

opportunities to pursue interests and projects and ongoing professional development is very much part of that.

The profession of educational psychology works from a strengths based model, is holistic and psychologists generally work with the adults in children's lives as the key people to ensure positive change. Educational psychologists keep up to date with the literature and evidence based practice and view 'problems' as fluid and not resting within the individual. This positioning engenders hope for change to occur.

The role in New Zealand can be quite diverse and educational psychologists from New Zealand are well regarded in other countries for their flexibility, innovation and the lens they bring to work.

Thanks Val – this seems like such a varied and interesting role you have!

Seeking Wellbeing for Māori Women with

Parewahaika Harris, Waikaremoana Waitoki & Linda Waimarie Nikora

Māori and Psychology Research Unit, University of Waikato



Name: Parewahaika Erenora Te Korowhiti Harris (Pare)

Tribal Affiliations: Te Arawa, Ngāti Whakaue

Achievements: BSocSci (2011); BSocSci with First Class Honours (2012); MSocSci with First Class Honours (2014; Thesis title - Wāhine whāiora: Māori women's experiences of bipolar disorder and their pathways to recovery)

Study Programme: Postgraduate Diploma in Psychology (Clinical), Second year

Associations: Student cultural representative (Institute of Clinical Psychology/ICP); Rangatahi advisor (Henry Rongomau Bennett Advisory Group, Te Rau Matatini); Student member (ICP, NZPsS & Te Waiora o Waikato/ Waikato University Māori Student Association)

Tēnā koutou. Ko Ngongotaha te maunga, ko Te Arawa te waka, ko te Rotorua-nui-a-Kahumatamomoe te awa, ko Te Arawa te iwi, ko Ngāti Whakaue te hapū, ko Te Papaouru te marae, ko Tamatekapua te tipuna, ā, ko Parewahaika tōku ingoa.

My name is Parewahaika (Pare), and I grew up in Rotorua surrounded by whānau and immersed in Māori culture. I am a fluent Te Reo speaker and a proud kapahaka performer. I have recently completed my Master's thesis, and am currently working towards my Postgraduate Diploma in Clinical Psychology (currently in my second of three years). My Master's project was conducted alongside the Māori and Psychology Research Unit (MPRU) under the supervision of Dr Waikaremoana Waitoki and Associate Professor Linda Nikora. The aim of my research was to recognise and appreciate the lived experiences of wāhine Māori with Bipolar Disorder, while also aiming to identify and understand help-seeking patterns and stories of recovery and wellbeing.

Abstract

It is important to understand the complex social issues that Māori women with a diagnosis of bipolar disorder face and why they are overrepresented in mental health statistics. This research explored the lived experiences of 11 women who live well in the presence of bipolar disorder by placing a specific focus on help-seeking patterns and stories of recovery and wellness. Through an exploration of the unique intergenerational experiences of Māori women, themes of recovery and wellness emerged that they used to maintain wellness. This article illustrates some of the life experiences of wāhine including the factors that led to a diagnosis of bipolar disorder, followed by a description of the pathways wāhine chose to achieve and maintain wellness for them and their whānau.

Bipolar Disorder: Creativity and Art

Introduction

While Māori are known to experience a higher burden of mental health problems compared to non-Māori (Baxter, 2008; Baxter, Kingi, Tapsell, Durie, & McGee, 2006; Beautrais & Fergusson, 2006; Durie, 1999; Tapsell & Mellso, 2007), little exploratory research has been conducted into the actual experiences of Māori with bipolar affective disorder (Barnett & Lapsley, 2006; Lapsley, Nikora, & Black, 2002; Mental Health Commission, 2000; Robertson et al., 2013), and even more specifically, Māori women. Our research builds on the Te Rau Hinengaro New Zealand Mental Health Survey (Oakley-Browne, Wells, & Scott, 2006) by providing a qualitative exploration of the life experiences of wāhine Māori who are living well with bipolar disorder, and their stories of recovery and wellbeing. The aim of this research was to contribute to the realisation of Māori potential by explicitly shifting from deficit-focussed frameworks to a focus on systemic factors that influenced Māori wellbeing.

...I had all of these terrible things happen in my childhood. It would have been a miracle if I hadn't ended up with bipolar or a mental illness (Niwareka).

The comment above reflects a feature of bipolar affective disorder where it is not always known whether situations within a person's life act as triggers to an existing biological vulnerability or whether the symptoms are normal reactions to intensely distressing life events. In either case there is a clear need to provide appropriate and timely supports to ensure that Māori live in ways defined as important to them.

