from which participants are recruited. Recruitment of Maori participants for our study was limited to Wellington and the South Island and it is possible that different geographic regions may produce different results. Prospective researchers in this area might also want to consider whether degree of affiliation to formal Maori contexts such as marae and schools of learning influences

perceptions of mental health. Moreover, the results presented here are limited to reporting perceptions held about depression and it is plausible that other psychological conditions could produce different results.

With these limitations in mind, we suggest that a more pragmatic approach to mental health promotion targeting Maori would involve ensuring that intervention efforts, including public health campaigns, were informed by empirically-derived and empirically-validated evidence. Such an approach would openly examine the veracity of the received view of how Maori conceptualise and respond to mental health phenomena. An underlying objective of this approach would be to distinguish between claims of an ideological kind and claims of an empirical kind. The rationale for this objective is that respectively, these sets of claims emerge from different commitments and often serve incongruent purposes (Bunge, 1996). We suggest that for the purpose of addressing mental health issues of relevance to Maori, the preferred set of claims are of the empirical kind, which would enable a foundation of evidence to be formed and fostered. As recent work undertaken in Australia has shown, enhancing the public's exposure to reliable information about depression can lead to greater awareness of the disorder by community members (Jorm, Christensen & Griffiths, 2006; Highet, Luscombe, Davenport, Burns & Hickie, 2006). Critically, improvements in public awareness of depression can lead to earlier identification of symptoms associated with psychological problems and therefore increase the likelihood of individuals engaging in positive help-seeking strategies to address such problems.

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