New Zealand Journal of Psychology

Editor's Introduction

This issue of the *New Zealand Journal of Psychology* marks something of a return to business as usual. The last issue was devoted to a rapid response to the events of March 15th, the atrocity perpetrated against the Muslim community in Christchurch. It is worth updating readership to the impact of that rapid response issue. Firstly, the work summarised in that issue represented a fairly extraordinary resource for those whose jobs subsequently involved formulating a response or action plan to those events. That issue was summarised and contributed to informing the Governmental response, among other things. When asked what she was reading during the 2019 Auckland Writer's Festival, Prime Minister Jacinda Ardern mentioned the rapid response issue. Past Prime Ministers may have included the Journal in their to-be-read list, but none that I'm aware of have admitted this publicly. Once again, I thank the people who contributed to that previously unprecedented issue, and hope it remains exactly that.

But back to business. This issue includes nine works, including a brace of reviews (Tan et al.; O'Toole et al.), an evaluation of a rangatahi treatment programme (Ape-Esera & Lambie), and a mixture of quantitative (Lee & Sibley) and qualitative (e.g., Nazari & van Ommen; Reeves & Treharne) empirical studies. Quite possibly something for every reader.

Indeed, this is a theme that I hope will continue in future issues – a mixture of papers that reflect not just the breadth of the psychological subject matter that we do, but that are relevant to both researchers and practitioners, *and* reflective of the diversity of methods and tools that makes Aotearoa New Zealand a meeting place of epistemological, theoretical and analytic traditions. To that end, I'd like to encourage submissions reflecting that diversity – and particularly from areas of psychology research and practice that may have been under-represented in recent years. At the same time, I also remind potential submitters to bear in mind our submission criteria and guidelines, and particularly those that make us distinctive – the requirement that all submissions establish clear relevance to our particular context as an officially bicultural nation.

Marc Wilson

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Going it Alone: Stories of New Zealand Women Choosing Single Motherhood

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Increasing numbers of women in New Zealand are choosing to become single parents via donor insemination and may be referred to as Choice Mothers. However, the issues these women face have yet to receive much research attention and thus little is known about them and their lives. This research explored the experience of being a Choice Mother in New Zealand using semi-structured interviews. Data was analysed thematically, and identified that despite variations within their individual situations, there were similar aspects to their experiences. These included: their determination to become a parent, grief at not having achieved the "traditional family unit", challenges of partner absence, difficulties in explanations of their family unit, managing complex family structures, and their pride at having taken action to achieve their family, albeit unconventionally.

Keywords: Choice Mother, Grief, Donor, New Families, Support

Introduction

The term 'Choice Mother' refers to unpartnered women who opt to become single mothers through donor insemination or adoption. These women tend to differ from other single mothers not only in the way in which they plan for motherhood, but also their typically older age, their more advanced educational level and their employment and financial status, which makes them a relatively specific and homogenous subset of single parents (Murray & Golombok, 2005a). Since the number of Choice Mothers in New Zealand is increasing (Bilby, 2015), a better understanding of their experiences and needs and their alternate family form within the New Zealand context is required.

The numbers of Choice Mothers in New Zealand are hard to gauge since women may conceive without the involvement of a fertility clinic, or may travel overseas for fertility treatment. As of 1993, following a complaint to the Human Rights Commission (NZ Law Commission, n.d.), all fertility clinics must accept single women and those in lesbian relationships for donor insemination. However, sperm donors are able to select recipients for their sperm, and thus single women are likely to wait longer to access sperm than partnered heterosexual women. Further, compared to other countries, in particular, the United States, the demand for sperm outweighs supply in New Zealand (Ainge Roy, 2016) which can limit the number of single women able to access donor sperm or result in long waiting periods.

Nonetheless, in 2015, of the 300 women treated by donor insemination at Fertility Associates, New Zealand's biggest fertility clinic, the largest group (52%) were single women. While the numbers of heterosexual and lesbian couples undergoing treatment using donor sperm have remained about the same, the reported numbers of single women accessing donor insemination have almost doubled in the past three years, from 80 in 2012, to 156 in 2015 (Bilby, 2015).

The rise in Choice Mothers may be due to several factors, including what has been termed in the press as a "Man Drought" in New Zealand, or a shortage of available men (Callister & Lawton, 2011). Population estimates for June 2011 suggested that there were around "50,000 more female than male residents aged 25-49, with the greatest imbalance in the prime relationship forming and childrearing age group of 30-44" (Callister & Lawton, 2011, p.1). 2013 Census data showed a similar pattern with the ratio of men to women between 25-49 years old estimated to be 91 men to every 100 women (Callister & Didham, 2013). Along with the low levels of children available for adoption in New Zealand (Adoption Option, n.d.), the increasing acceptability of using assisted reproductive technologies to build families, and the emergence of more diverse family structures, this situation may contribute to an increasing number of women contemplating becoming parents in the absence of partners.

Being a single parent may still be accompanied by stigma however (Marriner, 2016), as evidenced by research conducted in the United States, where 61% of study participants stated that a child needs both a mother and a father to grow up happily (Heimlich, 2011).

Indeed, some initial research that explores outcomes for children in single parent families has suggested that children of single parents do not fare as well educationally and occupationally (Waldfogel, Craigie, & Brooks-Gunn, 2010). Furthermore, these children were reported to have been at greater risk of having emotional and behavioural problems, as well as an elevated risk of poor health, child abuse and neglect (Waldfogel et al., 2010). While the reasons for this are not well understood, it has been assumed that the absence of a father is a major contributing factor (Mackay, 2005). Much of the stigma associated with Choice Mothers may be similarly intertwined with assumptions about normative heterosexual families and children's healthy

development. Yet some research has indicated that factors related to parental separation, such as inter-parental conflict, which are not relevant to Choice Mothers, have been more strongly associated with adverse effects (Mackay, 2005) than paternal absence itself.

Indeed, Choice Mothers may represent a more distinct and homogenous subgroup as compared to the more diverse umbrella group of 'single parents'. They tend to be older, have more advanced educational levels, employment and financial statuses (Murray & Golombok, 2005a; Jadva, Badger, Morrissette, & Golombok, 2009). Choice Mothers are women who have actively sought to become single mothers from the outset. While parenting alone tends not to have been their first choice, neither were they prepared to form relationships with men solely for the purpose of building a family (Murray & Golombok, 2005a). Research gives strong support to the fact that Choice Mothers are a specific sub-group of single parents, and that they and their children are doing well (Murray & Golombok, 2005a and 2005b). For example, research which focused on the parenting quality and emotional and behavioural wellbeing of children of Choice Mothers reported positive results for both parenting quality and the wellbeing of the offspring (Murray & Golombok, 2005a and 2005b). Similarly, a recent study on children between four and nine, reported that both the Choice Mothers and children were doing well and that children of Choice Mothers were experiencing similar levels of parenting quality to those from two parent families (Golombok, Zadeh, Imrie, Smith & Freeman, 2016).

The distinction between single and Choice Mothers is not without controversy, however, with Seals Allers outlining how this may create a certain hierarchy within single motherhood, possiblyfurther stigmatising single mothers by virtue of how they achieved their single status, "glorifying some while demonising others, mostly across racial and socioeconomic lines" (Seals Allers, 2016). Choice Mothers, distinguished often by their age, economic security and the fact that most are middle-class, may be placed on the higher rungs of single motherhood above younger, poorer and coloured single mothers (Seals Allers, 2016).

And yet on the other hand, Choice Motherhood as a form of modern family-building may also carry stigma stemming from other reasons. In New Zealand, an opinion poll carried out by Daniels and Burn (1997), found that "a majority of New Zealanders feel that lesbian couples, single women and couples where women were past the age of menopause should not have access to AHR (fertility) services" (Hargreaves, 2001, p.196). While this research is now somewhat dated, more recent overseas research in the United Kingdom and Australia suggests continued societal stigmatisation of single parents, including Choice Mothers (Marriner, 2016). Part of the stigma associated with Choice Motherhood may come about as a result of how this group of 'single mothers' became Choice Mothers – intentionally, and usually through the use of donor sperm.

In New Zealand, unlike in some other jurisdictions, gamete donation must be on an open identity basis and donors may not be anonymous. This means that donors must register their identifying information and be willing to have this disclosed to offspring at the age of majority or earlier by application from donor-conceived children or parents on behalf of their children (Human Assisted Reproduction Act - HART Act, 2004). The HART Act, drawing on Māori cultural perspectives (Daniels, 2007) also has as one of its principles that donor offspring should be made aware of and have access to information about their genetic heritage. This ties in with Māori valuing of "whakapapa" or family relationships, regarding knowledge of ancestry as critical to a sense of identity and an understanding of ones place in the world (Daniels & Douglas, 2008).

In following the path to parenthood, Choice Mothers may be faced with significant issues and challenges, both related to being a single parent as well as to the means of conception. These include the fact that for many, embarking on single parenthood is not their first choice and there is often some grief associated with that (Ainge Roy, 2016). In addition, donor conception brings with it challenges such as the timing and method of disclosure of the conception to the child and navigating the relationship with the donor and the donor's family network, which may include his immediate and extended family and that of other donor offspring (Daniels, Kramer, & Perez-y-Perez, 2012). Deciding what to call the donor, and the level of information exchange and contact may be part of the complexity.

Research suggests that donor offspring may struggle with their origin and identities, although also that early disclosure tends to promote wellbeing and healthy identity formation (Crawshaw & Montuschi, 2013; Mahlstedt, LaBount, & Kennedy, 2010; Turner & Coyle, 2000). Disclosure is likely to be easier for both the parent and the offspring, if there is never a time when the child can not recall not knowing about their family formation (MacDougall, Becker, Scheib, & Nachtigall, 2007). In the New Zealand context, cultural considerations such as the construct of whakapapa underscore policy guidelines which encourage openness and early disclosure to children (Fertility Associates, n.d.). While these are issues confronting other families in which donor conception has been used in family-building, some research has suggested that donor-conceived children of single or Choice Mothers appear to be "hurting more" (Marquardt, Glenn, & Clark, 2010). While concerns have been raised about the quality of some of this research (Blyth & Kramer, 2010), it is important to develop a better understanding of this type of family formation and its outcomes.

Much of the current research on Choices Mothers and donor insemination has been conducted overseas, with different societal norms and regulations, which make it difficult to extrapolate findings to the New Zealand situation. For example, most research in the United States has focused on women who have used an anonymous donor, thus research relevant to the New Zealand context in which whakapapa and knowledge of one's own heritage is respected, is needed. Further, studies have tended to focus on parenting relationships between children and their mothers, and outcomes for the children, rather than the experiences and wellbeing of the Choice Mothers themselves. This study aims to address this gap through conducting semi-structured interviews with Choice Mothers. It explores how women choose to make the

choice to build families in the absence of partners, the factors that drive them to make this choice, the process they undertake, the support structures in place, the challenges they face and how they describe their lives.

METHODOLOGY AND METHOD
Recruitment

Participants for this study were recruited through an advertisement on the private New Zealand Facebook group SMBC (Single Mothers by Choice) page. Eight participants emailed the researchers directly to indicate their interest. All potential participants met the research criteria which included, having used a donor to conceive, currently having a donor-conceived child or children, having been single at the time of conception and currently residing in New Zealand.

All potential participants were sent an email with the participant information sheet informing them of the research in more detail. In total, seven participants took part in this research project as the eighth participant was unable to be interviewed due to time restraints. Of the seven women interviewed, three had used donors known to them previously. Two of these conceived via self-insemination and the other via the fertility clinic. Three of the remaining women used clinic-selected donors through New Zealand clinics, with the fourth woman using egg and sperm donors from an overseas clinic. Six participants identified as Pakeha, and one participant identified as Māori/Pakeha.

Data Collection

Semi-structured interviews were used beginning with a broad open question asking the participant about her experience of being a Choice Mother. More specific questions were asked around experiences of undertaking this route to motherhood as follow up where needed, and included questions around factors leading to the decision to parent alone, experiences of raising a child without a father/partner and issues regarding disclosure and openness. Each interview took around 60 minutes to complete. Interviews were audio recorded and later transcribed by one of the researchers. Participants were offered the opportunity to review the transcripts to ensure their accounts were as accurate as possible, as well as to comply with ethical guidelines. Only minor changes were requested to be made to the transcripts.

Epistemological Approach

Interpretivism reflects the view that the context is all important in order to make sense of people's perspectives and views of the world. The researcher is an active participant and seeks a relationship with the research participants in order to obtain insight into their actions, beliefs and explanations (Grant & Giddings, 2002). Thus, the researcher's subjectivity is not ignored but actively acknowledged as contributing to the results in this study. The interpretivist paradigm is informed by social constructionism, where truth and meaning arise out of engagement with the world, and there is no one reality, rather multiple realities (Crotty, 1998). The researcher and participant work together to create the results; values and biases are unavoidable and acknowledged; the design is emergent, and findings may be inductive (Polit, Beck &

Hungler, 2001). It is thus important to note that the themes identified in this research were not regarded as a single truths to be uncovered, but as possible constructions viewed through the lens of the primary author. In this study an inductive approach to the data was used to generate an understanding of the world or in this case, of these women's experiences, rather than any prior theories (Dew, 2007).

Data Analysis

Data analysis was conducted using Thematic Analysis (TA). TA is useful in under-researched areas where the perspective of the participants is not well known (Braun & Clarke, 2006), as is the case for Choice Mothers. TA can be applied to provide a rich, detailed description of themes across the entire data set, and TA is also useful where the research question is broad and exploratory with no pre-determined hypothesis (Braun & Clarke, 2006), again, as is the case in the current study.

Thematic analysis is a theoretically flexible method (Braun & Clarke, 2006) and is compatible with the constructionist paradigm within psychology. Thematic analysis conducted within a constructionist framework, attempts to understand the cultural and sociological context that shape people's explanation of their experience (Braun & Clarke, 2006). Furthermore, thematic analysis is an inductive process in which codes are assigned to the data without trying to fit them into a pre-existing theory or match the researcher's preconceptions (Braun & Clarke, 2006). These themes reflect the entirety of the data set, providing a rich descriptive analysis of the findings (Braun &Clarke, 2006).

Data was processed using the six steps outlined in Braun and Clarke (2006): familiarisation of the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. While some of the themes identified in the data set related to the general journey and challenges of single parenting, these areas were not a research focus, rather an attempt was made to identify and analyse what was unique about the journey of being a Choice Mother. These themes related to the meaning that these women shared around their decision to become a single parent, some of the challenges that have related to this experience and those which they are currently navigating.

Ethical and Cultural Considerations

Participants were made aware that all information collected during the course of the interview was subject to confidentiality, all participants were de-identified and participants chose pseudonyms for themselves and all other persons referred to in their interview. Given the size and nature of the community however, it is possible that participants may be identified by other members of the community. This risk was acknowledged in the consent form. Further, and given the potentially sensitive nature of the subject matter, participants were made aware that they could access counselling from AUT's Counselling Clinic in relation to distress brought about by participating in the research.

New Zealand is a bicultural society, and as such research needs to be considered relevant to the needs of

Māori. Culture and diversity were respected by enquiring as to any special considerations that the interviewer needed to be aware of, such as inviting whanau to be present during the interview. In particular research needs to incorporate the three Treaty of Waitangi principles of partnership, participation, and protection (Hudson, Milne, Reynolds, Russell & Smith, 2010). Due to the use of semi-structured interviews, the participants played a critical role in contributing their stories in a mutually collaborative manner. Each participant had the opportunity to review and approve their own transcript once transcription had taken place. Finally, informed consent was obtained from all participants prior to the commencement of their interview and the purpose of the study made transparent to them. It was stressed that participation was voluntary, and the participant could withdraw from the study until data collection was completed. In order to further support each participant during the interview process, effort was made to provide a supportive interview environment including simple interview protocols and ensuring ample opportunities for breaks if necessary.

Ethical Approval was obtained from the Auckland University of Technology Ethics Committee on 6 May 2016 (AUTEC Reference number 16/154).

