Decolonising Mental Health through an Indigenous Māori Lens

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Abstract

Māori is a collective term for the Indigenous peoples of Aotearoa (New Zealand) (Jaguar Bird, 2018). Even today there is a significant impact of colonisation and ongoing institutional racism on Māori mental health in Aotearoa (New Zealand) which leads to substantial mental health disparities faced by Māori. The Western paradigm, characterised by a dominant biomedical model and deficit-based approaches, often overlooks the cultural, historical, spiritual, and social contexts essential to Indigenous well-being. This literature review examines the inadequacies of the Western mental health paradigm for Indigenous peoples and addresses the question: Why is the Western mental health paradigm ineffective for Indigenous peoples, and what can be done about it? The review highlights the impact of colonisation and ongoing institutional racism on Māori mental health, critiquing the limitations of monocultural methods in addressing trauma. It explores decolonising methodologies, Māori mental health models, and traditional Māori healing practices as viable tools to create more equity in Mental Health Care. The study implies that effective mental health treatment must be part of a broader decolonisation effort addressing the root causes of health disparities such as historical collective trauma and institutionalised racism and advocates for a shift towards a well-being paradigm rooted in Te Ao (Māori culture). Future research should focus on Indigenous models within a decolonisation framework while acknowledging the right to self-determination and thus the need to fund research that is by Māori, for Māori.

Keywords: Māori, Indigenous, decolonisation, traditional healing, colonialism

Disclaimer

Growing up in Germany and Spain I identify as a white person, and recognise I have been influenced strongly by a Western cultural lens. While on a study exchange in Aotearoa in 2023, I spent time there with Māori friends, supervisors, and teachers. In writing this thesis I aim to represent Māori knowledge in my respective field of psychology and to reciprocate the assistance of being educated about the disastrous effects of colonization and post-colonial societal structures, especially, on the mental health of Māori and effective Māori ways of healing. Having that said, I do not speak for all Māori and want to highlight that some Māori might disagree with me. My Western upbringing and education biases me and I acknowledge this reality.

No content generated by AI technologies has been presented as my own work. I acknowledge that I utilized AI tools, such as ChatGPT (OpenAI, 2023) for assistance in improving my writing (e.g. spelling), however, ChatGPT (OpenAI, 2023) was not used to generate content, to ensure originality. I acknowledge the use of ChatGPT (OpenAI, 2023) to give me feedback on clarity, and to check whether my intended arguments came across well, while explicitly asking not to rewrite my texts for me.

I am dedicating this work to Sija, Akshika and all the Māori who became my friends and mentors and supported me with all their love throughout my stay in Aotearoa (New Zealand), including Teena, Moana, Edmond, Logan, Cheri, Atarangi and the ones who are remaining unnamed. They have enriched my life in beautiful ways and opened up their culture to me, which is one of the greatest privileges of my life. Tēnei te mihi nui ki a koutou mō tō koutou manaakitanga me tō koutou aroha. Mauri ora ki a tātou katoa!

I also want to highlight the existence of podcast episodes that I produced in connection with this thesis in which I discuss many of the topics of this review with Māori scholars and practitioners. It can be found under Keller Muñoz (2024) in the reference list.

Glossary (Disclaimer: highly simplified)

Haka

Traditional posture dances or war dances are used to express and convey emotions, tell stories, and connect with cultural heritage.

Hapū

A sub-tribe or clan within Māori society, typically consisting of several extended families that share common ancestry and genealogical ties.

Iwi

A tribe or a large social unit in Māori society, composed of multiple hapū (sub-tribes) that trace their descent from a common ancestor.

Karakia

Prayers or incantations that are integral to healing practices, connecting individuals to their spirituality, land, ancestors, and deities.

Mātauranga Māori

Māori knowledge encompassing the body of knowledge originating from Māori ancestors, including worldviews, perspectives, creativity, and cultural practices. It is a unique cultural lens on the world, incorporating both visible and invisible aspects of the universe.

Mirimiri

A traditional Māori bodywork practice, roughly comparable to massage or physiotherapy with spiritual and possible talking components used as part of holistic healing.

Mōteatea

Traditional laments or chants that are an integral part of Māori oral traditions, often used to convey history, genealogy, and cultural values.

Pūrākau

Traditional stories or narratives that serve to pass down knowledge, values, and cultural teachings through generations.

Rangatiratanga

Political self-determination and autonomy. Historically denied by colonial governments, it is considered a crucial element for Māori health and well-being.

Raranga

Traditional weaving, which is a cultural practice that helps cultivate Mauri Ora (well-being) and connect individuals with their heritage.

Ritenga

Incantations and rituals involved with healing, forming part of the broader practice of Rongoā Māori.

Romiromi

A traditional Māori bodywork technique similar to deep tissue massage used to promote physical and spiritual healing.

Rongoā

Physical remedies derived from natural sources such as trees, leaves, berries, fruits, bark, and moss, used in traditional Māori healing practices.

Te Reo Māori

The Māori language, which is considered vital for Māori well-being. Learning and using Te Reo is emphasized as a means to deepen understanding of Mātauranga Māori and tikanga.

Tikanga

Māori customs, traditions, and behavioral guidelines that embed fundamental values. It plays a vital role in maintaining balance and addressing imbalances from trauma.

Tohu

Signs, omens, marks, or directions that provide guidance and indications. Tohu is a body of knowledge requiring attentiveness to the environment, people, language, memory, and spiritual elements.

Tohunga

A revered expert or specialist in Māori culture, traditionally responsible for spiritual, medicinal, or educational guidance. Tohunga possess deep knowledge in areas such as healing, carving, weaving, or ritual practices, and play a crucial role in maintaining and passing on Māori customs and wisdom.

Wai

The use of water in healing practices, reflecting the holistic nature of Rongoā Māori.