Within the mental health system, Māori experience significant and unnecessary disparities in outcome compared to non-Māori. Since 2006 diagnoses of mental health disorders for Māori have increased (Māori Ora Associates, 2006; Ministry of Health, 2012; Waikato District Health Board, 2008). There are significant inequalities among the various ethnic groups in New Zealand, particularly for those who come from lower socio-economic groups. Māori feature disproportionately across all health statistics and experience the highest rates of health disorders among ethnic groups in New Zealand (Baxter, 2008; Māori Ora Associates, 2006; Neilson-Hornblow, 2009; Oakley-Browne et al., 2006). Baxter (2008) concluded that significant unmet mental health needs exist among Māori, reflecting differences in: access at a primary

care level, diagnostic practices and referral to secondary care.

Bipolar Disorder

One of the purposes of this study was to identify why Māori have high rates of bipolar disorder, therefore a description of bipolar disorder and the subtypes is warranted. In considering the characteristics of bipolar disorder the presenting features overlap markedly in disorders such as substance abuse, anxiety, depression, schizophrenia, personality disorders and trauma. Bipolar onset tends to occur around 19-21 years of age, when individuals seek independence (Jones & Tarrrier, 2005). Early-age of onset (prior to age 17) is associated with a more severe course and poorer outcomes (Waikato District Health Board, 2008).

Bipolar disorder is a mood-related disorder producing extreme contrasts both in mood (hypomanic/manic euphoria and irritability vs. depression) and in functioning (Urosevic, Abramson, Harmon-Jones, & Alloy, 2008). The disorder impacts on emotional regulation producing affective highs and lows with some states combining feelings of mania, depression and other moods or emotions concurrently (Gruber, Eidelman, Johnson, Smith, & Harvey, 2011; Power, 2005). The description of bipolar disorder has changed with the new Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-V) released by the American Psychiatric Association in 2013 (American Psychiatric Association, 2013). However, this study was conducted prior to 2013 and the previous version of the manual has been used (DSM-IV) (American Psychiatric Association, 2000).

Within the mental health system, Māori experience significant and unnecessary disparities in outcome compared to non-Māori.

Bipolar disorder (also known as manic-depressive illness) is a prevalent, chronic, serious and complex psychiatric disorder that is particularly difficult to treat and is often misdiagnosed or underdiagnosed, often going unseen for many years (Montoya et al., 2010; Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Bipolar Disorder, 2004). Around two-thirds of individuals diagnosed with bipolar disorder experience delusions which often accounts for misdiagnosis of schizophrenia (Cosgrove & Suppes, 2013). Delusions

and grandiosity are also common in substance abuse disorders (Knowles, McCarthy-Jones, & Rowse, 2011). The implication here is that care is needed when individuals present to health services with psychotic or manic features and are also under the influence of substances.

Findings

The key findings of this study highlighted pathways into mental illness that could have been avoided earlier. The life-span approach to this study highlights how unmet needs impacted on wāhine to the extent that psychological issues were perpetuated from childhood into adulthood and on into the next generation.

Origins of illness in the past

Exposure to varying levels of childhood adversity, such as sexual and physical violence, parental mental illness and abandonment issues, led to post-traumatic stress, substance abuse, poor relationship choices, depression, anxiety and safety issues for these wāhine. Niwareka described a life of foster care, neglect, and sexual and physical abuse which was not addressed despite being involved in child protection services since she was 2 years-old, and the mental health system as an adult. She experienced hardship and stress for almost her entire life.

My first suicide attempt was at age 14, my second attempt was at 23, and my third was somewhere into my 30s. Each time I was just put in hospital and then sent home. I was never ever sent to a psychologist for help (Niwareka).

Across the study, wāhine experienced unstable and inadequate living conditions, difficulties in attaining and maintaining employment, poverty, and low education. The majority of wāhine

were often powerless and vulnerable in their intimate relationships and during pregnancy and childbirth. Wāhine lived in fear of losing their children, had their children taken from them, or they were told not to have children by health professionals. Each of those wāhine described a deep sense of loss or trauma about not being able to raise their own children, or contact their grandchildren. The consequences of losing a child, or being the child who was removed, signifies a serious gap in support systems for parents with mental illness.

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Onset of the illness

The level of unmet need for many participants created a landscape of hardship and adversity that was barely tolerable. Wāhine became unwell when their right to self-determination was compromised in any way, or when their support systems were fragmented. For example Tania started seeing a psychologist when her children were taken from her by the Child, Youth and Family Services (CYFS). Her mother and sister notified CYFS after they learned that she was living in a bus in a motor camp.