ANALYSIS

Six main themes, as outlined and illustrated below, were identified in the data analysis. Themes relate to women's experiences from the time of contemplation of becoming Choice Mothers, through conception to parenthood. The first of these was "Determination and Desire" and identified the similarities between the women interviewed including personality characteristics, a 'refusal to settle', and maternal yearning. The second was "Loss of the Dream" including sub-themes of letting go of the fairy-tale of having a child within a relationship. The third theme identified was "All on our own", reflecting Choice Mothers' isolation in the experience, including on the path to pregnancy, and in child-rearing. The fourth theme identified was "Challenging Conversations' and included subthemes of disclosure (to the child), openness (to others), and managing stigma. The fifth theme identified was "Redefining families" and related to terminology used to describe the donor, defining roles and relationships, and contemplating future partners. The sixth and final theme was "Living the New Dream" and included the subtheme, lucky families.

Determination and Desire

With an increase in the number of single women undertaking this route to motherhood, it was interesting to identify factors that women described as defining characteristics of those that choose single parenthood, and which may distinguish them from other women, such as, other single mothers and other single women who do not opt to pursue motherhood. Commonalities identified included similar characteristics, a refusal to choose a partner for the purpose of achieving motherhood, and a strong desire to be a mother.

In addition to a degree of financial security or, as Tina described it, "being reasonably well organised financially", women described themselves in terms of key

personality traits they deemed critical to making the decision to embark on this path to parenthood. For example, many of the women described themselves as 'self-reliant' (Rachel), 'determined' (Cara), and 'resilient' (Katie), in order to become Choice Mothers. Katie commented, "you need to have it together and be prepared for the ups and downs and you need to be really well informed" reflecting a belief in a need for stability and preparation. Women also identified that Choice Mothers needed to be individuals who could cope with the challenges associated with doing something that goes against the norm, and to thus have an ability not to care too much about what others might think. Tina, for example, stated, "it does take a level of confidence and maturity of thinking to deal with, to have enough spine to go, actually I don't care what others think. And Eliza reflected that "it takes a certain amount of strength and strong will to go against something society considers to be normal'.

Women also spoke of not having compromised and engaged in a relationship solely to have a child. Ultimately their preference was to go it alone rather than be in a relationship for the wrong reasons. Lucy explained her relief at making this choice:

I look at my friends, my baby groups and just go, wow there is a reason we didn't just pick one up off the street and take him home... I said I'm not going to settle.

Fiona similarly spoke of friends who "might not have been 100% happy with who they were with but they were with them at the time they thought they were having kids", and how she felt she'd, "rather do what I've done and be happy, rather than feeling like I've settled for or compromised on the person just for the outcome".

All of the women spoke of a strong desire to be a mother. This strong desire may be one of the key determining or differentiating factors between those women who choose single motherhood and those who decide not to follow this unconventional route. For example, Eliza spoke of her longing for a child despite her single status:

For me the urge to have a child was so strong that it was very hard to leave it and I just felt that was what I wanted. And I think a lot of women are like that whether they're in a relationship or not. That urge is just there.

Similarly, Rachel spoke of her determination saying that even when she was younger, she felt that, "I will have a child some day and if I don't find anyone, I will do it on my own."

Loss of the dream

This theme represents the inevitability of declining fertility along with the aging process and the ensuing pressure on women to find a partner in order to create a family while they are still biologically able to do so. Most of the women spoke of having always wanted a family and assuming that it would come about in the conventional way. When they realised this might not happen, there was an inevitable sense of loss and grief at the 'loss of a dream' along with a fear about potential regrets later in life. Fiona, for example, commented on her decision to act to become a Choice Mother:

... I didn't want to get to 45, 50, when it was too late and suddenly go, I wish, if only, I should've, would've, could've, kind of thing…

There was also a realisation that meeting a potential partner and father of their much-longed-for child was becoming more urgent as their fertility deadline approached. However, there was also a recognition that this could add pressure to dating and developing relationships. Tina reflected on the fact that rushing into a relationship in order to have a family, could have resulted in her making poor choices:

I was starting to kind of rush relationships, or rush, and it was starting to put the wrong pressure on new relationships. In my view a new relationship needs time to nurture and grow and not have the tick tock, tick tock, tick tock, in the background.

Fiona similarly reflected how the prospect of intended parenthood at more advanced age could put a, "huge amount of pressure on an early relationship" asking, "first date, second date, when do you bring it up?"

Most of the women spoke of holding out for the 'dream' of doing things the conventional way and that Choice Motherhood had not been their first or preferred choice. However, each woman reached the point where she realised she needed to separate the ideal of having a partner with whom to have a child, from having a child. Eliza describes her challenge to make peace with her choice:

To tell you the truth, I haven't always made my peace with it you know. There are times when it really bugs me and really gets to me …. because I really didn't want it to be the way that it was you know.

All on our Own

Along this pathway to motherhood, there were some challenges that had to be managed and women reflected on how they needed to confront these on their own. Despite their varying experiences, common issues were around how they selected their donor, experiences at the fertility clinic, and the need to access support throughout.

Women spoke of their difficulties in selecting a donor, with some approaching their friendship groups or advertising, and some choosing from clinic-recruited donors. Whichever approach they took, women spoke of feeling isolated and described the selection process as "overwhelming" (Tina), "consuming" (Katie) and "hard work" (Lucy). For Katie this meant that she reached a stage where she "was so exhausted" that she felt she "needed to get on with it" and "couldn't just keep looking for the right donor". For her it was difficult not to have a partner with whom to share the decision, and who could say, "Come on, let's just make a decision".

All five of the women who went through the journey with a fertility clinic spoke of some of their difficulties in navigating the system as a single person. One participant spoke of her feelings of powerlessness of being a patient within the fertility system where the patient is vulnerable and dependent on the clinic's services for a positive outcome. For Katie, her experience at a clinic when she attempted to freeze her eggs showed a lack of sensitivity in the process of notifying her, as a single woman, about her results:

You come out of your surgery… in this communal recovery room, and then this doctor… she basically told me that they were no good. And I can remember, I was still half asleep, I can remember lying there, tears streaming down my face, as she goes to the couple next door to tell them how great theirs were.

So not only did she feel unsupported by the manner in which she received the bad news, Katie also had to deal with it on her own while the couple next door were given a far better result.

Similarly, Cara felt that the clinics "just take your money. They don't seem to look at individual circumstances". For Tina it was difficult not having someone to confide in as she waited to find out if her pregnancy was viable, stating that "it was the centre of her world" but that she struggled, "not having a lot of people to talk to about it."

The absence of a partner in relation to rearing a child solo was also noted by the women. This seemed to be more often identified as a lack of emotional rather than practical support. Rachel who had an eight-year-old daughter stated:

I think the hardest thing I find is more on an emotional level. There isn't anyone else I can turn around to and… someone who feels that exact same sense of pride in what they've done… being able to go isn't she great? And have someone go yeah, didn't we do well? So, from that point of view, that's probably my hardest challenge. Just feeling like I don't have that other person…

Accessing support was portrayed as a critical part of the journey to become a Choice Mother. In the absence of a partner, single women spoke of needing to get support while initiating the process, during pregnancy and after the birth of their child. Most of the women reported that their families and friends had provided some assistance, but many, especially those without local family support, spoke about the role of connection with other Choice Mothers as significant. Katie described attending a coffee group for Choice Mothers:

Yeah, I can't tell you how amazing it was to walk into that coffee group on that first day. Like I just wanted to burst into tears. It was so weird. Like I thought you're flipping kidding me this whole room, like I thought I was one of the first women in New Zealand to do it. I had no idea.

Fiona spoke about how support from other Choice Mothers was "really awesome" not only for her but also, "for the kids growing up, knowing that there are kids in a similar situation".

While the journey of Choice Motherhood was described as a challenging one, women also spoke about some of the advantages to being single parents. Fiona commented that, "I didn't feel like I had to maintain a relationship with another person", and Lucy that, "in some ways it's going to be easier because I don't have to factor a third person in."

Challenging Conversations

Choosing to bring up a child as a single parent from the outset involves a specific set of challenges, identified as the extent to which the mothers were willing to be open

with their children about the manner of their conception, how to talk to others about their situation and how to manage their reactions.

Because all but one of the children of the Choice Mothers in this study were primarily pre-verbal, most of the women had yet to have a conversation with their children about their conception or family structure. However, it seems that most had conducted research into how they would go about this, had books they could refer to for guidance or spoke of approaching experts for advice. Cara's approach seemed centred around that some families are created differently, rather than the fact that there was something (or someone) missing:

> I want to bring her up that all families are different…because I don't want her to think that she doesn't have a Dad, I want her to think that some people don't have Dads.

Choice Mothers in this study planned to tell their children early in their lives, with Eliza commenting that, "I think we'll just weave it into life…to the point where it's seamless", and Katie saying that she wanted "to do all the right things and be open from the outset".

Once they had their child, most of the women talked about varying degrees of openness with others regarding sharing their situation as Choice Mothers. Lucy spoke of how she "was not going to hide it" saying it was "nothing to be ashamed of". Eliza likewise commented that she was "not ashamed to talk about it with other people, or if anyone asks me or it comes up in conversation". Rachel spoke of her daughter's right to share her story, "I won't ever ask (my daughter) not to say, because it's her story". However, there was an almost tentative nature about most of the women's sharing of information with others.

While most of the women denied that they had experienced societal stigma, most had had experience with less than positive reactions. This included speculation from others as to the nature of conception, with Tina describing how men at her workplace speculated, "was it a one-night stand at the pub or something?" Rachel described her experience with a religious aunt, "and drove all the way to my house so she could come and tell me that she disapproved terribly about my decision". And Cara told of a woman at her church who enquired about her daughter's conception:

> But this one lady said, I need to ask you, how did she come about? And so, I told her. And she said, I don't agree, I don't agree with that. She said I don't agree with sperm donation. And I said, Oh Ok.

Eliza similarly described the reaction of her stepmother as Choice Motherhood as a violation of social norms, saying that "that's not how it's meant to happen."

Finally, women also described a prejudicial view of the type of women who choose to become Choice Mothers. These included that Choice Mothers are "all in their forties, white women" (Eliza), "all ten tonne, hideously unattractive" (Cara), that they're "man-haters" (Katie) who "say all men are arseholes" (Cara). Nonetheless women believed it was their and their children's right to share this information, with Rachel saying that her daughter "had as much right to talk about it as any other child does".

Redefining families

Families formed through donor conception are inherently more complex because of the involvement of a party outside of the family unit. Many of the women seemed to be navigating their paths to their particular family dynamic as they unfolded and spoke of having to clarify for themselves the definitions and terminology they wanted to use to explain, and manage, the complex family relationships. This appeared to be an evolving issue particularly as the children were currently mostly pre-verbal. Tina talked of her concerns when she first met with the donor and he referred to Harry (her son) as his son:

> He (the donor) referred to Harry as his son. And he referred to other sons and daughters (via donor conception) and that has bothered me. And I need to say something to him about it. Because I don't consider Harry his son… And it's a fine line, but it's just, it's 'father', 'son', they're emotionally-connected words. They infer a role in life versus it's a transaction.

While Choice Mothers were uncomfortable with donors assuming the role of father, they seemed less concerned about donors' children being defined in terms of siblings in relation to their child. Cara commented that, "At (donor's daughter's) birthday party, (donor) introduced us to everyone as this is Cara and (her daughter), (donor's daughter's) sister, half-sister". She reflected that, "she wasn't too fazed by this. If that's how he wants to introduce her then that's OK."

For those who had used known donors, the role of the donor in their lives was not without some complexities. This included possible emotional conflict for the child in having a relationship with the donor, but also recognising that the donor is not fulfilling the role traditionally ascribed to that of a father. Fiona described some of the benefits of a known donor but also identified potential risks due to the fact that he might suddenly "go off the rails" or "demand custody":

> So, I guess it's quite different from when you go through and you have an anonymous donor. There's kind of a lot more issues and I guess it's quite risky.

Fiona preferred the role to be more akin to "something like an uncle", thereby distancing the donor's role somewhat, and likewise, Tina reflected that she wanted a relationship but not "too close".

Only one of the seven women interviewed is currently in a relationship. Some were open to that possibility in the future and yet others felt that it would only happen under very special circumstances, or not at all. For them, having a child involved additional considerations that needed to be considered in forming new relationships, including how to introduce the new partner into their already more complex family dynamic. Eliza, the only woman currently in a relationship, contemplated:

> But I do wonder with the guy that I'm seeing, I'd like if we stay together, if he's comfortable that he'd be called Dad. That's a conversation that I need to have with him if we stay together...

Living the new dream

While women spoke of the challenges of Choice Motherhood, there was also a sense that they felt blessed and grateful to have made the decision to take this journey into single motherhood. Many of them described themselves as lucky, particularly with regard to the nature of their child. There was also a sense from some of the women of not allowing circumstances to control their fate, but being willing to take action to achieve their parenting desire.

Eliza, who had talked of struggling to make peace with the situation, managed to have a philosophical view of her situation:

And I wouldn't be without (her son), he's such a special little kid you know… I think it must have been meant to be and everything happens for a reason…I'm really proud of myself for making that decision and taking control of my life and not sitting back…

While building a family in this way may not have been a first choice for Choice Mothers, there was also a sense of being fortunate to have been able to have this option. As Cara reflected, "I think it's far the superior, if you really want children…isn't it far better to go this route than not have any?"

DISCUSSION

Results from this study suggest that Choice Motherhood, while experienced as rewarding, may also bring with it a unique set of challenges for women becoming parents in this way in the New Zealand context. At each stage of their journey from contemplation, conception, through to parenthood, there are significant challenges to be negotiated by Choice Mothers largely on their own, and they may need information and support to promote positive outcomes both for themselves as well as their offspring.

Choice Mothers in this study appeared to be similar to the subgroup of single mothers identified by other research (Murray & Golombok, 2005a, Jadva et al, 2009). For example, while they appeared similar due to being older mothers and having a certain degree of financial security, they shared personality traits, such as determination, a refusal to settle for the wrong relationship, and a strong desire to do what was needed to become a mother.

Most of the participants also talked of how Choice Motherhood was not necessarily a first choice or preferred option. Within this group of women, some were reconciled to this situation, while others, like in other research, appeared to continue to grieve or experience challenges with 'going it alone' (Ainge Roy, 2016). In addition, while some of the women remained open to meeting a partner in the future, for others this appeared less important now that they had become mothers, or even not necessarily desirable given their family make-up and the challenges of integrating a new person into what was now their 'new normal'.

Some of the women had a long journey to reaching motherhood and spoke of this process as very isolating. Many spoke of the fertility procedures as challenging due in part to having to make significant decisions and wait for results, all on their own. This sense of sole responsibility can continue through pregnancy and child-rearing and may be complicated by Choice Mothers' experiences of stigma. Despite the fact that they may be regarded as having an 'elevated status' in the single parent hierarchy (Seals Allers, 2016), the majority of participants had experienced less than positive reactions from others and were able to recall responses indicative of stigmatisation.

Risk of possible judgement or stigma may be one reason that women find it difficult to be open about the use of donor-insemination (Landau & Weissenberg, 2010). Daniels (2007) highlights the importance of assisting fertility clients in managing actual or perceived stigma, as this also increases the likelihood of honesty and openness with their offspring. Connection with other Choice Mothers may be an important way of addressing isolation and coping with stigma. This highlights the potential role of groups, such as those organised by Fertility New Zealand (FNZ), in meeting the needs of both Choice Mothers, and their children. FNZ has a designated support person, and regular support meetings are organised for women investigating or undergoing treatment to become Choice Mothers in Auckland. A Facebook group allows women from other regions to also connect and share support and information, including ways in which to talk to others and their children about the child's conception.

Most of the women in this study had researched how they might manage disclosure conversations with their children, despite most of their children being pre-verbal. All of the participants seemed to be committed to open discussion with their child, as backed by research which indicates there should never be a time when the child does not know of their origins (MacDougall, et al., 2007). Disclosure, openness and honesty, and healthy identity formation are held to be closely linked, with most of the research to date which cites negative outcomes for donor-conceived offspring being conducted in jurisdictions with less open legislation, or on partnered couples where deception of the offsprings' conception history has often played a part. As the majority of women in this study had very young children, disclosure patterns and outcomes for children were not able to be explored. However, the intention to be open may bode well for future outcomes given the research underscoring the need for transparency.