Wairuatanga

Spirituality, considered an integral part of health and well-being, alongside physical, mental, and social aspects.

Waiata

Songs that are part of Māori oral traditions, used to convey cultural values, history, and emotions.

Whakapapa

Genealogy or lineage, which is crucial for understanding one's place within the Māori community and maintaining cultural continuity.

Whānau

Extended family, which is the foundation of Māori society. Whānau connections are essential for individual and collective well-being.

Whanaungatanga

The relational nature of Māori society, emphasising the importance of relationships and kinship ties in health and well-being.

Decolonising Mental Health through Indigenous Approaches

"The answers are within ourselves".

-(First Nations declaration, Pihama & Smith, 2023, p. 14)

The inadequacies of the Western mental health paradigm for Indigenous peoples have become increasingly apparent in the last decades (Government Inquiry into Mental Health & Addiction, 2018). This thesis uses the term Western Mental Health Paradigm as an umbrella term to encompass the dominant mainstream system consisting of Western psychiatry and clinical psychology, characterised by the dominance of the biomedical model (Deacon, 2013) and leading deficit-based approaches that utilise diagnostic tools and classification methods rooted in the Anglo-European/American Western scientific method and evidence-based treatments stemming from scientific institutions (King et al., 2017; Government Inquiry into Mental Health & Addiction, 2018). This dominant approach often fails to address the cultural, historical, spiritual, and socio-political contexts crucial to the well-being of Indigenous communities (Durie, 1994; Kirmayer, 2001; Samson, 2009).

This literature review aims to answer the following question: Why is the Western mental health paradigm so ineffective for Indigenous peoples, and how can it be improved? To do so, it examines the mental health disparities for Māori in Aotearoa (New Zealand) and explores the structural issues within the Western mental health paradigm stemming from colonisation and ongoing institutional inequities, including racism (Waitangi Tribunal, 2023; Pihama & Smith, 2022). I found parts of the literature through recommendations by Māori scholars and researchers throughout my study exchange at the University of Waikato in New Zealand. I then looked for related literature in the references and I searched for specific topics such as Kaupapa Māori, Rongoā, and Māori Mental Health models, mainly on Google Scholar. The review then presents possible solutions to these structures, such as decolonising

methodologies, Māori Mental Health models, and Māori Indigenous knowledge, worldviews, and healing practices (Durie, 1999; Wirihana & Smith, 2014). Through that, it aims to show pathways towards more culturally appropriate and effective mental health care for Māori by outlining the challenges of Western models and the potential of Māori methodologies. The review is structured to first contextualise the health and social inequalities faced by Māori, followed by a critique of Western mental health approaches and research from an Indigenous perspective, and concludes with an exploration of the potential of decolonising Māori mental health models and traditional Māori knowledge (Taitimu et al., 2018; Kopua et al., 2019).

The Health and Social Inequality of Māori in New Zealand

The structural inequality towards Māori, the Indigenous Peoples of Aotearoa (New Zealand) in the health care system is presented by the Waitangi Tribunal (2023). It is a permanent commission of inquiry in New Zealand which investigates claims brought by Māori relating to actions of the Crown that breach the promises made in Te Tiriti o Waitangi (Treaty of Waitangi), which is the foundational document of New Zealand between representatives of the British Crown and various Māori chiefs. The Tribunal has emphasised that governments have consistently failed to address Māori health needs adequately and found “broad inequities across the health sector; failure in policy and legislation that underpin consistent breaches of Te Tiriti o Waitangi (Treaty of Waitangi) obligation; inadequate resourcing of Māori health services; significant evidence of Māori health disparities; institutional and systemic racism; and inadequate support for culturally appropriate services and service provision”(Pihama & Smith, 2022, pp. 43-44). The Government Inquiry into Mental Health & Addiction (2018, p. 40) argues in line with this that the mainstream system represents a “colonising worldview largely hostile to Māori understandings of wellbeing”.

This inequity originates within the process of colonisation for Indigenous peoples and Māori in particular as the Indigenous peoples of New Zealand which is marked by violence through colonial forces, ethnocide and genocide (Stanley, 2002), extreme depopulation (Durie, 1997), the loss of lands, language, social structures (Koea, 2008, Smith, 2022; Waretini-Karena, 2013) and positive identity (Paradies et al., 2008). The ongoing intergenerational reproduction of inequality and disparities in particular (Harris et al., 2006; Robson & Harris, 2007) such as poverty, severe health issues, lack of opportunities in education and the work environment has profoundly impacted Māori and other Indigenous communities to their detriment (Durie, 1994; Jackson, 1992). Today, Māori face significant disparities across various health and social indicators (New Zealand Ministry of Health, 2013, 2023, Harris, 2006; Robson & Harris, 2007). The life expectancy of Māori falls well short of the general population, with Māori representing 16.5% of the under-65 age group but only 5.6% of those aged 65 and over (Statistics New Zealand, 2013). Māori are also associated with significantly higher rates of serious mental illness compared to non-Māori, the prevalence of mental distress among Māori is almost 50% higher than among non-Māori while Māori are 30% more likely than other ethnic groups to have their mental illness undiagnosed (Cunningham et al., 2018). Overall, 51% of Māori experience a mental disorder during their lifetime. On a closer look anxiety, substance abuse, and mood disorders are among the most common conditions reported (Baxter et al., 2006), with Māori being 1.7 times more likely than non-Māori to be hazardous drinkers, a prevalence of schizophrenia almost 3 times that of non-Māori (Kake, Arnold, and Ellis 2008), 1.2 times more likely to report a diagnosis of anxiety disorder as non-Māori, twice as likely to have been diagnosed with Bipolar Disorder as the general population (Cunningham et al., 2018), and increased rates of suicidality with 15.9 for Māori and 10.1 for Pākehā (descendants of white European settlers) per hundred thousand people and suicide attempts (Mental Health Foundation, 2023;

New Zealand Ministry of Health, 2012). Additionally, the outcomes for Māori who access mental health services are poorer across a variety of measures and diagnoses (Cunningham et al., 2018).