I was finally diagnosed with bipolar and by that time CYFS had taken my children. We were left at home by ourselves as children, all six of us; yet my mother was quick to judge me and call CYFS to report me. My family all knew that I had been diagnosed with bipolar but they never told my sister. She [Tania's mother] told CYFS that the whole family had tried to support

me and help me with my living situation, but that wasn't true at all (Tania).

A significant finding was that wāhine lacked support to be mothers, and faced a constant risk that they would lose their tamariki. Some wāhine described how they struggled to be mothers, while others had their tamariki taken from their care and were unable to see them again.

At times, due to the repeated and severe nature of multiple stressors, wāhine reached breaking point, causing them to react out of character. Some of the significant events that precipitated mental illness included abusive or unstable relationships, relationship break-ups, drug and alcohol abuse, childbirth, the death of a loved one, employment, and study.

In many cases, the reaction of wāhine to stressful events were used to confirm the presence of bipolar disorder, which shifted the focus from external factors to biological causes. All wāhine spoke of very little talk therapy and a heavy reliance on medication.

The difference between people who don't live well with bipolar and those who do is that they're in residential care and they're over-medicated and under-talked... Without the talking there's no healing, and medication only numbs it (Tania).

The evidence for the accuracy of a bipolar disorder diagnosis was unclear as the stories showed considerable pre-existing mental health concerns and situational stressors that were left unaddressed.

Pathways to Recovery

The journey towards recovery for wāhine emphasised the pivotal role played by whānau and social supports. Wāhine defined what they thought wellness looked like to them in the

context of their own lives. Consistent with the recovery literature, wellness was not just the absence of mental illness, but more so the ability to live normal and fulfilling lives (Dyall et al., 1999; Lapsley et al., 2002; Mental Health Commission, 1998; Provencher & Keyes, 2011). Wāhine wanted to have trusting and nurturing relationships with whānau and intimate partners, to be employed and to have support from employers, to keep busy and contribute in some way to their communities, to live in stable accommodation, and to reconnect and remain connected with friends and whānau. Strong whānau connections were associated with faster recovery and longer periods between relapse for these wāhine.

Tamariki as a source of wellness

Wāhine consistently spoke of their tamariki as pivotal to their wellness and recovery. However, when wāhine were unwell, they needed support to keep their tamariki safe and secure, to continue with school, and to provide appropriate information about parental mental illness. When wāhine were well, they needed to have their tamariki returned to them and appropriate supports put in place. These findings are consistent with whānau ora literature and research outlining the importance of support for parents with mental illness (Durie, Cooper, Grennell, Snively, & Tuaine, 2010; Ihimaera, 2007; Robertson et al., 2013). This quote highlights the lack of support from external agencies:

CYFS was around me a lot when I was unwell in the early days... The father was really abusive and it kept making me unwell and I was making bad judgments. CYFS were constantly threatening to take the baby away. I fought that, I didn't want to lose my baby. I dug deep within myself. They weren't supportive. They policed me and my whānau. They didn't say which organisations could help (Tina).

The importance of keeping whānau together was evident. Although at times, tamariki and whānau were seen as stressors, they were also seen as protective factors, as wāhine tried to improve their personal wellbeing to benefit their whānau.

Creativity and Art

Creative pursuits were featured in almost all of the narratives. Some Māori leisure pursuits that have been used to good effect in healing practices include painting, flax weaving, wood and bone carving, singing and playing musical instruments (Kingi, 2005). In this regard, occupational therapy activities become more relevant when Māori crafts are introduced. Similarly, when it is difficult for tangata whai ora to converse with words, non-verbal cultural activities can produce a “greater sense of effective

communication” (Kingi, 2005, p. 15).

One wāhine in particular found comfort in traditional Māori healing practices and tikanga such as whakawhanaungatanga and weaving. Before Pua became unwell she was studying full-time at University, studying full-time at the wānanga, working full-time at a Kōhanga Reo (child-care) and also working on releasing her own music album. After she was diagnosed with bipolar disorder, the university would not allow her to go back until she was “*completely in the right place*”, however the wānanga allowed her to continue her Bachelor of Māori Visual Arts from home.

Wāhine consistently spoke of their tamariki as pivotal to their wellness and recovery.

During her low periods, Pua described the wānanga as an environment that supported her recovery and her rehabilitation, and said that the ability of others to listen to her was also greatly valued.

Pua continued on with her Bachelor of Māori Visual Arts and managed to complete her degree within the allocated four years. Over time, the work she produced through weaving demonstrated her healing process:

“In the year I was diagnosed I made a hieke, like a rain cape out of corn husk, and I died them all black, called one te pango o te pō because I was in that kind of state. And then the year after that I made a contemporary korowai out of rainbow emu feathers all different colours, and I called that te uenuku harikoa. Quite a bit of a transition, through that process I did heal, creating things”

Pua's wellbeing was also enhanced through singing and song writing.