Research has suggested that donor-recipient-offspring relationships can be complex, especially when the recipient is a single woman (Daniels, et al., 2012). New Zealand legislation has among the most open legislative requirements in the world and enables the recipient to request identifying information (i.e. the donor's name and other details) once a child has been born (HART Act, 2004). The only participant who had conceived outside of New Zealand spoke of the donor's openness to being identified as a key factor in her selection, and thus all of the participants had open identity donors, which brings with it the possibility of contact and relationship with the donor.

How to define the role of the donor and the relationships of the donor to the child remained a challenge however, and was discussed in relation to terminology used for the donor. In this study, participants were uncomfortable with ascribing a father role to the

donor, and yet were comfortable with sibling relationship terms and a more distant family connection between the donor and offspring. Establishing boundaries remained a challenge however and seemed to constitute unchartered territory, and indeed, Daniels et al. (2012) have suggested that women need to be counselled around how to manage these relationships and the importance of creating appropriate boundaries around levels of contact (Daniels et al., 2012).

In spite of the challenges reported by women, however, they all spoke positively of their decision to become Choice Mothers, with many reflecting on how fortunate they were. It would appear that having overcome the lack of a partner that they were able to reflect on how grateful they were to have this alternative form of family-building available to them.

Study Implications

This research highlights the need for more information and support throughout the Choice Motherhood journey. New Zealand clinics typically offer a number of counselling sessions for women electing to use donors. However, this support tends to be limited to the time period prior to conception, and more support could be offered to women both during treatment and in the post-treatment phase. For example, the Australia New Zealand Infertility Counsellors Association (ANZICA) guidelines suggest that a counselling session should take place with the Choice Mother prior to meeting with the donor (ANZICA guidelines, n.d.). However, women in this study who had met with their donor or a sibling family had not received counselled prior to meeting. Given the importance in managing the expectations around this experience, the potential for encountering someone who may react in unanticipated ways, and the consequences of this for family formation and relationships, (Daniels et al., 2012; Michelle, 2006), it would seem pertinent that this recommendation is followed.

More support could also be offered to manage grief around 'letting go of the dream', and then around disclosing the nature of their child's conception. While this may be part of pre-treatment counselling, grief may complicate adjustment (Lukse & Vacc, 1999), and furthermore, non-disclosure has been directly linked with a lack of counselling from fertility clinics specifically with regard to the process of disclosure (Hargreaves & Daniels, 2007). Opportunities to discuss this in a group situation might be useful for some women.

Further, it is also important to consider the access to information and support by those Choice Mothers who may follow unregulated channels to treatment. This likely occurs as a direct result of long waiting lists for sperm and expensive treatment. The limited access to donor sperm raises policy issues around donor recruitment, and cross border reproductive care. In 2016, the Advisory Committee on Assisted Reproductive Technology (ACART) recommended to the Ministry of Health that importation of gametes should occur subject to New Zealand legislation, including the need for open-identity donation, and that no payment should have taken place (Lawton, 2016). While such a move is not without its difficulties, it could potentially allow women to access donor sperm in a regulated manner from overseas. This

recommendation is currently still being considered by the Minister of Health.

Study Limitations and Further Research

As discussed in the introduction, there are a range of pathways to Choice Motherhood which means that as a group Choice Mothers are not always easily accessible, which can complicate recruitment. A further challenge lies in the fact that given the size and nature of the community, it is possible that participants may be identified by other members of the community, which may further present challenges for recruitment. The sample size of this study is small with only seven participants, and extrapolation of results to the wider group of Choice Mothers need to be made cautiously. Small sample sizes are however, considered meaningful for thematic analysis studies (Braun & Clarke, 2013) such as this one.

All but one of the women in this study had children under two years of age which meant that they were all quite early into their experience of being a Choice Mother. This also meant that the children were mostly pre-verbal and thus the issue of disclosure was not particularly relevant yet. More research is needed to explore the ongoing challenges of Choice Motherhood at various developmental stages of the offspring.

A further limitation of this study was that only one of the women in this study identified as Māori/Pakeha. It is currently difficult (if not impossible) to access figures on the number of Choice Mothers who identify as Māori, however it would be useful to explore attitudes towards and experiences of Choice Mothers who identify as Māori further, also given the impact of Māori values and belief systems on New Zealand policy (Daniels, 2008). Few of the participants spoke specifically about the importance of whakapapa, which may reflect the mostly European heritage of the participants, or, since donor identifiability is key to New Zealand legislation, unlike jurisdictions where women are given a choice between identifiable and non-identifiable donors, it may be that this aspect of Choice Motherhood is taken for granted.

Conclusion

Choice Motherhood presents women with a set of unique challenges throughout their parenting journey. Women require access to information about the options available to them to become mothers and the implications of each of these options to make fully informed decisions. Throughout the journey, women also need support to help them navigate the process of donor selection, to manage the reactions of others, and to manage ongoing issues that may arise in the course of building their families, including disclosure of conception to their children and negotiating relationships with donors and their families. Further, as family structures become more complex, there is a need to ensure that the best interests of the children are managed so that stigma is reduced, and societal norms reflect this evolving diversity and inclusivity. With the right resources and support to promote their wellbeing, Choice Mothers and their offspring have the opportunity to thrive as an alternative family model in New Zealand society.

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What predicts healthy lifestyle habits? Demographics, health and personality correlates of healthy lifestyle factors in New Zealand

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This study used data from the 2010 New Zealand Attitudes and Values Study (N = 4,441) to examine the demographic, health and personality correlates of healthy lifestyle habits among New Zealand adults. Participants reported their perceived importance of various behaviours (e.g. limiting salt, sugar intake) for leading a healthy lifestyle and regularity of engaging in them. Relative to importance ratings, considerably fewer people reported habitually engaging in positive health behaviours. Women, older, partnered individuals, those living with diabetes, high on Conscientiousness and Honesty-Humility showed increased regularity of healthy dietary behaviours. Māori and Pacific individuals, those living in highly deprived areas and with high BMI and Neuroticism showed reduced behaviour regularity. There were also important group differences in health-related perceptions (e.g. access to resources, social support to live healthy lifestyle).

Keywords: Health Behaviours, Healthy Lifestyle, Personality, New Zealand

Introduction

Dietary habits and lifestyle behaviours are important predictors of one's risk of various illnesses and mortality (Khaw et al., 2008; Loef & Walach, 2012). In New Zealand, lifestyle-related illnesses continue to show a high prevalence and are among the leading causes of death. One in three New Zealanders live with obesity (Ministry of Health [MOH], 2018a), over 240,000 have been diagnosed with diabetes (Virtual Diabetes Register, 2018), and more than 5000 die from ischaemic heart disease each year (MOH, 2018b). Diabetes and obesity rates are particularly high among Māori and Pacific peoples, and those with higher deprivation (MOH, 2014; 2015; 2016; 2018a). This can be linked to their low access to healthcare and negative health behaviours such as tendency to be physical inactive and adopt unhealthy eating habits (MOH, 2016; 2018a). Disparities in health behaviours are also evident among other demographic groups. For instance, women, older and Asian peoples tend to be physically inactive (MOH, 2014; 2015; 2016), whereas men and younger individuals exhibit higher cholesterol and sugar intake (University of Otago and MOH, 2011).

Identifying group disparities in specific health behaviours help us recognise the negative behavioural patterns of and type of intervention required by different groups. To develop more effective interventions, it is not only vital to be aware of demographic differences but to also understand the contribution of psychological factors to one's health behaviours. As personality traits are indicative of one's "enduring pattern of thinking, feeling and behaving" (McCrae & Costa, 1997, p.509), many international studies use personality theories to increase insight into the relationship between psychological characteristics and health behaviours. The most commonly used framework to describe personality is the 'Big-Five' model (McCrae & Costa, 1997; Sibley et al.,

2011). People high on Neuroticism tend to be anxious and insecure, while people high on Conscientiousness tend to be diligent and organized. Extraversion is associated with being active and sociable, Openness with being curious and open-minded, and Agreeableness with being co-operative and altruistic (Sibley et al., 2011). More recently, Honesty-Humility (i.e. being fair, sincere) has been identified as the sixth personality dimension (Ashton & Lee, 2007; see Appendix for more detailed definitions).

Conscientiousness has been associated with a range of beneficial health behaviours, including adopting healthy diets with increased fruit and vegetable consumption and lower meat consumption (Bogg & Roberts, 2004; Keller & Siegrist, 2015; Mõttus et al., 2012, 2013). Conversely, Neuroticism has been linked with increased sugar and savoury food intake, emotional eating and a convenience diet (Elfhag & Morey, 2008; Keller & Siegrist, 2015; Mõttus et al., 2013). Openness and Extraversion have also been related with restrained eating (i.e. cognitive restriction of energy-dense food; Elfhag & Morey, 2008) and health-aware diets (Mõttus et al., 2012). However, little is known about the generalizability of these findings to the New Zealand context. One of the few studies conducted in New Zealand found that high Openness and Extraversion, and high Conscientious to a lesser extent, were associated with increased fruit and vegetable intake among young adults aged 17 to 25 years (Conner et al., 2017). As this study solely focused on fruit and vegetable consumption, the influence of personality traits on other specific health behaviours is still largely unknown. Moreover, the association between personality traits and health behaviours among middle-aged or older New Zealand adults has yet been examined.

Using a nationally representative sample of predominately middle-aged/older New Zealand adults, the current study assesses the unique effect of the Big-Six

Table 1. Interpretation of Big-Six personality traits, including example traits, and likely adaptive benefit and costs resulting from high levels of each personality dimension (adapted from Sibley et al. 2011)

Factor	Interpretation	Example Traits	Likely adaptive benefits of high levels (in evolutionary history)	Likely costs of high level (in evolutionary history)
Extraversion	Engagement in social endeavours	Sociability, leadership, exhibition	Social gains (friends, mates, allies)	Energy and time; risks from social environment
Agreeableness	Ingroup co-operation and tolerance; reciprocal altruism in HEXACO model	Tolerance, forgiveness, (low) quarrelsomeness	Gains from cooperation, primarily with ingroup (mutual help and nonaggression)	Losses due to increased risk of exploitation in short-term exchanges
Conscientiousness	Engagement in task-related endeavours	Diligence, organization, attention to detail	Material gains (improved use of resources), reduced risk	Energy and time; risks from social environment
Neuroticism (low Emotional Stability)	Monitoring of inclusionary status and attachment relations; kin altruism in HEXACO model.	Anxiety, insecurity, (low) calmness	Maintenance of attachment relations; survival of kin in HEXACO model	Loss of potential gains associated with risks to attachment relations.
Openness to Experience	Engagement in ideas-related endeavours	Curiosity, imaginativeness, (low) need for cognitive closure and (low) need for certainty	Material and social gains (resulting from discovery)	Energy and time; risks from social and natural environment
Honesty-Humility	Reciprocal altruism (fairness) Fairness, sincerity, (low)	Fairness, sincerity, (low) entitlement and (low) narcissism	Gains from co-operation, (mutual help and non-aggression)	Loss of potential gains that would result from the exploitation of others (and in particular outgroup members)

personality traits, demographic factors and diet-related illnesses on various health behaviours and perceptions. As 'health behaviour' is a very broad concept, we decided to take a more sophisticated approach and assess the correlates of specific health behaviours and relevant health attitudes. This included one's perceived importance and self-reported regularity of limiting salt or sugar intake, consuming fruit and vegetables, and access to resources to live a healthy lifestyle. We aim to identify key demographic, personality and health factors that show independent associations with individual health behaviours. Our findings will provide a framework for future research on the main determinants and nuanced patterns of New Zealanders' health behaviours, and inform the development of tailored interventions for target groups. Table 1 presents a guide to interpretations (and example attributes) of the Big-Six personality traits, and a summary of their likely benefits and costs.

METHOD

Sampling Procedure

The New Zealand Attitudes and Values Study (NZAVS) is a longitudinal postal survey study with a large probability sample of New Zealand adults. Data from this study has been published in numerous studies that examine New Zealanders' social attitudes, personality traits and health outcomes. This study is reviewed by the University of Auckland Human Participants Ethnics Committee every 3 years and has most recently been renewed on 05-September-2017 until 03-June-2021. Time 1 (2009) participants of this study were recruited from across the entire country by randomly selecting samples from the New Zealand electoral roll

(response rate: 16.6%; N = 6,518). In Time 2 (2010), the retention rate from Time 1 was 67.87% (N=4,425) with 16 new opt-ins. The current study used data from the Time 2 (2010) wave of the study (N = 4,441).

Participants

Participants had a mean age of 51 years (age range: 19 to 95; SD = 15.23) and median household income of $70,000 (SD = 71981). Around 62% of participants were female (38.4% male), 85.9% identified as being of European, 15.5% as Māori, 3.6% as Pacific and 4.0% as Asian ethnicity (ethnic categories were not mutually exclusive). Sixty eight percent of participants were parents and 72.7% were employed. The mean Body Mass Index (BMI) of the total sample was 27.30 (SD = 6.07), and 6.6% were diagnosed with diabetes, 6.1% with heart disease, 21.7% with high cholesterol and 21.5% with high blood pressure.

Measures

Participants were initially asked "how important do you think the following behaviours are for a healthy lifestyle, and how regularly do you do them?" Subsequently, above a list of six health behaviours they were asked; "How important do you think this is for leading a healthy lifestyle?" (0=unimportant, 3=important) and "How regularly do you do this on a daily basis" (0= never, 3= always). The six behaviours included: "limit intake of salt," "limit intake of saturated fats," "limit intake of foods/drinks high in sugar," "eat lots of fibre and whole grain," "eat lots of fruit and vegetables" and "engage in regular physical activity." Participants rated their agreement to various statements about health-related perceptions (1= strongly disagree, 7=strongly agree). Example: "It is important for people to know the facts about healthy eating/nutrition" (See notes in Table 4 for all statements). Subjective rating of leading a healthy lifestyle and access to resources to live a healthy lifestyle were reported (1=definitely no, 7=definitely yes). Participants indicated whether they had "been diagnosed by a doctor" with heart disease, diabetes, vitamin/mineral deficiency, high cholesterol or high blood pressure.

Participants reported their gender, weight, height, relationship and employment status, date of birth, and annual household income. Ethnicity was measured using the standard New Zealand Census item, in which participants could indicate each ethnic group they belonged to. The four main ethnic groups of interest in this study were European, Māori, Pacific and Asian peoples. Deprivation was measured using the 2013 New Zealand Deprivation Index, which uses census information to assign a decile-rank index from 1 (least deprived) to 10 (most deprived) to each meshblock unit (Salmond & Crampton, 2014). Socio-economic status was measured using the measured using the New Zealand socio-economic index (Milne, Byun, & Lee, 2013).

Personality traits were measured using the Mini-IPIP6 (Sibley et al., 2011) – a short from measure of the Big-Six personality traits using four-item subscales rated from 1 (very inaccurate) to 7 (very accurate). Exploratory

and confirmatory analyses of the 2009 NZAVS (N=5,562) sample validated the Mini-IPIP six-factor structure in the New Zealand context (Sibley et al., 2011). The six personality traits reliability predicted variations in hours spent on different trait-related activities (e.g. Extraversion was strongest predictor of time spent with friends).

RESULTS

A series of multiple linear regressions were conducted to predict people's health behaviour regularity and health-related perceptions.[1] All demographic, health and personality variables were simultaneously included as predictors for each outcome to assess their unique association with the outcome variable. Europeans were used as the reference group for ethnicity. Missing data for exogenous variables were estimated using Rubin's procedure for multiple imputation. Final parameter estimates were obtained by averaging 1000 imputed datasets (thinned using every 200th iteration) generated based on information in the existing data and random elements. Descriptive statistics were calculated using SPSS after applying sample weighting based on gender, ethnicity and region of residence.