Challenges of the Western Mental Health Paradigm from an Indigenous Perspective

Indigenous communities across the world are grappling with the challenges of reclaiming a positive identity following centuries of colonial oppression and genocide (Gracey & King, 2009; Paradies, 2016) and face disproportionately high morbidity, mortality, and mental illness rates (Cunningham et al., 2018; Statistics New Zealand, 2013). Western-based approaches to addressing these challenges often neglect the spiritual and cultural dimensions of the Indigenous experience and medicalise or psychologise the categorisation of such suffering (Gone, 2008), which often may worsen the situation (Higgenbotham & Marsella, 1988). Many scholars, practitioners, and activists believe that Western psychiatry is poorly equipped to effectively address the psychological and social complexities emerging within Indigenous societies (Kopua et al., 2019) because of many unacknowledged cultural assumptions (Bracken et al., 2016; Foucault, 1972). Crucially, the evidence reveals that the Western Mental Health Paradigm can cause a prejudicial mindset towards various groups, neglecting critical factors such as ethnicity, sexuality, gender, socioeconomic status, spirituality, and the vast traditional and modern resources of Māori culture (Government Inquiry into Mental Health & Addiction, 2018; Johnstone & Boyle, 2018; Russell et al., 2020) that I am presenting later on. This growing counter-discourse expresses concerns regarding the integration of Western psychiatry across diverse communities worldwide, questions the benefits of Western psychiatry, and calls for caution regarding the unbalanced nature of having an “experts” and “patients” dichotomy (Bracken et al., 2016; Fernando, 2014; Mills, 2014; White & Sashidharan, 2014; Bracken & Thomas, 2017). Indigenous scholars stress the urgent need for heightened awareness of the scientific limitations

(Gøtzsche, 2015) and ethical corruption (Whitaker & Cosgrove, 2015) inherent in much of Western psychiatry, and the over-dependence on psychiatric medications whose serious physical and psychological side effects are simultaneously being played down (Cromby et al., 2013). Moreover, this critique highlights the rich diversity of healing traditions in various communities globally and warns against the potential suppression of these traditions due to the widespread adoption of Western psychiatric practices as this phenomenon could diminish the therapeutic options available to these communities (Sood, 2016). According to advocates of this counter-discourse, there is a need for less emphasis on psychiatry and greater recognition of the inherent wisdom within Indigenous knowledge and healing traditions (Kopua et al., 2019).

During the process of colonization, Indigenous healing systems frequently faced suppression and prohibition, leading to the decline of public Indigenous cultural practices and the outlawing of such practices by colonial institutions (NiaNia et al., 2017, Kirmayer, 2012), such as through the enactment of the Tohunga Suppression Act in 1907. This legislation explicitly outlawed traditional health interventions and rituals, leading to the prosecution of many practitioners (Kopua et al., 2019). Western medicine and its institutions often played a complicit role in these processes of colonisation and genocide in Indigenous communities (Hunter, 2001; Verma, 1995; Naidu, 2021; Amster, 2022).

These institutional structures still cause significant economic, cultural, and spiritual struggles, leading to heightened levels of distress, addiction, and dislocation. While conventional discourse often frames these issues within the context of "mental illness" and employs diagnostic terms the narrow focus of psychiatry fails to capture the collective struggles experienced by entire communities such as colonisation, displacement of refugees, etc. (Sangalang & Vang, 2017; Cho, 2023; Wirihana & Smith, 2014). This individualised approach can obscure the broader social, cultural, and economic factors (Samson, 2009;

Kirmayer, 2001), unresponsive services, and experiences of social injustice (Mental Health Commission, 1998).

This is additionally highlighted by evidence showing that the Western Mental Health paradigm is not effective for many Indigenous peoples, including Māori (Taitimu et al., 2018; Cohen, 2014, Durie, 1999a) and has contributed to the harm experienced by Māori communities due to colonialism through pathologising Māori individuals, depicting them as excessively vulnerable to "mental illness" (Cohen, 2014). Thus, there is an imperative to develop alternative frameworks for discussing states of distress, dislocation and mental illness within Indigenous societies that do not rely solely on the language and assumptions of Western psychiatry.

One of those frameworks is the concept of "historical trauma" which was developed as a means to move beyond the individual-centric approach of Western psychiatry (Pihama et al., 2014; Wirihana & Smith, 2014). Historical trauma refers to the collective, cumulative emotional and psychological wounds that affect individuals and communities across lifetimes and generations, also referred to as intergenerational trauma (Pihama & Smith, 2023). It stems from catastrophic, large-scale traumatic events, with the resulting unresolved grief impacting both personal and intergenerational well-being (Brave Heart & DeBruyn, 1998). While acknowledging its limitations (Kirmayer, Gone, & Moses, 2014), Gone asserts that "historical trauma" highlights the collective, cumulative, and intergenerational psycho-social impacts stemming from colonialism (2013, p.683).

Diagnosis and Classification Models

Even though there are Western strength-based approaches such as e.g. positive psychology (Seligman, 2011), clinical psychology and psychiatry remain dominant with diagnostic models (Bracken & Thomas, 2017) such as the Diagnostic and Statistical Manual

of Mental Disorders (DSM) and International Classification of Diseases (ICD) that focus on deficits rather than sources of strength and resilience and thus pathologise the mental health problem (Cartwright, 2024). These models characterise mental health issues as stemming from universally described and individually situated emotional, cognitive, or biological processing issues, perceived to exist in isolation from other contextual factors such as historical and intergenerational trauma, relationships, cultural practices, meaning, values, beliefs, and the institutionalised racism leading to economical and educational disadvantages including, homelessness, poverty, and addictions (Rangihuna et al., 2018; Russel et al., 2020; Health Quality and Safety Commission, 2019; Reid et al., 2000; Russel et al., 2013).