Wellness for wāhine was also about having a sense of self and knowing exactly what they enjoy and what makes them happy. When Tania became unwell, her sister encouraged her to find a hobby and taught her how to make jewellery. This soon became a passion of hers and she explained that she enjoys keeping busy and hasn't stopped making jewellery since.

Huia's wellbeing was enhanced by the excitement of having her own home and creating a Māori atmosphere full of Māori designs – which for her, was about reclaiming her identity as Māori. Awhi also engaged in many creative pursuits mainly artwork and painting. She explained that getting creative with artwork, painting or gardening kept

her mind from dwelling on negative thoughts or moods. She enjoyed creating art with broken discs, and explained that people also purchased some of her paintings which made her happy.

There is very little research conducted on how fostering and preserving creative and productive traits can enhance and improve outcomes for individuals with bipolar disorder (Galvez, Thommi, & Ghaemi, 2011; Murray & Johnson, 2010), however for the wāhine involved in this study, such activities were very beneficial throughout their wellness journeys. Being able to engage in meaningful activities provided wāhine with a sense of purpose, hope, and a positive view of life.

Wellness strategies for wāhine also included being able to study, be employed, maintain a household, exercise and eat well, and to look after their tamariki, mokopuna, and whānau, which are all consistent with the recovery literature (Dyall et al., 1999; Mental Health Commission, 2001; Robertson et al., 2013).

Conclusion

This study reinforces the importance of understanding Māori mental health needs from a broader systemic perspective, while also recognising the potential factors placing wāhine at greater risk of developing mental health and addiction issues (such as poverty, inadequate housing, unemployment, and low education).

The overall finding from this research points to the urgency to provide additional support to strengthen wāhine and their families throughout their lifespan. When external and internal factors to achieving wellness were optimal, wāhine were more productive in their lives enabling them to reconnect with and enjoy their family and personal relationships. The

external factors that contributed to, and maintained wellness for wāhine were access to stable and appropriate medication, access to prevention and early intervention services, access to information, access to psychological therapy, treatment for co-existing mental illness, access to kaupapa Māori services, and being productive, creative, and able to contribute in meaningful ways.

Improving Māori mental health and reducing inequalities cannot be achieved by health services alone while social and economic factors such as employment, housing and poverty continue to impact on mental health, wellbeing and recovery (Cram, 2011; Durie, 1999; Kingi, 2011). Also, inequity in access to health services across the life-span prevents the full realisation of wellbeing for Māori (Mental Health Commission, 2012), creating cycles of disparity.

The overall finding from this research points to the urgency to provide additional support to strengthen wāhine and their families throughout their lifespan.

It is important that all policy directives emphasise the importance of whānau receiving timely, high quality, effective and culturally appropriate services (Mental Health Commission, 2004). This approach recognises the whānau as the principal source of connection, strength, support, security and identity, and that each person within that whānau is central to the wellbeing of Māori individually and collectively.

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STUDENT HQ - student page on our website

STUDENT HQ has lots of interesting information. Not only about joining the Society as a student subscriber and listing all the benefits this entails, but also information about the different careers in psychology and links to other sites, such as access to webinars on different pathways in psychology; e.g. health, counselling and coaching psychology; "Selfcare for students", "Lifehack", "Tuning in to Psychology: Free Lectures through iTunes University", "Simply Psychology" and other research sites.

The site also has a link to the new **Facebook** page for graduate students of psychology in Aotearoa administered by Kathryn Jenner, the student editor of *Psychology Aotearoa*.

The screenshot shows the 'Student HQ' page of the New Zealand Psychological Society. The page is designed with a clean, professional layout. At the top, there is a navigation menu with options like 'About NZPS', 'Membership', 'Ngā Kaiti', 'PD & Events', 'Study & Careers', 'Publications & Media', 'Community', and 'Members Only'. The main content area is titled 'Student HQ' and includes a sub-header 'The NZPS welcomes post-graduate students in psychology and psychology interns as student subscribers of the NZPS.' Below this, there is a list of benefits for joining as a student subscriber, such as reduced rates at the Society's Annual Conference, access to prizes and scholarships, and a professional network of peers. The page also features a sidebar with links to 'Apply for Membership', 'Working as a Psychologist', 'Overseas Psychologists', 'Psychologist Vacancies', and 'Useful Links'. At the bottom, there is a section for 'Events' and 'Latest News' with a 'View all' button.