As seen in Figures 1 and 2, most participants indicated that healthy dietary behaviours and regular physical activity were highly important for leading a healthy lifestyle (i.e. rating of 3). Of the six behaviours, the least proportion of people reported an importance rating of 3 for limiting salt and the highest proportion for regular physical activity and eating fruits/vegetables. Relative to importance ratings, less participants reported regularly engaging in each health behaviour. For instance, whereas 65.9% of Māori and 75.6% of females indicated that limiting saturated fats was highly important, only 16% and 29.1% respectively reported always engaging in such behaviour (i.e. rating of 3). Compared to Europeans and Asian peoples, fewer Māori and Pacific peoples indicated always engaging in positive dietary behaviours and having 'high' subjective healthy lifestyle or 'high' access to resources to lead a healthy lifestyle (high: ratings of 6-7).

Multiple regression predicting health behaviour importance and regularity

A series of regressions were conducted to assess the demographic, health and psychological correlates of health behaviour importance (0=unimportant, 3= important) and regularity (0=never, 3=always). Only key findings are reported in-text. As seen in Table 2, gender showed a particularly strong association with dietary behaviours (β's >1). Women reported higher ratings of importance for limiting salt (b=-.190), saturated fats (b=-.159), sugar (b=-.198), eating fibre/whole grains (b=-.179), eating fruit/vegetables (b=-.113), and regular exercise (b=-.048). Older age was associated with higher rated importance for limiting salt (b = .005) and eating fibre/whole grains (b = .003) but lower rated importance for regular exercise (b = -.002). High blood pressure was associated with higher rated importance for limiting salt

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[1] We chose not to use an ordinal logistic regression as this would increase the number of estimated parameters in our model and increase the complexity of our results.
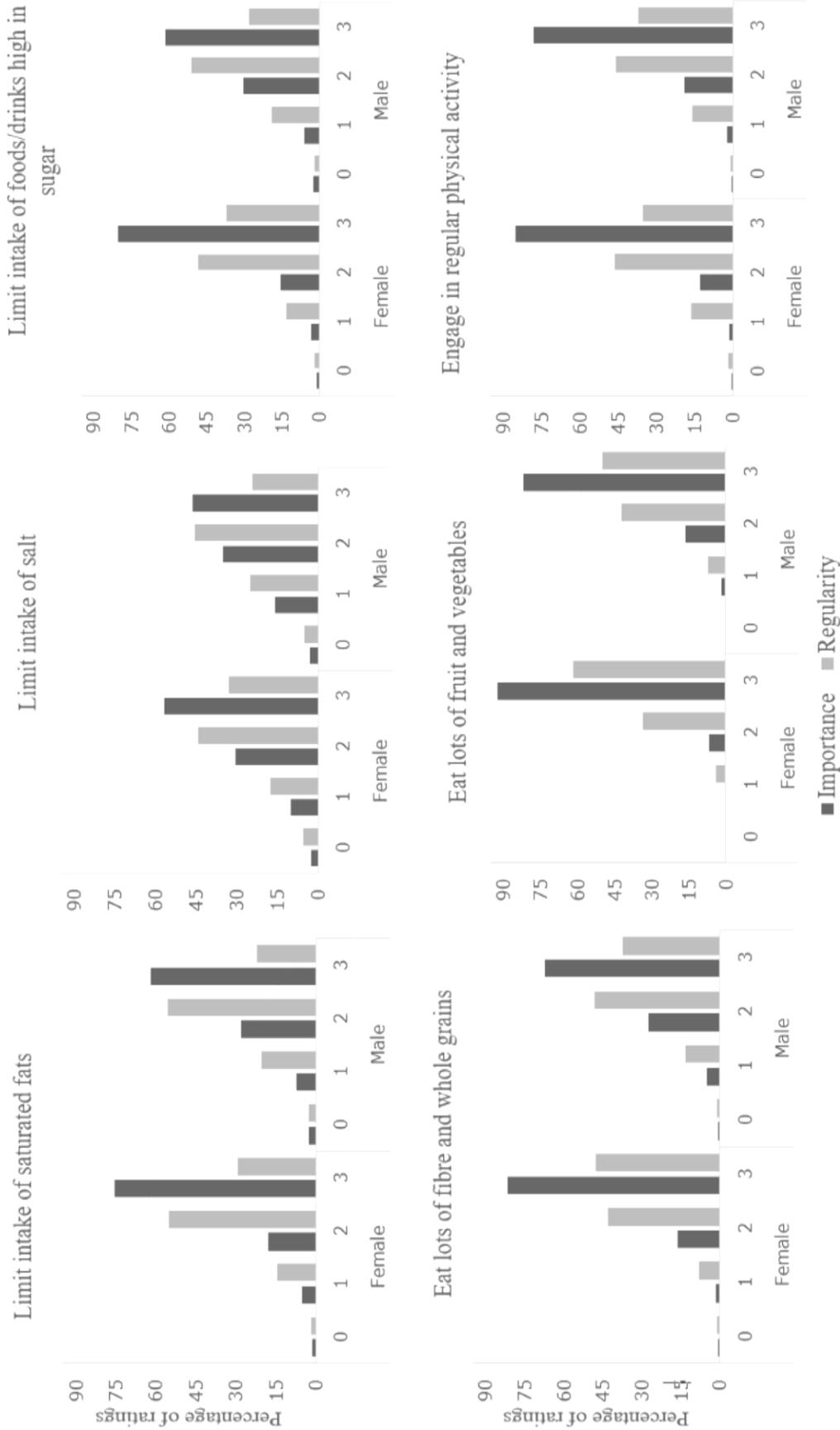
Figure 1. Gender differences in perceived importance of behaviour for leading a healthy lifestyle and regularity of engaging in them.

(b = .136) and sugar (b = .051), and high cholesterol was
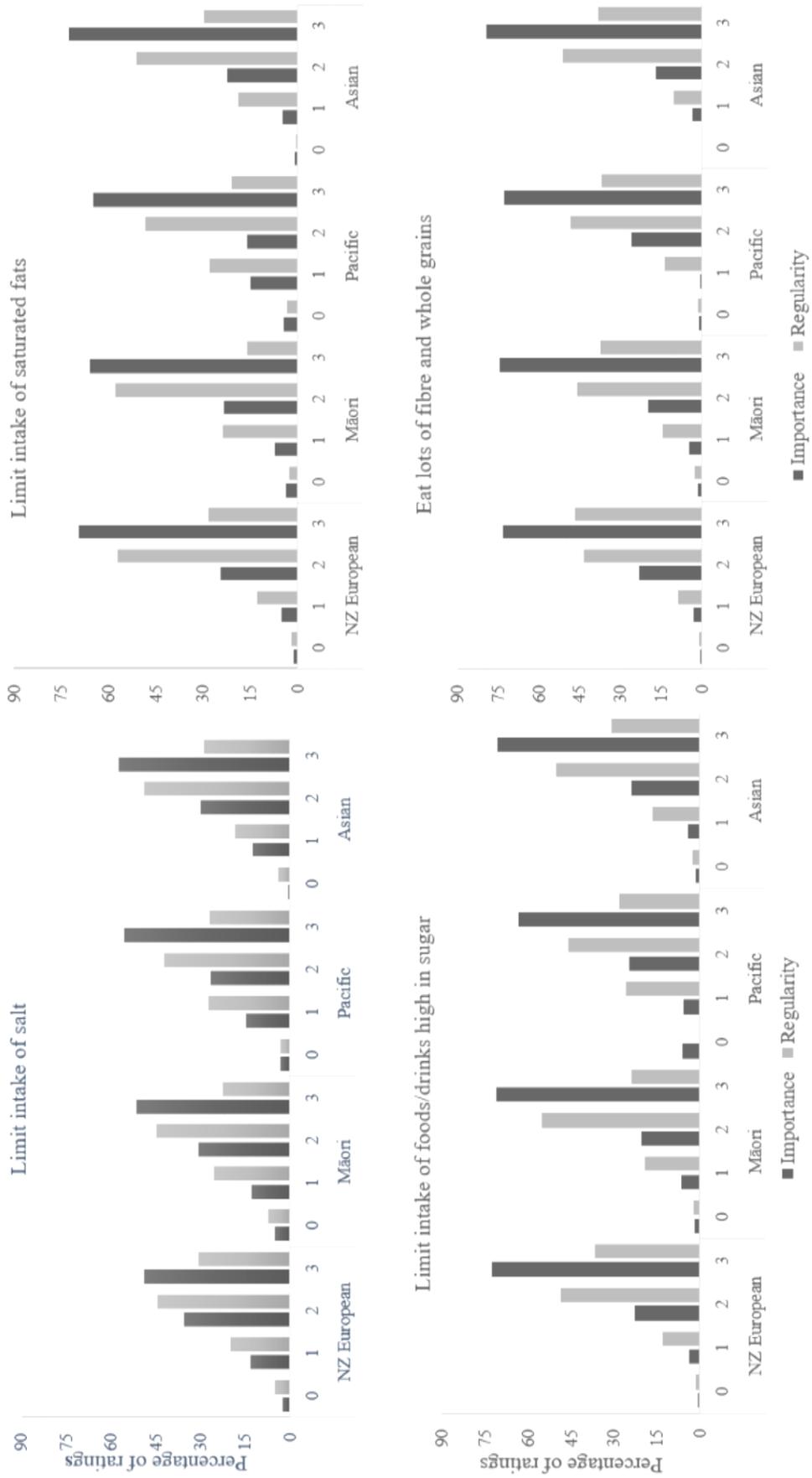
Figure 2. Ethnic differences in perceived importance and regularity of engagement in health behaviours, and ratings of subjective healthy lifestyle and access to resources.
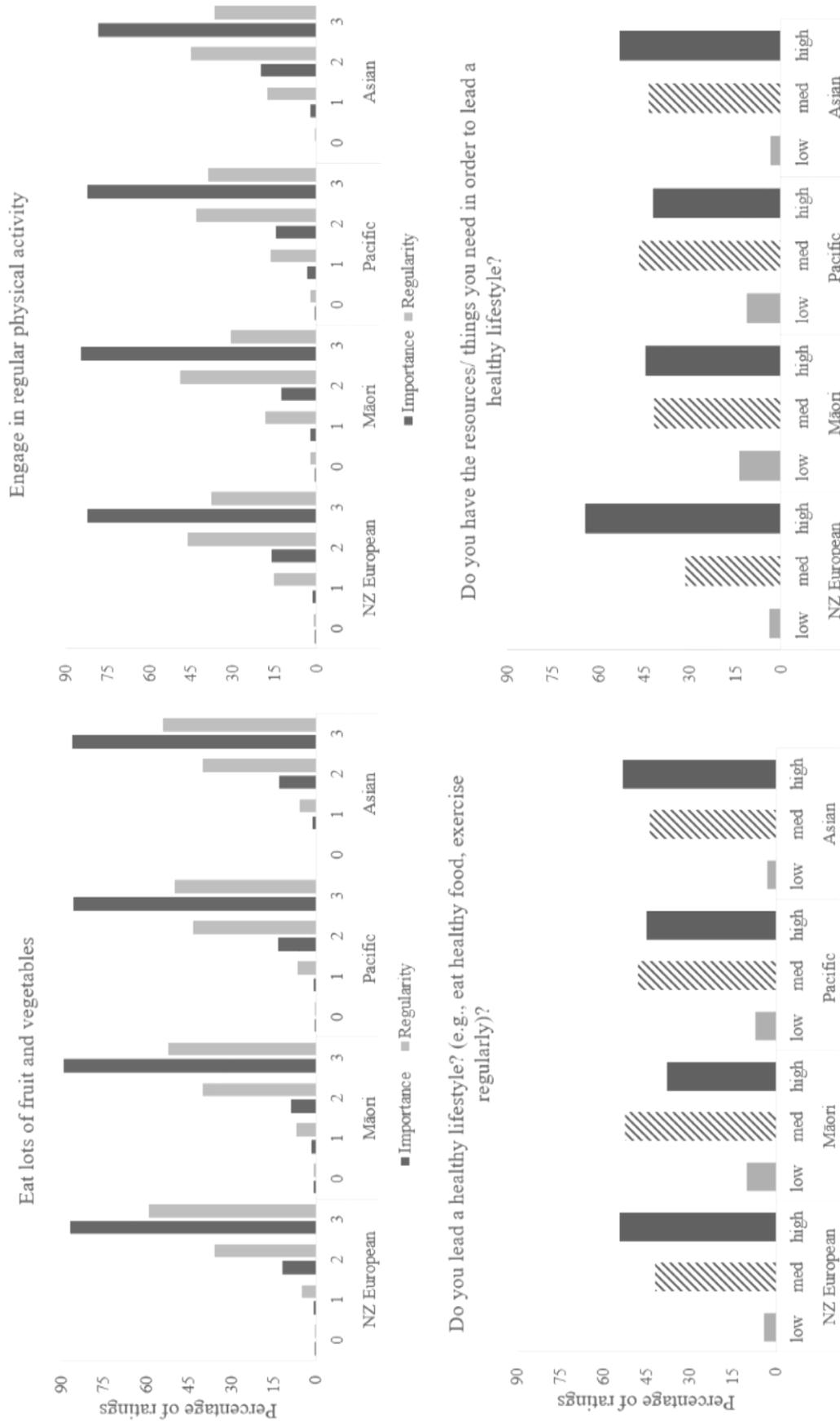
Figure 2 continued. Note: ratings for healthy lifestyle and access to resources split into three categories; low (1-2), medium (3-5) and high (6-7)

associated with higher rated importance for limiting salt (b=.100) and saturated fats (b=.055).

Agreeableness and Conscientiousness were consistently linked with increased ratings of importance

Table 2. Regression coefficients and 95% confidence intervals for regression predicting health behavior importance (IMP).