Another core issue is that they conceptualise distress as an illness, thus leading to the need for people to receive a diagnosis first and identify as 'sick' to have access to the mental health care system (Government Inquiry into Mental Health & Addiction, 2018). Although distress can be debilitating, it can also be dealt with without having to put the label of an 'illness' on people (Government Inquiry into Mental Health & Addiction, 2018). The symptoms are often normal responses to common and difficult life situations, which the current mental health system does not recognise with the medicalisation of issues (Timimi, 2013).

Indigenous scholars also argue that services based on diagnostic tools also tend to have limited treatment outcomes through a lack of effectiveness in practical applications, or even exacerbate the difficulties (Initial Commission Reporting, 2024; Johnstone et al., 2018), and highlight the missing empirical evidence for its clinical usefulness (Timimi, 2013; Beresford, 2002). These frameworks are still seen as superior to other treatment pathways e.g. within Indigenous psychologies and Indigenous traditional knowledge though (Bracken & Thomas, 2017), creating the idea that a diagnostic-based, universal model and understanding of distress is the only possible pathway towards healing (Kopua et al., 2021).

The conceptual shift from psychiatric classifications towards a more contextual understanding also finds advocates within the Western paradigm such as the British Psychological Society, which presents a “Power Threat Meaning Framework” that aims to understand and address mental distress and behaviour by considering the role of power dynamics, threats faced, and the meanings and responses individuals create (Johnstone et al., 2018); and the BPS Division of Clinical Psychology with their position statement outlining the need for a change in how psychiatric diagnoses are conducted (British Psychological Society, 2013).

Cultural Biases and Colonial Power Structures in Western Science

The challenges found in the Western Mental Health paradigm are highly interlinked with the history of research and its imperial and colonial roots. The encounters of numerous Indigenous cultures highlight the atrocious effects that apparent ‘objective’ researchers have had on them (Bishop & Glynn, 2003; Cram, 2000; Gibbs, 2001; Smith, 2013). From an Indigenous viewpoint, Western research imposes a cultural orientation, values, specialized forms of language, structures of power, and distinct conceptualizations of elements like time, space, subjectivity, gender, and race (Hall, 1992; Smith, 2022). These perspectives stem from Western knowledge systems and philosophies which Foucault described as a ‘cultural archive’ of knowledge which establishes hierarchical worldviews (1972). Foucault further suggests that this archive encompasses implicit 'rules of practice' which are taken for granted and cannot be perceived when operating solely through a Western lens (Foucault, 1972; Bernstein, 1971). Some of these notions involve beliefs about what qualifies as acceptable evidence and credible research, a preference for written text over oral traditions, and the fragmentation of concepts which is in stark contrast to the fundamentally interconnected worldview of Māori (King et al., 2017; Ritchie, 1992; Mika, 2015). Together, these principles establish the broader norms that maintain Western dominance (Smith, 2022). This is reflected

by Te Awekotuku's notion of research(1991), arguing that "[r]esearch is the gathering of knowledge – more usually, not for its own sake, but for its use within a variety of applications. It is about control, resource allocation, information and equity. It is about power" (p. 13). From this perspective, research is an effective mechanism to uphold power structures while marginalising minorities (Mahuika, 2008).

One key issue is a reliance on samples from Western, educated, industrialised, rich, and democratic (WEIRD) societies (Henrich et al., 2010). This limited perspective provides a narrow cultural lens for understanding the world, often disregarding and appropriating other cultural perspectives. Such an approach can further marginalise Indigenous peoples (Watkins & Shulman, 2008; Walia, 2013) by assuming universality and creating a deficit view of Indigenous cultures (Gergen et al., 1996; Waldron, 2010).

It is crucial to note that Mātauranga (knowledge) Māori approaches are often evaluated by Western institutions within the dominant Western research paradigm which has played a major role in failing to deal with health inequities for Māori in the first place (Russel et al., 2020). This prompts critical questions about addressing issues originating from colonial authority using solutions from the same system. (Kopua et al., 2021). Recognising the necessity for culturally relevant evaluation and assessment methods, treatment quality for Māori should be defined by Māori themselves (Mahuika, 2008; Health and Disability System Review, 2020). Incorporating Māori data and analytical approaches can enhance and diversify healthcare (Health Quality and Safety Commission, 2019). The implementation of new initiatives should not proceed without robust research and evaluation (Government Inquiry into Mental Health & Addiction, 2018). While there is continued emphasis on building an evidence base for effective approaches, the same level of attention and consequences is often absent when the ineffectiveness of imported, mainstream models to change mental health inequalities for Māori in meaningful ways becomes evident (Kopua et

al., 2021). Many Māori responding to the Government Inquiry into Mental Health & Addiction (2018) are astonished at the continued reliance on mostly deficit-oriented foreign mental health models due to the clear absence of benefits for Māori (Health Quality & Safety Commission, 2019) coupled with the expanding body of evidence that supports the effectiveness of Indigenous models (Russel et al., 2020; Government Inquiry into Mental Health & Addiction, 2018; Kopua et al, 2021).

Racism in Mental Health Care and Research

For Māori, intergenerational trauma stemming from colonisation (Wirihana & Smith, 2014; Pihama et al., 2014) persists due to systemic, institutional, and interpersonal racism, which significantly impacts their health (Harris et al., 2006; Walters, 2007). Crucially, racism is experienced both on a personal level (such as being followed around by staff in shops, being insulted, treated with less respect than non-Māori) (Cormack et al., 2019) and within still-existing colonial societal structures which can be found in mental health and research institutions, education, the political system, etc.(Ramsden, 2002; Pihama et al., 2017; Waretini-Karena, 2013; Wirihana & Smith, 2014). For a current specific example of these structures please read my overview on Western complicity regarding the war in Gaza and the apartheid regime in Israel in Appendix A. Timimi (2013) recognises diagnostic-based services as part of these structures and as "inherently institutionally racist, and no service that takes seriously trying to provide a culturally appropriate service can claim to have made such forward strides in doing so without first abandoning the use of diagnostic-based thinking"(p. 26).

The hallmarks of institutional racism are a lack of action, inappropriate actions (Health & Disability System Review, 2020), and a lack of consequences for poor outcomes (Kopua et al, 2021). This can be found in research and mental health care system in the

significant investment of resources in strategies and research that fail to address inequity (Government Inquiry into Mental Health & Addiction, 2018; Russel et al., 2020) despite evidence suggesting the inefficacy of such approaches (Health Quality & Safety Commission, 2019), coupled with inadequate allocation of resources to expand the research for development of Mātauranga Māori approaches ((Government Inquiry into Mental Health & Addiction, 2018) and the predominance of monocultural worldviews and perspectives (Wirihana & Smith, 2014).

Solutions within Indigenous Ways of Healing

After having laid out the issues within the Western mental health paradigm and Western research that contribute to inequity for Māori, the second half of this study will be an overview of the possible solutions to decolonise research and mental health, and to treat Māori more culturally appropriate and effectively. I will go over Kaupapa Māori as a decolonising methodology, some specific Māori mental health models, and traditional cultural concepts that are crucial to integrate into a path towards healing and flourishing for Māori.

Kaupapa Māori as a Decolonising Methodology

Kaupapa Māori is a broader decolonisation and liberation movement which seeks to foster a distinctly Māori perspective across community development, philosophy, psychology, research, and social science (Smith, 2022; Baker & Levy, 2013). Indigenous psychologies continue to face marginalization within the broader discipline of psychology including Indigenous scholars being systematically denied recognition as legitimate contributors to psychological knowledge (Groot et al., 2018). This movement thus inherently challenges dominant paradigms of knowledge production and research methodologies (Smith, 2022). Crucially, Kaupapa Māori theory intrinsically examines prevailing power structures and

societal disparities. This theory thus unveils underlying assumptions that mask existing power dynamics in society, illustrating how dominant groups construct 'facts' to sustain the oppression of Māori people" (Smith, 2022).

Māori Mental Health Models

There are many well-known Indigenous mental health models such as e.g. Mahi a Atua (Kopua et al., 2019), Te Whare Tapa Whā (Durie, 2001), Te Te Wheke (Pere & Nicholson, 1997), Te Tuakiritanga, and Mana Kaitiakitanga (Pihama & Smith, 2023). I will present two in more detail in the following section.

Mahi a Atua.

The concept of "Mahi a Atua" represents a culturally embedded approach to engaging with individuals, families, and communities within the context of what Western scholars would describe as Māori ontology, epistemology, and linguistic expressions. Rather than being a therapeutic modality or a novel set of techniques, Mahi a Atua embodies a process rooted in the exploration of pūrakau, which are Māori creation stories. These narratives open up new words, concepts, imagery, and stories that serve as a framework for addressing communal, familial, and individual challenges and are central to the recovery of healing processes for Māori (Mikaere, 2017; Swann & Crocket, 2017). Importantly, Mahi a Atua diverges from conventional psychological or psychiatric paradigms while abstaining from "psychologised" or "psychiatrised" vocabularies. (Rangihuna et al., 2018, as cited in Kopua et al., 2019, pp. 377-378). The following paragraph will give a practical example of the model (Kopua et al., 2019).

Practical example of Mahi a Atua.

In response to Judy bullying a child, the whānau (extended family) of the affected child opted for the introduction of Mahi a Atua to foster a broader cultural shift within the

state school environment. This decision paved the way for a comprehensive treatment strategy involving collaboration with the school community. Initially, discussions were held with both the whānau (extended family) of the bullied child and the school faculty, resulting in mutual agreement to embrace the principles of Mahi a Atua within the school's framework. Subsequently, Mahi a Atua was integrated into training sessions for school staff, encompassing both health and non-health professionals. Feedback from staff indicates positive progress in Judy's situation, alongside personal and professional growth attributed to their involvement in the Mahi a Atua sessions.

Te Whare Tapa Whā.

Whare Tapa Whā (four walls of health) is a well-recognized holistic Māori health model (Durie, 2001) that can be beneficial for understanding a wide range of health issues, by offering a cohesive approach to health services and is embraced within the health care system in Aotearoa (New Zealand) (Teinakore, 2023). This model is represented by the analogy of a house. The four walls of the house are taha tinana (physical), taha whanau (social), taha wairua (spiritual), and taha hinekaro (emotion). This framework stands as a potentially applicable concept while deeply rooted in the holistic perspective intrinsic and unique to the Māori worldview. Its distinct Māori background empowers Māori to embrace its insights fully, to reclaim agency, and to gradually reverse the major impacts of colonisation (Rochford, 2004). Rochford outlines in detail how this model can be used in specific examples such as in the case of Diabetes Type 2 (2004).

Whare Tapa Whā can serve as a diagnostic and treatment pathway, functioning as a direct clinical tool that encompasses the psychological, social, historical, and often overlooked spiritual dimensions (Durie, 2011; Milne, 2005) of mental illness. It also takes into account the connection between overall Māori development and health. It can be used as

a community development strategy by encouraging coordination from the health sector with Māori and Government initiatives to find solutions for some of the root factors of mental illnesses and distress such as housing, education, and unemployment (Rochford, 2004).

What is Healing according to Māori Culture?