	Limit salt (IMP)			Limit saturated fats (IMP)			Limit sugar (IMP)		
	B	95% CI	[B]	B	95% CI	[B]	B	95% CI	[B]
Gender C (0=women, 1= men)	**-.190****	**-.243**	**-.137**	**-.159****	**-.204**	**-.114**	**-.198****	**-.240**	**-.156**
Age	.005**	.003	.007	.001	-.001	.002	.001	-.001	.002
Deprivation	-.007	-.016	.002	-.004	-.011	.004	-.011**	-.018	-.004
Household income (log)	-.007	-.033	.019	.007	-.015	.030	.007	-.015	.028
Māori C	.036	-.031	.103	-.038	-.095	.019	-.013	-.065	.039
Pacific C	.024	-.120	.169	-.166*	-.305	-.027	-.124	-.249	.001
Asian C	.106	-.006	.219	.015	-.080	.109	-.013	-.110	.085
Parent C	-.006	-.070	.059	-.021	-.074	.032	-.004	-.051	.042
Partner C	.072*	.015	.130	.048	-.001	.097	.033	-.011	.077
Religious C	.105**	.057	.154	.061**	.022	.100	.016	-.020	.053
Employed C	.041	-.020	.102	.044	-.008	.095	.037	-.010	.084
Urban C	.077*	.027	.127	.036	-.004	.077	.018	-.019	.055
SES	-.001	-.003	.001	.002**	.001	.004	.001	.000	.003
BMI	-.002	-.006	.003	.000	-.004	.003	.002	-.002	.005
Heart disease C	.054	-.048	.156	.033	-.051	.117	.033	-.042	.107
Diabetes C	.034	-.065	.132	-.022	-.107	.063	.085*	.007	.163
High blood pressure C	.136**	.075	.196	.036	-.016	.087	.051*	.003	.098
High Cholesterol C	.100**	.042	.158	.055*	.006	.104	.034	-.011	.079
Vitamin deficiency C	-.022	-.122	.079	.055	-.020	.130	.014	-.059	.086
Extraversion	-.009	-.032	.013	-.007	-.025	.012	-.005	-.021	.011
Agreeableness	.042**	.014	.070	.041**	.018	.064	.041**	.021	.062
Conscientiousness	.059**	.035	.083	.057**	.036	.077	.028**	.010	.046
Neuroticism	-.005	-.028	.018	-.011	-.029	.008	-.021*	-.037	-.005
Openness	-.001	-.026	.023	.011	-.008	.031	.021*	.003	.039
Honesty-Humility	-.005	-.025	.015	.000	-.017	.016	.017*	.002	.032

Notes: * p<.05, **p < .01, R^2=.059, .059, .062 respectively, N= 4419. 'C' denotes categorical variable; 0= no, 1=yes. Standardized beta

(Table 2 continued)

	Eat fibre/whole grains (IMP)			Eat fruit and veges (IMP)			Physical activity (IMP)		
	B	95% CI	[B]	B	95% CI	[B]	B	95% CI	[B]
Gender C (0=women, 1= men)	**-.179****	**-.218**	**-.140**	**-.113****	**-.142**	**-.084**	-.048**	-.080	-.015
Age	.003**	.001	.004	.000	-.001	.001	-.002*	-.003	.000
Deprivation	-.006	-.013	.000	-.004	-.009	.001	-.009**	-.015	-.004
Household income (log)	-.004	-.022	.015	-.005	-.017	.007	.006	-.009	.020
Māori C	.022	-.025	.069	.031	-.001	.063	.040*	.002	.078
Pacific C	.015	-.080	.111	-.026	-.102	.049	.008	-.079	.095
Asian C	.064	-.012	.141	-.002	-.059	.055	-.046	-.117	.024
Parent C	.002	-.043	.047	-.011	-.044	.022	-.010	-.046	.026
Partner C	.023	-.017	.063	.023	-.007	.052	.010	-.026	.045
Religious C	.053**	.019	.087	.038**	.014	.063	.027	-.002	.056
Employed C	.021	-.022	.064	.004	-.027	.036	.018	-.021	.057
Urban C	.009	-.025	.043	.000	-.024	.025	.019	-.010	.048
SES	.001	-.001	.002	.001	.000	.002	.000	-.001	.001
BMI	.000	-.003	.003	-.001	-.004	.001	-.002	-.005	.001
Heart disease C	-.039	-.111	.033	-.028	-.088	.031	-.040	-.117	.037
Diabetes C	.012	-.056	.080	-.007	-.062	.048	-.084*	-.158	-.011
High blood pressure C	.000	-.043	.043	.009	-.026	.043	-.007	-.048	.034
High Cholesterol C	.040	.000	.080	.009	-.021	.039	.019	-.018	.055
Vitamin deficiency C	-.009	-.080	.063	-.012	-.061	.037	-.003	-.063	.057
Extraversion	-.005	-.021	.011	-.001	-.012	.011	-.003	-.015	.010
Agreeableness	.038**	.018	.057	.031**	.017	.045	.035**	.019	.051
Conscientiousness	.022**	.006	.038	.019**	.007	.030	.030**	.016	.045
Neuroticism	.000	-.015	.016	-.012*	-.023	.000	-.016*	-.029	-.003
Openness	.009	-.008	.025	.006	-.006	.018	.015*	.001	.029
Honesty-Humility	.004	-.011	.019	.000	-.011	.011	.002	-.010	.014

Notes: * p<.05, **p < .01, R^2 = .052, .047, .044 respectively, N= 4419. 'C' denotes categorical variable; 0= no, 1=yes. Standardized beta greater than .1 bolded.

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for all health behaviours. This included limiting salt (b=.042 and .059 respectively), saturated fats (b=.041 and .057), sugar (b=.041 and .028), eating fibre/whole grains (b=.038 and .022), eating fruit/vegetables (b=.031 and .019), and regular exercise (b=.035 and .030). In contrast, Neuroticism was linked with lower perceived importance of limiting sugar (b = -.021), eating fruits/vegetables (b= -.012) and regular exercise (b = -.016).

Women, older individuals and those with low BMI reported increased regularity of all dietary health behaviours (see Table 3). This included limiting salt (b=-.17, .008 and -.006 respectively), saturated fats (b=-.177, .010 and -.009), sugar (b=-.185, .010 and -.004), and eating fibre/whole grains (b=-.162, .008 and -.004) and fruit/ vegetables (b=-.194, .007 and -.005). Gender and age showed particularly strong effects (β's >1). Partnered individuals reported increased regularity of limiting salt (b=.079) and saturated fats (b=.074), and eating fruit/vegetables (b=.076). Diabetes showed a strong association with higher regularity of limiting sugar (b = .331) and was further linked with increased regularity of limiting salt (b = .164), saturated fats (b = .164), eating fibre/whole grains (b = .107) and fruit/vegetables (b = .115). Māori (b = -.078) and Pacific peoples (b = -.129) reported lower regularly of limiting saturated fats. High cholesterol was linked with lower regularity of eating fibre/whole grains (b = -.053) and fruit/vegetables (b = -.083).

Conscientious and Honesty-humility were associated with increased regularity of all dietary health behaviours. This included limiting salt (b=.049 and .036 respectively), saturated fats (b=.041 and .031), sugar (b=.057 and .038), eating fibre/whole grains (b=.053 and .020) and eating

fruit/vegetables (b=.050 and .017). Openness was associated with increased regularity of limiting saturated fats (b=.022) and sugar (b=.029) and eating fibre/whole grains (b=.025). Extraversion was linked with increased regularity of eating fruits/vegetables (b = .029) and exercise (b = .039). Conversely, Neuroticism was related to decreased regularity of limiting saturated fats (b=-.022), limiting sugar (b=-.029), eating fibre/whole grains (b=-.020), eating fruit/vegetables (b=-.031), and regular exercise (b=-.058).

Multiple regression predicting health-related perceptions

As shown in Table 4, older age was associated with higher rated importance of public health knowledge (b = .004), women's health education (b = .021), need for money to lead a healthy lifestyle (b = .014), greater social support (b = .008), increased subjective healthy lifestyle (b = .019) and access to resources (b = .018). Men reported lower belief in the importance of public health knowledge (b = -.163), lower perceived social support (b = -.113) and subjective healthy lifestyle (b = -.179). Having a partner was linked with greater social support (b = .176), higher subjective healthy lifestyle (b = .135) and access to resources (b = .229). Being Pacific (b = .369) or Asian (b = .323) were also associated with increased social support. Being Māori, a parent, having higher deprivation and BMI were associated with decreased subjective healthy lifestyle (b = -.126, -.145, -.025 and -.066 respectively) and access to resources (b = -.208, -.179, -.046 and -.046).

Conscientiousness and Agreeableness were linked with higher rated importance of public health knowledge

Table 3. Regression coefficients and 95% confidence intervals for regression model predicting health behavior regularity (REG).

	Limit salt (REG)			Limit saturated fats (REG)			Limit sugar (REG)		
	B	95% CI	[B]	B	95% CI	[B]	B	95% CI	[B]
Gender [C] (0=women, 1= men)	**-.175****	**-.231**	**-.120**	**-.177****	**-.223**	**-.131**	**-.185****	**-.232**	**-.137**
Age	**.008****	**.006**	**.011**	**.010****	**.008**	**.012**	**.010****	**.008**	**.012**
Deprivation	.001	-.009	.011	.000	-.008	.008	.002	-.006	.011
Household income (log)	-.009	-.038	.021	.002	-.027	.023	.006	-.018	.030
Māori [C]	-.043	-.115	.028	-.078**	-.133	-.023	-.057	-.115	.001
Pacific [C]	-.048	-.189	.093	-.129*	-.251	-.007	-.087	-.202	.028
Asian [C]	.074	-.053	.200	.084	-.019	.187	.001	-.114	.116
Parent [C]	.029	-.040	.098	-.030	-.086	.026	-.021	-.078	.037
Partner [C]	.079*	.017	.140	.074**	.024	.124	.029	-.023	.082
Religious [C]	.059*	.007	.111	-.009	-.050	.033	-.041	-.084	.002
Employed [C]	.075*	.010	.140	.043	-.011	.097	.075**	.022	.129
Urban [C]	.011	-.042	.064	-.017	-.060	.025	.012	-.032	.056
SES	.002	.000	.004	.003**	.001	.005	.003**	.001	.004
BMI	-.006*	-.010	-.001	-.009**	-.013	-.005	-.004*	-.008	.000
Heart disease [C]	.100	-.005	.205	.079	-.008	.166	-.026	-.118	.066
Diabetes [C]	.164**	.067	.262	.164**	.080	.247	**.331****	**.246**	**.416**
High blood pressure [C]	.064	.000	.129	-.025	-.078	.027	-.020	-.075	.035
High Cholesterol [C]	.047	-.016	.109	.020	-.031	.071	-.029	-.083	.024
Vitamin deficiency [C]	-.073	-.181	.035	-.047	-.135	.041	-.073	-.163	.018
Extraversion	-.012	-.036	.012	.012	-.007	.032	-.006	-.026	.013
Agreeableness	.000	-.030	.029	.016	-.008	.040	.021	-.003	.046
Conscientiousness	.049**	.023	.075	.041**	.020	.061	.057**	.036	.078
Neuroticism	-.013	-.037	.011	-.022*	-.042	-.002	-.029**	-.049	-.009
Openness	.003	-.022	.029	.022*	.002	.043	.029**	.007	.050
Honesty-Humility	.036**	.015	.058	.031**	.014	.049	.038**	.020	.056

Notes: * p<.05, **p < .01, R^2=.069, .111, .105 respectively, N= 4415. 'C' denotes categorical variable; 0= no, 1=yes. Standardized beta greater than .1 bolded.

(Table 3 continued)

	Eat fibre/whole grains (REG)			Eat fruit and veges (REG)			Physical activity (REG)		
	B	95% CI [B]		B	95% CI [B]		B	95% CI [B]	
Gender [C] (0=women, 1= men)	-.162**	-.207	-.117	-.194**	-.235	-.153	-.017	-.065	.032
Age	.008**	.007	.010	.007**	.005	.008	.005**	.003	.007
Deprivation	-.007	-.015	.001	-.008*	-.015	-.001	-.002	-.011	.006
Household income (log)	-.001	-.023	.020	.004	-.016	.025	.006	-.018	.030
Māori [C]	-.083**	-.142	-.024	-.001	-.052	.050	.004	-.056	.064
Pacific [C]	-.011	-.125	.104	-.016	-.122	.091	.147*	.019	.274
Asian [C]	.000	-.097	.097	.034	-.058	.126	-.038	-.152	.076
Parent [C]	-.047	-.101	.008	-.025	-.074	.024	-.061	-.121	.000
Partner [C]	.041	-.007	.089	.076**	.031	.120	.035	-.019	.089
Religious [C]	.016	-.026	.057	.020	-.017	.056	-.037	-.081	.007
Employed [C]	.016	-.036	.068	.005	-.040	.050	.045	-.012	.101
Urban [C]	-.054*	-.096	-.011	-.060**	-.097	-.023	-.037	-.082	.008
SES	.001	.000	.003	.000	-.001	.002	-.001	-.003	.001
BMI	-.004*	-.008	-.001	-.005**	-.008	-.002	-.026**	-.031	-.022
Heart disease [C]	.017	-.068	.102	.019	-.059	.097	-.089	-.186	.008
Diabetes [C]	.107**	.027	.186	.115**	.040	.190	.007	-.089	.103
High blood pressure [C]	-.001	-.054	.051	.006	-.042	.054	-.054	-.113	.004
High Cholesterol [C]	-.053*	-.104	-.003	-.083**	-.129	-.038	-.057	-.113	-.001
Vitamin deficiency [C]	.019	-.067	.106	-.056	-.136	.024	-.123*	-.216	-.030
Extraversion	.025**	.006	.044	.029**	.012	.046	.039**	.019	.060
Agreeableness	.021	-.003	.045	.023*	.001	.045	.016	-.009	.042
Conscientiousness	.053**	.032	.073	.050**	.032	.067	.067**	.045	.089
Neuroticism	-.020*	-.039	-.001	-.031**	-.048	-.013	-.058**	-.079	-.038
Openness	.025*	.005	.045	.015	-.003	.033	-.009	-.030	.013
Honesty-Humility	.020*	.002	.037	.017*	.001	.033	.009	-.010	.027

Notes: * p<.05, **p < .01, R^2= .082, .094, .098 respectively, N= 4415. 'C' denotes categorical variable; 0= no, 1=yes. Standardized beta greater than .1 bolded.

Table 4. Regression coefficients and 95% confidence intervals for regression model predicting health-related perceptions.

	Public health knowledge IMP			Women health education			Social Support		
	B	95% CI	[B]	B	95% CI	[B]	B	95% CI	[B]
Gender [C] (0=women, 1= men)	-.163**	-.226	-.100	-.569**	-.670	-.469	-.113*	-.203	-.024
Age	.004**	.001	.006	.021**	.017	.025	.008**	.005	.012
Deprivation	-.002	-.013	.009	.028**	.010	.045	-.005	-.021	.010
Household income (log)	-.004	-.036	.028	-.044	-.098	.009	.001	-.047	.049
Māori [C]	.109**	.029	.188	.142*	.016	.267	.032	-.082	.147
Pacific [C]	.227**	.064	.391	.418**	.172	.664	.369**	.135	.604
Asian [C]	.002	-.144	.148	.643**	.437	.849	.323**	.121	.525
Parent [C]	-.068	-.142	.006	-.033	-.153	.088	-.109*	-.215	-.004
Partner [C]	-.009	-.077	.058	.026	-.082	.133	.176**	.078	.274
Religious [C]	.109**	.052	.166	.117*	.026	.208	.174**	.093	.254
Employed [C]	-.015	-.089	.060	-.181**	-.299	-.063	-.131*	-.233	-.029
Urban [C]	.018	-.041	.077	-.014	-.108	.079	-.022	-.105	.060
SES	.000	-.002	.002	-.002	-.006	.001	.001	-.002	.004
BMI	-.006*	-.012	-.001	.006	-.002	.014	-.008*	-.015	-.001
Heart disease [C]	.029	-.089	.148	.004	-.199	.207	.168	.002	.334
Diabetes [C]	.175**	.069	.282	-.045	-.238	.147	.160	-.004	.324
High blood pressure [C]	-.038	-.112	.036	-.026	-.145	.092	-.116*	-.223	-.010
High Cholesterol [C]	.078*	.008	.147	-.040	-.155	.074	-.032	-.131	.068
Vitamin deficiency [C]	.003	-.127	.133	-.088	-.284	.109	-.059	-.234	.116
Extraversion	-.012	-.039	.015	.030	-.014	.074	.090**	.052	.129
Agreeableness	.136**	.102	.169	.127**	.073	.180	.113**	.063	.163
Conscientiousness	.106**	.077	.135	.095**	.049	.141	.083**	.042	.125
Neuroticism	-.037*	-.065	-.008	.044	.000	.089	-.081**	-.122	-.039
Openness	.018	-.011	.047	.014	-.032	.061	.021	-.021	.064
Honesty-Humility	.010	-.015	.035	-.140**	-.178	-.102	-.038*	-.072	-.005

Notes: * p<.05, **p < .01, R^2= .075, .112, .063 respectively, N= 4441. 'C' denotes categorical variable; 0= no, 1=yes. Standardized beta greater than .1 bolded. Statements used in questionnaire (1= strongly disagree, 7=strongly agree): "It is important for people to know the facts about healthy eating/nutrition," "We need to invest specifically in educating young girls and women about healthy lifestyles for the sake of future generations," "people close to me support and encourage me to lead a healthy lifestyle."