"So that's the healer's way; you want to teach people to heal themselves. Teach our children to heal themselves and then they will teach their children." (Pihama et al., 2017, p. 102)

This quote reflects the preventative nature of Māori Healing and its focus on taking responsibility. One of the crucial concepts to outline is Mauri Ora and its holistic nature, which embraces mental, physical, spiritual, and environmental well-being (Durie, 2001; Pere & Nicholson, 1997; Pohatu, 2008) and encompasses human happiness, positivity, flourishing, balance, harmonious relationships with both the living and the spiritual realms, a sense of exploration, and overall strength (Pihama & Smith, 2023), which is one of the stark contrasts with the deficit-oriented Western paradigm (King et al., 2017). It is connected with Mauri, whose several meanings encompass lifeforce, energy, vibration, vitality and connection (Marsden & Royal, 2003). Being well then means being in a balanced state of mauri (Mead, 2003). Many traditional cultural practices cultivate Mauri Ora including rongoā (traditional healing methods) (Mark, 2012), raranga (traditional weaving) (Campbell, 2019; Nopera, 2017), kapa haka (Kerehoma, 2017; Pihama et al., 2014) mara kai (traditional gardening) (Hond et al., 2019; Hutchings, 2015), and crucially Te Reo (Māori language) (Hutchings et al., 2017; Lee-Morgan et al., 2019).

An overview of these practices and principles is now presented based on He Oranga Ngākau: Māori approaches to Trauma Informed Care, which consulted Māori experts within trauma and healing spaces ranging from traditional healers and experts on Tikanga (customs, values) and Mātauranga (knowledge) to social workers, and independent and social service

provider practitioners (Pihama et al., 2017). It is important to remember that there is a range of interpretations that one can find for the presented cultural concepts depending on a person's tribal and general background.

Tino Rangatiratanga.

An important principle is Tino Rangatiratanga (political self-determination, sovereignty) which represents the fundamental right of Māori to decide what is best for themselves (One & Clifford, 2021). Historically it has been and is still being denied by Pākehā (White settler) governments and their institutional structures, leading to continued disregard of crucial resources for healing such as Te Reo (the language) Māori, Tikanga, and Mātauranga (knowledge). The validation of Tino Rangatiratanga has to be a basis of Māori health and wellbeing practices (Pihama et al., 2017; Lancet, 2020).

Tikanga.

Tikanga is Māori Customs, traditions, and behavioural guidelines in which fundamental values are embedded (Mead, 2016). Pre-colonisation, it served as a system promoting wellbeing, and post-colonisation additionally as a source of resilience. It is crucial for maintaining balance across all Māori contexts and can be expressed through whakapapa (see in glossary) in many ways such as stories, songs, and actions. Therefore, it plays a vital role in addressing imbalances stemming from both individual and collective trauma (Pihama et al., 2017).

Mātauranga Māori.

Mātauranga Māori, often referred to as Māori knowledge (Mead, 2003), encompasses "the body of knowledge originating from Māori ancestors, including Māori worldviews and perspectives, Māori creativity, and cultural practices" (Māori Dictionary, 2003). It is a unique Māori cultural lens on the world (Jones, 2012) and includes systems of knowledge transfer

and storage (Landcare Research, 1996, as cited in Hikuroa, 2016), and an understanding of both the visible and invisible aspects of the universe. (Hikuroa, 2016). Connecting to this traditional knowledge is an important factor in the healing process and can be done by using traditions such as e.g. Haka (Traditional posture dances or war dances), Pūrākau (Traditional stories or narratives), Mōteatea (Traditional laments or chants), and Waiata (Songs). In it are naturally integrated values, knowledge, and practices that can cultivate more connection to others, the world, and oneself (Pihama et al., 2017).

Te Reo Māori.

Te Reo Māori (the Māori language) was identified as a vital element for Māori well-being in all the interviews. It was underscored that learning Te Reo benefits Māori by deepening the use and understanding of Mātauranga Māori and Tikanga (Pihama et al., 2017).

Rongoā and Traditional Healing Practices.

Rongoā Māori is traditional Māori healing and has evolved from Māori cultural traditions. It is a holistic healing system encompassing a variety of diagnostic and treatment methods that integrate wairuatanga (spirituality) with mental, social, and physical aspects of health. The literature describes Rongoā Māori as a practice deeply rooted in local traditions. It includes a wide range of healing practices, all grounded in a Māori worldview and understanding of wellbeing (Durie et al., 1993) such as ritenga and karakia (healing incantations and rituals), Rongoā (physical remedies from trees, leaves, berries, fruits, bark, and moss), mirimiri and romiromi (bodywork roughly comparable to massage/physiotherapy), wai (the use of water for healing), and surgical interventions (Ahuriri-Driscoll et al., 2008). There is significant diversity in how specific modalities are applied as healers do not follow uniform practices (Durie et al., 1993). Jones (2000a) attributes this diversity to cultural traditions and the long history of oral knowledge

transmission, resulting in distinct traditional healing methods used by Māori that vary based on region, iwi (tribe), hapū (sub-tribe), and whānau (Ahuriri-Driscol et al., 2008).

Spirituality.

Wairua (Māori spirituality) and Karakia (prayer) are considered essential components of healing journeys, as they connect individuals to themselves, their community, their whenua (lands), and to atua (deities, ancestors). These elements integrate all aspects of the Māori world, linking people culturally, physically, socially, and spiritually to each other and their roots. They serve as reminders of the power of Tūpuna (ancestors) and the importance of strengthening one's spiritual self (Pihama & Smith, 2023).

Tohu is another crucial concept defined as a sign, indication, mark, pointer, omen, instruction, or direction. Smith (2019) describes Tohu as a body of knowledge that requires interpreting signs from the environment, people, language, Ngākau (heart, mind), memory, Tūpuna (ancestors), feelings, and perceptions of well-being or illness. Pere (1994) advises listening to the Tohu offered by one's 'grandmothers' and 'grandfathers' (p. 71). This guidance can manifest through physical elements, psychic phenomena (such as spiritual guardians), and communication with ancestors (Pihama & Smith, 2023).

For a deeper discussion of this topic, I recorded a podcast episode in connection with this thesis on the topic of spirits and entities with Professor of Education and Tohunga (healer, expert) Cheri Waititi (Keller Muñoz, 2024).

Mana.

Mana is the spiritual authority, power, or energy inherent in an individual or whānau (extended family). It grants them the authority over their own lives, circumstances, and any entities that may affect them (NiaNia et al., 2017). Mana is both a characteristic and a way of being intrinsic to every individual (others would argue that it is only intrinsic to some, see

under Keller Muñoz (2024) for a deeper discussion on a podcast episode with key knowledge keepers Ngahere Tonga O Te Rā Carrucan and Edmond Thomas Carrucan). It is inherent and earned, capable of being diminished or enhanced, and it can be present or absent in one's sense of self. Importantly, mana cannot be self-proclaimed; it must be acknowledged by others. A key objective of a Kaupapa Māori trauma-informed care model is to enhance both individual and collective mana (Pihama et al., 2017).

Relationships.

Whānau is the cornerstone of Māori society, a communal space where connections across generations are understood and nurtured. For many, whānau remains a source of collective well-being, obligations, and responsibility. However, for some, the effects of urbanisation, colonial ideologies, and other fragmenting factors have been significant, such as the preference for the Western nuclear family model over the extended whānau. Whanaungatanga is another crucial value and practice that broadly refers to the relational nature of Māori society (Pihama et al., 2017). Whānau and whanaungatanga were emphasised as vital for reconnection. Māori approaches grounded in tikanga and Mātauranga, nurtured through meaningful relationships with Māori whānau, hapū (sub-tribe), iwi (tribe), and communities, are crucial for whānau wellbeing (Pihama & Smith, 2023). Historically, each person in the tribe was vital to the survival and success of the whole, emphasising that for Māori, no individual is isolated from others or their whakapapa (genealogy). Support was available to everyone, and the health and wellness of each individual were crucial to the well-being of the entire iwi (tribe) (Mead & Grove, 2001), something that is seen across other Indigenous cultures (Resilience, 2023; Pihama et al., 2017). It is of utmost importance to keep cultivating this cultural and collective connectedness for the well-being of Māori (Milne, 2010).

Identity.

In Māori culture, the self is intertwined with and influenced by connections that extend outward into the world. These relationships are central to the Māori understanding of self (Rua et al., 2015, 2017). For Māori, personal identity is shaped by the places they inhabit, the individuals they interact with, and the cultural contexts in which they are immersed (King et al., 2017).

Discussion

The voices of Indigenous scholars, practitioners and activists in this review underscore the importance of a paradigm shift to address mental health and well-being among Māori. The resounding message from the 2018 Government Inquiry into Mental Health & Addiction emphasized the necessity for a fresh approach, with Māori voices unequivocally advocating for a departure from the prevailing biomedical model towards a well-being paradigm rooted in Te Ao Māori (Russel et al., 2020; Kopua et al, 2019). This shift is essential in acknowledging the specific cultural trauma experiences of Indigenous Peoples and other groups affected by collective trauma, thereby validating their experiences as a significant step in the healing process (Braveheart, 1999; Duran & Duran, 1995). At the core of the essential paradigm shift is a critical examination of the power dynamics accountable for the intentional and systemic marginalisation of Mātauranga (knowledge) Māori with unequal outcomes for Māori communities (Kopua et al., 2024). Additionally, to guarantee equitable outcomes for Māori in the healthcare system it is crucial to take action against deeply integrated institutional racism within mental healthcare and academic institutions (Kawai, 2017; Health & Disability System Review, 2020; Russell et al., 2020; Safe and Effective Justice Advisory Group, 2019).

It is required for future mental health care training to educate about the consequences of colonial factors that disadvantage Māori, e.g. through historical trauma (Pihama et al., 2014) and societal post-colonial structures (Kopua et al., 2024). Furthermore, it was stressed in the literature that indigenising and decolonising institutions is crucial as the mental and overall health care system has been influenced massively by a colonial perspective that "deliberately excludes and delegitimises Indigenous world views and knowledge" (Kopua et al., 2021, p. 6). Another important step is to rethink the past ways of categorising distress, and to find quicker and more effective answers to community struggles (Kopua et al, 2021). This can be advanced by working with Indigenous models and culture-specific, community-led initiatives (Johnstone & Boyle, 2018) with a focus on healthy relationships (Russel et al., 2020) and contextual factors.

Using Māori approaches does not completely have to leave Western approaches behind (Kopua et al., 2021). Psychiatry and clinical psychology are in a constant process of improvement; the Western mental health paradigm has produced new models such as the bio-psychosocial model and strength-based approaches such as e.g. positive psychology (Seligman, 2011) and new iterations of existing treatments such as Strengths-based cognitive-behavioural therapy (Padesky & Mooney, 2012). Additionally, there are excellent examples of collaboration such as in "Collaborative and Indigenous Mental Health Therapy" (2017), which shows how the Tohunga (expert, healer) Wiremu NiaNia and the youth psychiatrist Allister Bush work together in the intersection of Western psychiatry and spiritual/cultural ways of working. It highlights the crucial role of the increasing number of Rongoā and traditional healing practitioners in collaborating with other healing and social service professionals (Pihama & Smith, 2023). While some advocate for integrating local healing approaches with Western psychiatric practices, others highlight that the differing social

statuses of healers and healthcare professionals often put local practices in a disadvantaged position (Sax, 2014).

The biomedical model is still predominant (Deacon, 2013; Rocca & Anjum, 2020) despite the criticism it has received, partly because the bio-psychosocial model is challenging to implement within the already existing mental and general healthcare structures (Rocca & Anjum, 2020). Additionally, there is a considerable camp of 'orthodox-scientific' psychiatrists that hold onto a strongly bio-medically oriented framework, making the transition much harder (Cox & Webb, 2015). These are crucial reasons why the bio-medical model and the focus on deficits remain a regular point of critique in the review.