(Table 4 continued)

	Need for money			Subjective healthy lifestyle			Access to resources		
	B	95% CI	[B]	B	95% CI	[B]	B	95% CI	[B]
Gender [C] (0=women, 1= men)	-.085	-.205	.035	-.179**	-.266	-.092	-.071	-.163	.020
Age	**-.014****	**-.019**	**-.009**	**.019****	**.016**	**.023**	**.018****	**.015**	**.022**
Deprivation	-.001	-.022	.020	-.025**	-.041	-.010	-.046**	-.062	-.029
Household income (log)	.008	-.048	.065	-.027	-.069	.015	**.128****	**.072**	**.184**
Māori [C]	.058	-.102	.218	-.126*	-.242	-.010	-.208**	-.338	-.077
Pacific [C]	-.093	-.423	.237	.270*	.031	.508	.094	-.170	.359
Asian [C]	-.212	-.473	.049	.059	-.126	.244	.024	-.181	.228
Parent [C]	-.023	-.170	.124	-.145**	-.249	-.041	-.179**	-.291	-.067
Partner [C]	.081	-.051	.213	.135**	.041	.230	.229**	.124	.333
Religious [C]	-.081	-.192	.031	.046	-.031	.124	-.023	-.105	.059
Employed [C]	-.123	-.265	.020	.062	-.043	.167	.213**	.101	.326
Urban [C]	.087	-.027	.200	-.113**	-.193	-.034	-.012	-.098	.073
SES	.006*	.001	.010	.001	-.002	.004	.001	-.003	.004
BMI	.017**	.007	.027	**-.066****	**-.075**	**-.058**	-.046**	-.054	-.038
Heart disease [C]	.133	-.093	.358	-.084	-.264	.096	-.219*	-.409	-.029
Diabetes [C]	-.209	-.441	.023	.021	-.160	.202	.038	-.153	.229
High blood pressure [C]	.046	-.100	.191	-.018	-.123	.086	-.034	-.144	.076
High Cholesterol [C]	-.059	-.198	.079	-.157**	-.260	-.055	-.007	-.111	.096
Vitamin deficiency [C]	-.023	-.251	.205	-.156	-.327	.015	-.324**	-.524	-.124
Extraversion	-.050	-.103	.003	.066**	.029	.103	.072**	.032	.112
Agreeableness	-.037	-.103	.028	.012	-.035	.059	.055*	.004	.106
Conscientiousness	-.062*	-.118	-.006	.172**	.132	.212	.109**	.066	.151
Neuroticism	.068*	.013	.122	-.159**	-.198	-.120	-.147**	-.190	-.105
Openness	.021	-.035	.078	.022	-.018	.061	.014	-.028	.057
Honesty-Humility	**-.339****	**-.386**	**-.292**	.022	-.013	.057	.094**	.057	.132

Notes: * p<.05, **p < .01, R^2= .099, .209, .191 respectively, N= 4441. '[C]' denotes categorical variable; 0= no, 1=yes. Standardized beta greater than .1 bolded. Statements used in questionnaire (1= strongly disagree, 7=strongly agree): "It is easy to lead a healthy lifestyle if you make lots of money", "Do you lead a healthy lifestyle? (e.g., eat healthy food, exercise regularly)?" "Do you have the resources/ things you need in order to lead a healthy lifestyle?"

(b = .106 and .136 respectively), increased social support (b = .083 and .113) and access to resources (b = .109 and .055). Extraversion was associated with increased social support (b = .090), subjective healthy lifestyle (b = .066) and access to resources (b = .072). Alternatively, Neuroticism was related to lower rated importance of public health knowledge (b = -.037), decreased social support (b = -.081), subjective healthy lifestyle (b = -.159) and access to resources (b = -.147). Honesty-Humility was strongly linked with lower belief in the need for women's health education (b = -.140) and money to lead a healthy lifestyle (b = -.339).

DISCUSSION

The current study examined the patterns and correlates of health behaviours and perceptions among a large sample of predominately middle-aged/older New Zealanders. This included one's perceived importance of and regularity of engagement in specific health behaviours, and access to resources for leading a healthy lifestyle. Most participants regarded all health behaviours, especially fruit/vegetable consumption and exercise, as being highly important for leading a healthy lifestyle (51-87%). However, a considerably lower proportion reported always engaging in such behaviour (26-56%). Compared to European and Asian peoples, a lower proportion of Māori and Pacific peoples reported always engaging in health behaviours and having high access to resources. To increase insight into group differences in health behaviours, we further examined the unique demographic, health and personality correlates of various health behaviours and health-related perceptions.

Demographic characteristics

Consistent with other New Zealand studies (MOH, 2014; 2015; 2016; University of Otago and MOH, 2011), being female and older were associated with increased engagement in all positive dietary behaviours. Similarly, having a partner was associated with increased regularity of limiting salt and saturated fats, and greater fruit/vegetable consumption. Women, older and partnered individuals all reported higher social support and subjective healthy lifestyle ratings. Both women and older individuals showed stronger belief in the importance of public health knowledge, whereas partnered and older individuals indicated having greater access to resources. An interesting point to note is that older and partnered individuals did not report higher importance ratings for at least half of the dietary behaviours they regularly engaged in. Perhaps due to their greater access to resources and social support, maintaining a healthy diet is less effortful and regarded as a normal part of daily life for these groups.

Previously, parenthood has been linked to lower physical activity and young mothers were found to show higher energy intake (Berge, Larson, Bauer, & Neumark-Sztainer, 2011). In our study, parenthood was not significantly associated with ratings of health behaviour importance or regularity, but parents reported lower ratings for subjective healthy lifestyle, social support and resource accessibility. Those with higher deprivation and BMI also reported lower access to resources and subjective healthy lifestyle. In line with previous studies

(MOH, 2014; 2015; 2016; University of Otago and MOH, 2011), higher deprivation was linked with lower consumption of fruit/vegetables and lower perceived importance of limiting sugar. Although high BMI was not associated with lower importance ratings for any specific health behaviour, it was linked with lower regularity of all healthy dietary behaviours, exercise and decreased belief in the importance of public health knowledge. It is thus essential to provide focused health education and dietary interventions for those with high BMI.

In New Zealand, Māori and Pacific peoples are typically found to have lower income, poor housing, greater unmet need for healthcare and higher rates of physical illnesses (MOH, 2015, 2016, 2018a; Statistics New Zealand, 2014, 2015). Thus, it is not surprising that a lower proportion of Māori and Pacific peoples reported always engaging in healthy dietary behaviours and having high access to resources. Some of these ethnic differences were evident even after controlling for multiple health, demographic and psychological factors. Compared to Europeans, Māori and Pacific peoples showed lower regularity of limiting saturated fats, and Māori individuals exhibited lower subjective healthy lifestyle and access to resources. On a more positive note, Pacific peoples reported increased regularity of exercise and greater social support to lead a healthy lifestyle, and both ethnic groups showed stronger belief in the importance of public health knowledge. Capitalizing on this belief could help encourage Māori and Pacific participation in health education initiatives.

Our findings highlight important group differences in healthy lifestyle behaviours. Whereas some groups acknowledge the importance of health behaviours and regularly engage in them, others are less likely to recognize the importance of or experience various barriers to adopting positive health behaviours. It is thus imperative to identify the unique barriers encountered by different groups and implement tailored interventions accordingly. For Māori and Pacific peoples, financial barriers or access to resources may be a key factor preventing them from leading a healthy lifestyle. Additional research on the reasons why these groups have trouble limiting saturated fats is needed to identify the most appropriate way to address this specific health behaviour. On the other hand, men and those with high BMI are likely to require focused education about the benefits and importance of healthy eating. Understanding group differences in health beliefs and health-promoting factors can further inform interventions. For instance, as Pacific peoples report greater social support to live a healthy lifestyle, they may benefit most from interventions that cultivate community or family-oriented support groups.

Health conditions

Generally, people show minimal lifestyle changes after being diagnosed with diet-related illnesses (Booth et al., 2013; Chong et al., 2017; Ma et al., 2008). Difficulty in altering routine behaviour, lack of motivation or knowledge and cost of a healthy diet are commonly cited reasons for minimal change. Somewhat consistent with these studies, those previously diagnosed with heart disease or vitamin deficiency did not report increased importance or engagement ratings for any health behaviour. These groups also reported lower access to resources, suggesting that barriers to healthcare or financial strain may be playing a role. High blood pressure and high cholesterol were linked with higher importance ratings for limiting salt, saturated fats or sugar. However, high blood pressure was not associated with differences in behaviour regularity and high cholesterol was linked with decreased regularity of eating fibre/whole grains and fruits/vegetables. Hence, it is especially essential to emphasize the importance of consuming healthy food for those with high cholesterol. As for physical activity, those with diabetes reported lower importance ratings whereas those with vitamin deficiency reported lower behaviour regularity.

Despite only rating limiting sugar as having higher importance, those with diabetes reported increased regularity of all five healthy dietary behaviours and stronger belief in the importance of public health knowledge. Relative to those with other health conditions, individuals with diabetes appear more likely to actually adopt a healthy diet following their diagnosis. In line with ratings of importance, diabetes showed a particularly strong association with increased regularity of limiting sugar. This raises the potential that those with diabetes may further increase their regularity of other dietary behaviours if health professionals can effectively convey their vital importance. However, it is yet unclear whether New Zealanders with diabetes maintain long-term dietary changes or gradually divert to their original eating habits over time. In an Australian sample, amount of physical exercise decreased and body weight increased with increasing time since receiving a diabetes diagnosis (Chong et al., 2017). Further longitudinal research is needed to better understand these nuanced effects and identify key factors that foster long-term lifestyle change among New Zealanders.

Personality traits

Personality traits showed significant associations with health behaviours and perceptions independent of demographic and health factors. Generally, high Conscientiousness and low Neuroticism have been linked with positive health behaviours, health outcomes and longevity (Bogg & Roberts, 2004; Elfhag & Morey, 2008; Goodwin & Friedman, 2006; Keller & Siegrist, 2015). Our findings further substantiate these two traits as unique correlates of health behaviours and perceptions in the New Zealand context. Conscientiousness was found to be associated with both higher rated importance and regularity of all six health behaviours. Neuroticism was linked with lower rated importance and regularity of limiting sugar, eating fruits/vegetables and exercising, as well as decreased regularity of limiting fats and eating fibre/whole grains. In terms of health-related perceptions, Conscientious was associated with increased importance ratings for public health knowledge, higher social support, access to resources and subjective healthy lifestyle. Unsurprisingly, Neuroticism showed decreased ratings on these same measures.

There have been somewhat mixed findings on the effect of Openness, Extraversion and Agreeableness on health behaviours (see Conner et al., 2017; Keller &

Siegrist, 2015; Mõttus et al., 2012). In our study, Openness was associated with higher rated importance of limiting sugar and exercise, and increased regularity of eating fibre/whole grains and fruits/vegetables and limiting fats and sugar. Extraversion did not have a significant effect on ratings of importance but was associated with increased regularity of eating fibre/whole grains and fruits/vegetables, and exercise. Extraversion, along with Agreeableness, also showed associations with positive health-related perceptions such as increased social support and access to resources. Ironically, despite reporting higher importance ratings for all positive health behaviours and public health knowledge, Agreeable individuals only reported increased regularity of eating fruit and vegetables. As Agreeable individuals tend to adhere to group norms (Sibley et al., 2011), they may support the general consensus that dietary behaviours and exercise are important for leading a healthy lifestyle but lack sufficient motivation to actually carry out these behaviours.

Honesty-Humility is a relatively recently identified personality trait and thus few studies have examined its relation to health behaviours. This personality trait is characterized by low self-centredness, high pro-social motivation and humbleness (Ashton & Lee, 2007). Our results indicated that Honesty-Humility was associated with increased regularity of all positive dietary behaviours. Honesty-Humility was also significantly related to an interesting mix of health-related perceptions. This included greater access to resources, but lower social support, belief in the importance of women's health education and necessity of money to lead a healthy lifestyle. In regard to dietary behaviours, as humble individuals are better able to resist self-enhancing tendencies (Tangney, 2009), they may be capable of cognitively restraining their intake of tempting but unhealthy food. Tong et al. (2016) found that participants who recalled experiences of humility exhibited higher self-control in resisting consumption of chocolates. Although this study did not treat humility as a stable 'trait', it suggests that certain facets of Honesty-Humility may help maintain control over their dietary behaviours and resist unhealthy food.

As personality traits provide a useful framework for organizing groups of behaviours, they can help inform future policies and interventions (Bleidorn, 2019). We are not advocating that policies should strive to shape or change people's personality but intend to highlight the utility of personality frameworks in providing useful insight into the patterns of and motivations behind people's health behaviours. Greater knowledge about the psychological contributors of and barriers to health behaviours faced by different groups help us better identify the specific type of support or intervention they require. For instance, as one's personality traits influences the persuasiveness of differently framed healthy eating messages (Thomas, Masthoff, & Oren, 2017), health professionals may alter their communication style and health advice to best suit the patient's personality. Personality traits could also be used to help increase people's awareness about their own thought processes and behavioural tendencies that promote unhealthy habits – a valuable understanding that would aid health attitude or behaviour change.

Limitations and future research

Limitations of the current study include the use of self-reported and cross-sectional data. Thus, we are unable to infer causality form our results. We also did not examine the reasons why those from distinct groups reported greater engagement in certain health behaviours or expressed different health-related perceptions. Longitudinal research methods are needed to gain a deeper insight into the trajectories of New Zealanders' health behaviours and perceptions. This includes potential changes in the effect of certain variables on health behaviours over time, and how significant life events such as an illness diagnosis may initiate short-term or long-term lifestyle behaviour change. Additional research is needed on the specific thought processes that promote or discourage specific health behaviours among those with different personality traits. Such findings will assist the identification of more effective strategies to deliver health information and promote lifestyle changes to groups with distinct needs and characteristics.

Conclusion

The current study examined the demographic, health and personality correlates of various health behaviours and health-related perceptions using a nationally representative sample of New Zealand adults. Most people rated all positive health behaviours as being highly important for leading a healthy lifestyle, but a considerably lower proportion reported always engaging in them. Women, older, partnered individuals and those living with diabetes showed increased regularity of healthy dietary behaviours, whereas those of Māori and Pacific ethnicity, with high BMI or deprivation showed reduced regularity. High Conscientiousness and Honesty-Humility but low Neuroticism were linked with increased regularity of health behaviours. There were also notable group disparities in perceived importance of public health knowledge, access to resources and social support to live a healthy lifestyle. Taken together, our findings provide a useful framework for future research on the unique demographic and psychological barriers to a healthy lifestyle encountered by different groups. Increased insight into these factors will inform the development of improved health promotion interventions that tailor to the specific needs of diverse groups.

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Flexible identities: Narratives of Māori Italians in New Zealand

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Ethnicity is a key variable in social science research and is often assumed to be a stable construct. Yet, for more and more individuals in New Zealand's diversified society, ethnicity is flexible and individuals may choose to change and adapt their ethnic identities contingent on social contexts. Using material from narrative interviews with 44 Māori Italians conducted in New Zealand in 2013, this paper explores the relevance of the social identity theoretical approach for understanding the construction of mixed ethnic identities. Employing an interactionist conceptualisation of identity expression, our findings disclose four thematic patterns by which participants assert positive mixed ethnic identities that allow them to align with desirable notions of what it means to be Māori, Italian, and Māori Italian and to differentiate themselves from what they perceive as the less positive aspects of the dominant New Zealand culture.

Introduction

Māori, Italians, and Māori Italians in Aotearoa

In Aotearoa New Zealand, the term 'ethnicity' is defined as 'a measure of cultural affiliation', rather than 'a measure of race, ancestry, nationality, or citizenship'; furthermore, ethnicity is self-perceived and people can choose to belong to more than one ethnic group (Stats NZ, 2018). The indigenous people of Aotearoa, Māori, more than any other ethnicity, are likely to identify with more than one ethnic group (Stats NZ, 2014a). The number of Māori acknowledging multiple ethnic affiliations has been growing each year, with younger Māori (aged 18 to 25) most likely to identify with two or more ethnicities. In the 2013 Census, the most recent for which statistics are available, over half of Māori (53.5% or 320,406 people) identified with two or more ethnic groups. The most common second ethnicity for Māori is European/Pākehā; however, reflecting changing national demographics and mixed ethnic unions resulting from steady increases in Pasifika, Asian, and new-immigrant shares of the population, each year more Māori are identifying with other groups (Stats NZ, 2014b). Compared to Māori, the New Zealand Italian population is very small. Notably, though, in the 1996 Census proportionately more Italians than any other group identified their second ethnicity as Māori (Thomson, 1999, p. 91). In the 2013 Census only 3798 people usually resident in New Zealand claimed Italian ethnicity and 28% of them (1077 people) also identified as Māori (McGuigan, 2016).

British colonisation of New Zealand has had a profound intergenerational impact on Māori (see Reid, Rout, Tau, & Smith, 2017 for a discussion) and the history of Māori engagement with Pākehā has been fraught with conflict as well as intimacy. Māori–Pākehā unions have been commonplace in New Zealand for generations (King, 1988, 1999).

Māori–Pākehā hybridity has been studied relatively extensively, thus theorising ethnicity mainly in relation to Māori and Pākehā (Meredith, 1999; Rocha & Webber,

2017). Multi-ethnic groups and indigenous populations, on the other hand, remain relatively understudied. Recent qualitative studies of Māori Dalmatians (Božić-Vrbančić, 2005), Māori Indians (Pio, 2009), Māori Chinese (Ip, 2013), and Māori Jews (Ore, 2018) show that these immigrant minorities share with the indigenous Māori a past of employment in certain occupations (for example, gum digging in the case of Dalmatians) as well as of discrimination. While this facilitated interethnic exchanges, support, and marriages, it also gave rise to racial tensions and divided self-identities both within families and ethnic communities (on both sides) and in relation to the wider, external Pākehā community. However, notwithstanding the recent anti-Asian backlash affecting the Māori Chinese (Ip, 2013), there appears to be a tendency among the younger generations to value both heritages equally (see Pio 2009, pp. 14-15; Ore, 2018), possibly as a consequence of the shift from assimilationist politics to official biculturalism and unofficial multiculturalism, with each identity spurring the valorisation of the other.

It is noteworthy that none of these studies lists the Italians among the immigrant minorities with a similar history of discrimination and repression to that of the ethnic group under examination or the Māori. This suggests that the Italians may occupy a different and atypical position in relation to the indigenous Māori, other immigrant minorities, and even perhaps the Pākehā. And yet, like the Māori and other minorities, the Italians have been subject to discrimination, racism, prejudice, and stereotyping (Copland, 2005a, 2005b; De Marco, 2016; Elenio, 2012; Hill, 2011). The following outline of the Italian presence in New Zealand affords some insights into possible reasons for this omission.

Early assisted immigration from Italy was fraught with difficulties. During the 1870s, Italian migrants were wrongly deployed in projects for which they were not suited, notably the failed Jackson Bay settlement, which led to their being accused of misrepresenting their skills,

laziness, and sabotage, and to their being declared 'undesirable immigrants' (Ballara, 1975; Boncompagni, 1996; Hill, 2011, pp. 128-129; Laracy & Laracy, 1973). Nevertheless, they continued to migrate to New Zealand and established themselves as miners, fishermen, market gardeners, terrazzo workers, and in a variety of trades. Elenio (2012, p. 59) starts his account of the negative consequences of Fascism and World War II for Italians in New Zealand with the declaration that 'Italians in New Zealand had been well treated', to emphasise the contrast with the dark period of exclusion and racism that he is about to recount. With the war, 38 Italian men, some of whom were naturalized New Zealanders or were born in New Zealand, were interned as 'enemy aliens' for as long as four years, while others were forced to leave their jobs and sell their businesses (Hill, 2011, pp. 131-132; Elenio, 2012, pp. 59-71). It took some time for Italians to rebuild their reputation and overcome the humiliation of these experiences. Referring to the prejudice and intolerance he encountered in the 1950s, Italian immigrant writer Renato Amato 'was seldom allowed to forget his nationality for a day' (Shadbolt, 1967, p. 13). Hill (2011, pp. 131-135) reports that New Zealanders' prejudice towards the Italians, alongside widespread 'misperceptions of Italy as a backward, underdeveloped country', possibly a consequence of accounts of Italy's devastation and poverty by returning soldiers, continued well beyond the war and into the 1970s, when a change in perceptions started to be observed.

A markedly positive attitude was experienced first-hand by the Italian author of this article when she arrived in Aotearoa on a temporary lecturing contract in 1987, with both Pākehā and Māori people showing a keen interest in Italy and things Italian. We posit three concomitant factors for this shift: technological advancements in transport and communications had made Europe much more accessible to the New Zealand middle classes interested in Italian art, design, music, fashion, food, as well as landscape; following modernisation and prosperity in the wake of the 1960s economic boom, in 1987 Italy was ranked the 5th richest nation in the world after the USA, Japan, Germany, and France; the profile of the Italian immigrant was changing, with entrepreneurs, businessmen, and professionals arriving in New Zealand in search of alternative lifestyles replacing the economic, poverty-driven immigrants of the past (this profile has changed again in the new millennium, with highly qualified or highly skilled individuals being driven to migrate by economic instability in Italy and Europe). Giorgio's (2015) qualitative study reported positive self-perceptions among the Italians of Island Bay, Wellington, as an immigrant community that had made an important contribution to the host country. Giorgio and Houkamau (submitted) also report positive external perceptions of Italians and self-perceptions among Māori Italians, who claim a strong affinity between the two ethnicities on account of physical similarities, cultural commonalities, and long-standing good relations.

Hill (2011, p. 135) points at a 'very interesting and largely un-investigated connection between Māori and Italians'. Early missionaries' accounts of British oppression of Māori, newspaper articles, anecdotes, semi-fictional reconstructions of the lives of early Italian migrants, stories and memories of the soldiers of the 28th Māori Battalion who fought in Italy during World War II (on the colonisers' side against Italy), all attest to empathy, collaborations, respect, kindness, solidarity, and friendships between Māori and Italians (Dugo, 2014; Hindmarsh, 2004; Mokoraka & Rotondo, 2007; Raihania, n.d-a, n.d-b; Riseborough, 1986; Vaggioli, 2000). This gave rise to a significant narrative of a special bond between Māori and Italians which is still in wide circulation today among both peoples.

Italian-Kiwi actor Paolo Rotondo, who is married to a Māori Pākehā and has co-authored a play, *Strange resting places* (2007), on the encounter between an Italian soldier and a Māori one in Italy during World War II, expresses this connection thus: 'For both peoples the cult of the individual doesn't exist – life is about whānau, the importance of sharing food, song, intergenerational living, spirituality, tūrangawaewae or, in Italian, di dove sei. [...] Through Italian eyes I connect to the passion and emotional aspects of Māori culture and I deeply relate to the pride, care for ritual and living with history' (cited in Warnock, 2018). A Māori TV channel documentary entitled *Why be Māori when you can pass for an Italian?* (Iti, 2013) testifies to a similar perception among Māori. This semi-serious programme was not about Māori-Italian affinities (as the Italian author of this article was expecting and hoping), but about the implications of mixed identities for Māori. The references to Italians stop after the title and the opening frames of Māori actor Toi Iti getting out of bed, wearing a jacket, looking at himself in the mirror with great self-satisfaction, and saying: 'This jacket makes me look very Italian, like an Italian detective. I could very well be taken for an Italian. Why bother to be Māori?'. This opening ploy can only be effective (to attract audience?) because it gestures to the narrative that has just been outlined and that is expected to be recognised by all Māori: the Māori-Italian connection and the prestige Māori, if not all New Zealanders, attach to Italian culture, including the myth of Italian beauty and elegance.

While early good Māori-Italian relations in Aotearoa could be a consequence of both ethnic groups occupying a position of subalternity *vis-à-vis* the British colonisers, it is this claim to a deep connection between Italians and Māori rooted in similarities in a range of aspects from physical features to occupations, language, and musical abilities, to a social structure based on the family, that places the Italians closer to Māori than any other subaltern immigrant minority. This subtext may affect Māori Italians' identitarian self-perceptions in a very specific way. A study of the limited but not insignificant Māori-Italian lineage might give us new insights into the ways in which ethnic identity is experienced and expressed by Māori (Jaspal & Cinnirella, 2012; Wang & Collins, 2016). In particular, we ask whether the Italian heritage, in providing a positively-connoted identification, equips our respondents with psychological and social tools that help them to validate aspects of being Māori and especially negative stereotypes that are associated with being Māori, ultimately helping them to handle challenges to identity construction and to achieve increased life satisfaction.

In what follows, we first give an account of Italian migration to New Zealand and the perception of Italians

in this country. We then outline our theoretical approach to identity, a combination of Social Identity Theory, interactionism, and life stories which evidences the psychological complexities of mixed ethnic identities. Next we describe our sample and methodology. Then, using excerpts from interviews, we demonstrate how respondents talk about their identities and how Māori Italians articulate attitudes towards themselves, other groups, and the Pākehā majority, by means of four key strategies. The concluding discussion attempts to evaluate whether Māori Italians pose an alternative mixed ethnic group to other Māori, Pākehā and non-Pākehā, mixed ethnicities.

Theoretical foundations
Identity and social identity

Within the social sciences, identity may be defined as a person's answer to the questions 'Who am I?' (self-definitions) and 'What does it mean to be "me" as a member of society?' (self-descriptions and evaluations) (Erikson, 1968). Because various strands of theory and research in psychology suggest people hold quite resilient self-views (Markus & Sentis, 1982; Markus & Wurf, 1987; Swann, 1983) and report similar traits on different occasions when asked 'what they are like' as a person (Rosenberg, 1981), identity is sometimes referred to as if it were relatively stable. Consequently, some theorists treat it as an internal frame of reference guiding the individual's social behaviour towards the world outside (Banaji & Prentice, 1994). Yet identity may also be seen as an ever-changing aspect of self. At its core is social comparison. Because social situations, affiliations, and contexts change routinely, identity is not something stable but changeable, depending on setting and social context and intergroup dynamics (Josselson, 1996).

The multidimensional, context-dependent nature of identity is explained by Tajfel and Turner's (1979) Social Identity Theory (SIT), which delineates two aspects: personal identity is the sum of the individual's unique identity characteristics (including personal beliefs about the self, skills, and abilities); social identity is the self-concept an individual derives from perceived membership of social groups (Hogg & Vaughan, 2002) and comprises self-definitions, self-evaluations, and self-meanings associated with group affiliation. The social identity paradigm emphasises that identity is multidimensional, with many different social identities, including nationality, ethnicity, gender, family, social class, occupation, and sexuality varying in salience and expression, depending on environmental demands upon the individual. The assumption that people have both personal and social identities, and that there are multiple social identities, carries important consequences for understanding how identity is experienced and expressed contingent on social context. First, because part of the individual's self-esteem derives from their group/s, they are driven to elevate their social group/s, including the ethnic groups they affiliate with, over others. Intergroup contexts can therefore prompt intergroup comparisons and within-group solidarity and highlight group boundaries. Secondly, social context triggers individuals to think, feel, and act on the basis of their social identities: they behave in ways normative to their social group, particularly if group affiliation is central to their self-

definition (Tajfel & Turner, 1979). In this way, SIT accounts for various social phenomena such as in-group favouritism (why people show preference and have affinity for their own in-group) (Aronson, Wilson, & Akert, 2002), and out-group derogation (discrimination against out-groups) (Hewstone, Rubin, & Willis, 2002).

Ethnic identity and multiple ethnic identification

Ethnicity is an aspect of identity and refers to the significance and meaning individuals attach to belonging in their ethnic group (Phinney, 1993), including a sense of belonging connected by heritage, culture, shared language, and values (Phinney & Ong, 2007). Ethnic identity has long been recognised in psychological research as a critical determinant of minority individuals' attitudes about themselves, others in their ethnic group, and the ethnic majority (Lusk, Taylor, Nanney, & Austin, 2010; Thomas & Wagner, 2013; Umaña-Taylor & Updegraff, 2007). Given that ethnic minorities often face marginalisation, identity theory regarding ethnic minorities has generally assumed identity salience and 'problematisation' (Erikson, 1966; Pettigrew, 1964). Way, Hernández, Rogers, & Hughes (2013), for example, find ethnic and racial identity development is influenced largely by contextual stressors like negative societal stereotypes and discrimination (see also Crocker & Major, 1989; Crocker & Quinn, 1998; Cross, 1971, 1978, 1991). Discrimination and ethnic minority status may 'push' ethnicity to the fore for minorities as a particularly salient social identity and therefore a key aspect of 'who they are' (Shorter-Gooden & Washington, 1996).

Complicating ethnic identity for mixed ethnic individuals are their possible different approaches to identity development and the resultant identification with one, both, or neither of their ethnic heritages (Rockquemore & Brunsma, 2002). The relationship between psychological and social outcomes and ethnic and racial identity has primarily been examined exclusively among mono-ethnic minority groups; however, the research on mixed-ethnic individuals shows that, generally, individuals who have internalised a strong, secure, and positive identification with the ethnicity central to their identity also report higher self-esteem (Robinson, 2000). Moreover, they are more likely to reject the conception that biology predicts one's abilities and to see race and ethnicity as socially constructed, which may buffer them from the detriments of prejudice (Gaither, 2015; Shih, Bonam, Sanchez, & Peck, 2007). From the SIT perspective a key motivator to identify with social groups is to enhance self-esteem. Ethnic hybridity may therefore be a coping mechanism for the negative effects of discrimination and prejudice if individuals strongly align and identify with positive aspects of their ethnic group identity which enhance their self-esteem (Settles & Buchanan, 2014). Despite this possible psychological benefit to those with mixed ethnic affiliations, Gaither (2015) showed they may experience the added stress of an 'identity crisis', especially if they feel 'torn' between parents or ethnicities. However, raising individuals with dual ethnicities to identify with both parents and to understand their complex heritage can enhance their psychological and social adjustment (Binning, Unzueta, Huo, & Molina, 2009). Thus, while membership of

multiple marginalised groups can place individuals at risk for negative experiences and well-being (Settles & Buchanan, 2014), it can serve as a positive psychological resource by providing individuals with multiple sources of potentially positive self-definition and meaning.

SIT, interactionism, and life stories

To reconcile how people can have identities which are multidimensional and trans-situational yet situationally expressed, McAdams (1994, 2001) has proposed personal identity as an internalised life story comprising the person's accumulated understandings of who they are and what that means in society (see also Bertaux & Kohli, 1984). McAdams (1994) suggested the life-story approach is also consistent with situation-specific views of identity because people's public expressions of identity arguably represent a selection of aspects of their story, tailored for the time and audience.

Erving Goffman's early work adds another theoretical base for understanding identity expression. He took an interactionist perspective, asserting that meaning is produced through the interactions of individuals. Goffman (1959, 1963) observed that people varied their expressed identities to manage social stigma by manipulating how others perceive them through linguistic strategies and presenting selected aspects of their identities. His interactionist views have provided the rationale for many studies demonstrating that individuals, when talking about the groups they belong to, acknowledge stereotypes about their social category, yet present alternative interpretations of group membership to negate unwanted feedback (Crocker & Major, 1989; Crocker & Quinn, 1998; Verkuyten, 1997). Data also suggests that those with mixed ethnic affiliations can freely and easily switch between or identify with their multiple identities (see Gaither, Sommers, & Ambady, 2013) to manage the impression they make. For example, Houkamau (2006) found that Māori women with mixed affiliations selectively expressed aspects of their Māori or Pākehā identities in various social situations to fit in and achieve acceptance.

Our study applies these three theoretical lenses, namely Social Identity Theory, interactionism, and the notion that identity is expressed in the form of a personal life story (narrative), to our interpretation of Māori-Italian identities. The value of combining them is that by treating identity as socially constructed through conversation we can harness narrative data to explore how identity is articulated drawing from both Māori and Italian ethnic affiliations and cultural knowledge. Taking the approach to identity offered by Erikson (1968), and treating Māori-Italian identity as a person's answer to the questions 'Who am I?' and 'What does it mean to be "me" as Māori or as Māori Italian?', our narrative interviews explored how Māori Italians express their own ethnic identities in relation to themselves, others in their ethnic group, and those from the Pākehā ethnic majority. Our analysis particularly concerns intergroup dynamics, how in-group and out-group differentiation and alignment are achieved, and the impacts of racism on participants' identities. It was a fortunate coincidence that the interviews were conducted shortly after the Census of 5 March 2013, an event that had triggered reflection on ethnicity in some of them and on which the interviewer was able to draw.