And it is generally the case that local Indigenous knowledge which tackles physical and spiritual illness is often delegitimised, ignored and denied (Hill et al., 2010). Campbell and Burgess (2012) thus stress that empowering local communities to take control of health agendas that impact them is essential. The priority then should not be to improve Western models to fit Indigenous peoples, but rather to empower Indigenous scholars and practitioners to decide for themselves which treatments they want to implement by funding more research on Indigenous models and solutions and respecting their right to political self-determination (One & Clifford, 2021) that has been denied from them by colonial governments until this day. One step towards this is to acknowledge that the idea of global psychology and psychiatry is an illusion (Johnstone & Boyle, 2018). Rather than expanding the influence of Western psychiatry, Indigenous scholars advocate for a reduction of this paradigm towards more culturally sensitive models which are defined by Māori, for Māori according to Kaupapa Māori decolonising principles (Kopua et al, 2021; Smith, 2022; Baker & Levy, 2013).

Lastly, a persistent pattern within the literature was the understanding that colonial impact and the resulting mental and physical health inequalities have to be tackled holistically by keeping in mind the wider political and societal factors. Aligned with this, Durie (1999) proposed five strategies to improve Māori mental health, which include promoting a strong Māori identity and Te Reo, ensuring Māori participation in the economy, enhancing Māori experiences within the mental health system through Kaupapa Māori initiatives, developing a Māori mental health workforce, and supporting the autonomy of Māori service developers (Durie, 1999b).

Limitations

A major shortcoming of this review is the lack of examples of the Indigenous mental health models and healing methods and their practical application, and specific details about the cause of inequality for Māori in the mental health care system. The main objective is to reflect the voices of Indigenous scholars and to create a platform for the extensive body of literature found in the references that describes these issues and detailed mechanisms with expertise and in much greater detail.

Furthermore, evidence from Indigenous peoples around the world often strongly relates to Māori, and vice versa. Still, it is important to note that while the overall situation and possible solutions might be similar, not all the insights are transferable. This line between insights specifically about Māori and other Indigenous cultures remains blurry in some instances.

Additionally, this review lacks a deeper review of the intersection of Western and Indigenous models, leaving many questions open about a possible synergy. As discussed, developments in the Western mental health paradigm are promising and strongly lack representation in this review. It is crucial to keep in mind though that Māori should have

power over the implementation of such new techniques, and the freedom of choice to rather invest in their own models according to Tino Rangatiratanga (right of sovereignty). Anything else would be the continuation of colonial domination (One & Clifford, 2021).

Conclusion

The health and social inequalities faced by Māori persist as a result of enduring colonial structures that fail to address inter-generational historical trauma adequately (Pihama et al., 2014; Wirihana & Smith, 2014). Current mental health paradigms often overlook the unique cultural contexts of distress, relying heavily on diagnostic models that do not serve the Māori population effectively. Research practices frequently marginalise Indigenous knowledge, while insufficient funding for Māori-led initiatives worsens these disparities (Smith, 2022). Institutionalised racism remains a critical barrier, perpetuating unequal treatment and outcomes (Kopua et al., 2021). Decolonising mental health and research frameworks, e.g. through a Kaupapa Māori methodology is essential to addressing these issues (Pihama et al., 2017). By embracing Māori cultural solutions and redefining distress through a culturally informed lens, we can create more equitable and effective mental health systems. Empowering Māori to lead and integrate their own models and traditional healing practices within mental health care is crucial for achieving Tino Rangatiratanga and fostering holistic well-being and equity for Māori (Smith, 2022; Baker & Levy, 2013; One & Clifford, 2021).

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Appendix A

The overview I am giving in this study on institutionalised colonial structures might seem to most readers like a problem that is far distanced. Still, I want to highlight that we are deeply embedded in Western narratives of the world which make it hard to perceive these structures in our immediate surroundings (Foucault, 1974). With the war in Gaza going on while I am writing this I started noticing some of the Western structures regarding this conflict. Israel is also originally a settler colony, with Israel continuously expanding the settlements in the Palestinian West Bank and grabbing new land to this day, which is illegally occupied under International Humanitarian Law (OHCHR, 2022). As a response to the attacks of Hamas on October 7th on Israel the government launched a military attack on the Gaza Strip killing more than thirty-five thousand Palestinians, of whom more than 70% are women and children under 18 according to the Palestinian Health Ministry (Reuters, 2024). Additionally, the entire population of Gaza of 2.3 million people is facing the imminent risk of famine and around 60% of the population is experiencing “catastrophic” or “emergency” levels of food insecurity (Reidy, 2024), which many human rights organisations claim is the consequence of the total siege that Israel has put on Gaza. The allegation that Israel is imposing the risk of death from starvation for the population in Gaza is at the core of the case at the International Court of Justice (ICJ) accusing Israel of genocide brought by South Africa (Mekelberg, 2024). The war has also led to the displacement of civilians on a massive scale, with 800,000 civilians, nearly half of the population, having to flee from Rafah alone even though it was promised as a safe zone by the Israeli government (UN News, 2024).

The situation is catastrophic. Still, Western countries such as the U.S., the Netherlands, Germany, etc. are continuing to send weapons to Israel (Human Rights Watch, 2024), which is a painful example of our biases and ignorance about the illegal apartheid system and war crimes committed by Israel (Amnesty International, 2024).

Another specific example of the complicity of academic institutions in upholding colonial structures is the systematic discrimination against Palestinian students and communities, the engagement with the Israeli military-industrial complex of academic institutions such as Technion (Academics in Solidarity with Palestine, 2024) and the support for the state's apartheid policies in Israeli universities (Jacobin, 2024), which doesn't stop many European universities to keeping ties and collaborate (Israel Institute of Technology, 2024).