METHODS

Sample

This study is based on semi-structured qualitative interviews with 44 Māori Italians. The interviews were conducted by the Italian author of the article in 2013 in three main locations in New Zealand: Wellington, Porangahau in southern Hawke's Bay, and Turangi. Initial discussion with academic colleagues, the curators of the Museum of New Zealand Te Papa Tongarewa, and members of Wellington's Italian community led to key interviewees. More participants were found by snowballing. They were interviewed in their place of residence, mostly at home. Three main groups emerged.

The first group of 19 interviewees (15 women and four men) were descendants of Nicola Sciascia, an Italian man who reached New Zealand around 1873-1874 and in 1882 married a Māori woman, Riria McGregor, the descendant of a Scottish settler (Campbell, 2004; 'Jock McGregor', 2018) and a local Māori (Fulci, Ingravalle, & La Notte, 2007, p. 3; 'Nicola Sciascia and Riria McGregor', n.d.). Most respondents lived in Porangahau. The others who were interviewed in Wellington, Levin, and Hastings retained a strong connection with the family and the Marae in Porangahau. The Sciascia whānau have a level of public visibility, owing to some of their members occupying Māori-related public roles as well as for their research into their Scottish ancestry (Campbell, 2004) and their 50-year long search for their Italian whānau which attracted media attention in Italy and New Zealand (see Copland, 2005c; Fulci, Ingravalle, & La Notte, 2007; 'Flanders to Rome', 2008). The second group of 13 participants comprised 11 children and two grandchildren (eight females and five males) of Māori women and male tunnellers, mostly from the Veneto region in Northern Italy brought out to work on the Tongariro Hydroelectric Scheme (1967-1984), and now living in Turangi and surrounds. This group, most of whose first-generation fathers are still alive, maintained close ties with Italy and the Italian family, having spent long periods there, travelling there regularly, and having siblings currently living there. They also enjoy visibility in Turangi, and within the national Italian community, as attested by a tall statue of a tunneller erected in Turangi town centre in June 2019, following the 50-year anniversary celebrations in 2017 (see Codelfa-Cogefar, 2017), as a tribute to all those who worked on the scheme ('The Tunneller', 2019). The first and second group were featured in the exhibition 'Qui tutto bene. The Italians in New Zealand' (Te Papa Tongarewa National Museum, Wellington, 2004-2007), which emphasised the artistic and social links between Italians and Māori. The two groups have contributed to the consolidation of the idea of good Māori-Italian relations. The third group included 12 individuals, seven females and five males living in Wellington and on the Kapiti Coast, nine of whom descended from Italians from the Sorrento coast or the Isle of Stromboli in Southern Italy. Among these, only one had a first-generation Italian father.

The complete sample comprises 30 women and 14 men, aged 18 to 84 when interviewed. 19 fell in the 18 to 35 years age band, 17 were aged 36 to 55; six were aged 56 to 70, and two were aged 70 plus (some volunteered their exact age). Three had left high school without

completing it, 14 had secondary education, and 26 had tertiary or university education (one had a doctorate). Participants had worked or were working in various occupations: five were labourers; six were self-employed and ran their own business; 25 were employed in diverse businesses, professions, education, and public services (two in this group were also studying); four looked after the family; three were retired; and one (18 year old) was unemployed.

In presenting our data, we endeavour to make visible differences and trends in self-perceptions across the three groups. To this end, we have designated them as Groups 1, 2, and 3 and we will indicate the group in brackets, together with gender and age of the participants, after each interview excerpts.

Research design and procedure

Data was collected by face-to-face semi-structured interviews, recorded with the interviewees' written and verbal consent. All interviews were conducted in English, in one session lasting approximately one hour, except three with prominent members of the Sciascia family which were markedly longer and which twice spanned two sessions. The interviews formed part of a project on identity construction and multiple identifications among Italians in New Zealand. The project aimed to investigate perceptions of Italy and its culture and people among the Italian and Italian-Māori communities. Interviewees were asked to name three things they associated with Italy, what it meant for them to be Italian and what Italian values they thought they embodied or subscribed to. The same questions were then repeated for Māori to find out about their Māori identities and what being Māori Italian meant to them personally. Participants were interviewed alone, with five exceptions when family members attended but did not speak. In the very first interview, which was less structured and served to refine the questionnaire, a father and son contributed to the discussion. The interviewees could speak freely, with more questions being asked in response. Clarifications were given if requested. Unanswered questions were reformulated. However, interviewees were never forced to answer. The interviewer also took written notes. Once all data was collected, interview transcripts were produced by a research assistant in the United Kingdom and reviewed by the interviewer.

As a non-Māori researcher, the interviewer was conscious of the need to respect interviewees' cultural sensitivities. She attempted, whenever possible, to follow Māori cultural protocol using Smith's (1999) ethical research guidelines for Māori researchers: respect for people; the importance of meeting face to face; look, listen … speak; be cautious; do not trample the mana of the people; do not flaunt your knowledge (Smith, 1999, p. 120). Being only a visitor to New Zealand, she was not in a position to comply with Smith's last principle: be generous, share, and host people. She was instead the recipient of her interviewees' generosity and hospitality. Her own Italian origins and experiences of migration were shared to reveal some of her own personal background. All this, including the perceived affinity between Italian and Māori cultures, helped her establish trust and gain better insight into her interviewees' stories. Some

relationships continued after the interviews by email and Facebook.

Data analysis

Thematic analysis was conducted on the explicit content of the data. In line with SIT and interactionist analysis, both researchers were interested in how identifying as Māori, identifying as Italian, and identifying as Māori Italian provide a strong source of identification which can be emphasised or de-emphasised to promote a favourable notion of self and identity (Blumer, 1969). Thus, we have examined whether and how our respondents express views of being Māori, Italian, and both Māori and Italian (and switch between these social identities) to assert the value of their groups within a dominant Pākehā culture.

To identify these elements, we followed the five stages outlined by Braun & Clarke (2006). The first stage involved intimate familiarisation with the data through multiple readings of transcripts. Next, the transcripts were roughly coded. This process required identifying the aspects of the data most relevant to the research questions. In the first round of coding, as we were primarily concerned with how respondents in the study constructed positive identities and what resources they drew from (in both Māori and Italian cultures), the interviewer explored all the ways that they referred to being Māori and being Italian. Since identity was conceptualised as comprising definitional, descriptive, and evaluative elements, these elements served as a starting point. The data was examined to identify all the descriptions, evaluations, meanings, and associated behaviours the participants recounted that they 'had' or 'did' because they were both Māori and Italian. After this preliminary analysis, a second stage concentrated on clarifying core themes. Once chosen, these were compared with the results of the first round of coding to ensure they truly represented the key elements and recurring concepts. Excerpts were selected to demonstrate how respondents' identities reflected their experience as Māori and as Italian and how these in turn reflected their social relationships and contexts.

DATA PRESENTATION AND FINDINGS

Consistent with our stated theoretical lenses, data analysis disclosed four strategies employed by our respondents: Māori identity salience; A seamless marriage between Māori and Italian cultures and identities; Contextual flexibility: Why be Māori when you can be Italian?; Distinct and better: In-group favouritism and distinction. For each strategy, we will point out and comment on differences and similarities between groups.

Māori identity salience

In line with the Social Identity Theory research outlined above, our results revealed that ethnic identity for all recipients was complex and flexible. On the one hand respondents spoke of strongly valuing their Māori identities, yet on the other proudly identified as Māori *and* Italian. With rare exceptions, respondents identified primarily as Māori. This may reflect New Zealand's socio-political climate and Māori's status as the indigenous people and the largest ethnic minority of Aotearoa. Moreover, Māori have historically been

discriminated against and continue to experience discrimination in New Zealand (for a recent review, see Houkamau, Stronge, & Sibley, 2017). The fact that discrimination and ethnic minority status may 'push' ethnicity to the fore for minorities (Shorter-Gooden & Washington, 1996) may render being Māori a particularly salient identity. Likewise, in the 2013 Census, a large proportion of those of mixed Māori and Pākehā descent chose their primary ethnic group as Māori (Stats NZ, 2014a). Most of our respondents also made clear that biological aspects of ethnicity were not a crucial factor in how they self-define, and Māori identity was at times a conscious choice driven by cultural values and context:

We are Pākehā as well because my mother is Pākehā, you know, European. [...] Her grandfather came from England and he was a Stirling who came out on a whaling ship and married a Māori woman. On my mother's side there is European and Māori, so we are a bit of a mixture. [...] But we have chosen to be Māori because it is who we are, how we've grown up. We have grown up in both worlds but I choose to be Māori. We don't all as Sciascia choose to be Māori. (Female, 55-70 age range, Group 1)

[I am not Pākehā] because I am a Māori [... Having Italian or Scottish blood does not make you Pākehā] because we grew up as Māori. Our lifestyle, our cultural behaviour, if you like, is Māori. Even though we have characteristics of Pākehā, we've European eyes, like I said, we are very English in the way we speak, in our way of life, we have lived our lives as Māori. (Female, 70 plus age range, Group 1)

It means everything to me to say I am a Māori, everything, because that honours all my ancestors. It is who I am and to acknowledge that is honouring them. That's honouring myself. It gives you a place to stand, you know, your ownership and your responsibility and obligation. If you were to say 'I am a Māori', then that comes with obligations and responsibilities that I am aware of, whereas a lot of Māori aren't. I do my best to fulfil those things. (Female, 55-70 age range, Group 1)

The most dominant [identity] is Māori, because it is the culture in which I live. [...] Yes, because I am exposed to it a lot more, especially at my workplace. The underlying values are the same for Italian and Māori. (Female, up to 35 age range, Group 2)

Probably Māori would come first because I live in New Zealand [...], then Italian. [...]. New Zealand [identity] is not really there. Sometimes I consider Māori and New Zealand the same. (Female, up to 35 age range, Group 2)

[I am] Māori and Italian, but Māori probably is [more dominant] because that's how I have been brought up. My uncles and aunties and cousins are Māori, I was brought up that way. (Male, 36-55 age range, Group 2)

For being Māori there is a sense of belonging to this land. [... I'm] Māori [first], Italian [second], New Zealander [last]. They are at the same time, I'd say they are what makes me, so they are all there together.

[...] only because probably I am here I focus more on the Māori [than Italian]. (Male, 36-55 age range, Group 3)

Thankfully for me, I feel comfortable being Māori because I have the language and I know how the culture works. So I feel comfortable in that culture and I feel proud of that culture especially when I perform, when I use my music. And because I am brown, I think that means a lot to me. [...] I have a white brother and I don't think he has the same connection with that culture or feels as comfortable or confident, so I feel I look like a Māori and I speak like a Māori, so I feel more comfortable in that culture. [...] I just feel strong in that culture that has supported me through life. I have been employed through my culture most of my life. [My strongest identity is] definitely Māori. (Male, 36-55 age range, Group 3)

The view of ethnicity as choice was more prominent among the members of Group 1, the Sciascia whānau, perhaps as a consequence of the positive way in which Māori identity and culture have been experienced by them. As noted earlier, this attitude aligns with the predictions of Social Identity Theory (Tajfel & Turner, 1979) which underlines the tendency of groups to elevate ethnic groups they affiliate with over others (thus showing in-group favouritism), particularly if group affiliation is central to their self-definition.

Group 3, consisting primarily of third- and fourth-generation Italian individuals, recounted memories of their Māori and Italian parents' loss of heritage, and revealed an awareness of the shift from assimilation to, and repression by, the dominant Pākehā culture to biculturalism and increased tolerance of Māori and other ethnicities, from which they had benefitted. Group 2, on the other hand, displayed much more nuanced self-identifications, with some switching between the two heritages *vis-à-vis* their importance during the course of the interview. Nevertheless, they appeared secure in both their identities. Even the few who declared their stronger affiliation to their Italian heritage, which was often confined to specific areas, they expressed their total commitment to their Māori heritage. With the exception of two participants, who demonstrated confusion about their self-identifications as both Italian and Māori, Group 2 expressed a secure sense of self as both, perhaps as a consequence of their younger ages, of the fact that they, as well as their Māori mothers, had been brought up in more protected rural communities, and that their Italian fathers had come to Turangi with good work contracts and under the protection of an Italian company. The next three strategies provide a more detailed and refined understanding of the participants' views of their Māori-Italian hybridity and the value they attribute to each heritage.

A seamless marriage between Māori and Italian cultures and identities

Although generally claiming Māori as their foremost ethnicity, respondents of all ages, both males and females, spoke of an easy and uncomplicated blending of the two ethnic groups and cultures. With the exception of the same two atypical participants from Group 2 mentioned above

who reported some conflict, no sense of being torn between ethnicities was reported. Respondents, by and large, claimed that the affinity between the two cultures, whether real or perceived, made it easy and 'seamless' to align the two. Many referred to cultural and physical similarities between Māori and Italians. These perceived similarities allowed respondents to identify with both 'sides' of their identities and embrace how their dual (or multiple) heritage can enhance their lives and identities:

I think the fact that they [Italian and Māori heritages] are so much alike, we were immediately at home [in Italy]. [...] I was home. (Male, 83 years old, Group 1)

Some parts of our culture [Italian and Māori] are pretty near the same. It's how we present ourselves, it's how we eat [...]. We are gatherers of food, we build things to make it easy for us, like we make nets for fishermen. We are gardeners, we are builders, those things. [The professions are close] in both cultures. (Male, 55-70 age range, Group 1)

We had an experience many years ago [...]. We walked into a restaurant in Turangi [...] and the people were looking at us. [...] They [a Māori-Italian family of miners] said: 'You look like us'. And I said: 'We were just saying the same thing'. (Male, 55-70 age range, Group 1)

No, [my Italian and Māori selves are] never at odds. I'd say they complement each other. [...] Italians have a similar family thing that Māori have [...] that's a connection. (Female, 36-55 age range, Group 1)

We are the same in the way, to me ... family, food, and entertainment [...]. Maybe different types of food, but [food is important for both peoples]. (Female, 36-55 age range, Group 1)

It's hard to know whether [some of my values] were always there or there was an Italian influence, [or they were] Māori, because they are very similar. Probably the big one's about family and connection, and meeting and occasions when we meet as a family, celebrations, food, and song quite often, you know, speaking and the arguments with the family, [something that] is quite a robust, lively thing. (Female, up to 35 age range, Group 1)

I don't notice [differences]. To me it's the same. [...] Both cultures in my eyes are similar. (Female, 36-55 age range, Group 2)

[Italian and Māori] are very similar cultures really. I mean, Māori love food, Italians love food, Italians love family, Māori love family. They love gatherings. Very, very similar. That's probably why they get on very well, and the language, the vowels even, is so similar. (Male, 36-55 age range, Group 2)

Although there are some protocols, procedures that are different, the important things of both cultures are so similar. [...] I couldn't be me without being one or the other. [My Māori and Italian selves] work rather harmoniously together. [...] I think it is evident from my family [that there are affinities]. (Female, 30 years old, Group 2)

I believe that Italian values are similar if not the same as Māori. [...] both my parents, one is Italian and one is Māori, were Catholic, were brought up in the Catholic faith and [...] the values are very much family oriented. I cannot distinguish between the two cultures at all. [...] My perception of what it is to be Italian and my knowledge of what it is to be Māori are pretty much the same. [...] I don't think I could separate them. (Female, 36-55 age range, Group 3)

From all I can say, from what I know, I think Māori Italians have so many similarities in the way that we are raised and values, that I think that they go well together. [...] my grandfather being in the Māori battalion, when he went to Italy he found the same things, you know. He felt good in Italy. He loved Italy. And I suppose, yes, having a Māori father and an Italian mother, we were learning the same things. Respect your elders. Family is important, religion is important, all of those things, land is important, where you're from, having a connection to..., blood is important. There's all the same messages, the Māori message, the Italian message, they're the same. (Female, up to 35 age range, Group 3)

The main thing [...] that I say is similar between Italian and Māori is the food, they are very big on food and looking after people. That way it is very similar. [...] Caring and very welcoming, they look after you in the same sort of way. (Female, up to 35 age range, Group 3)

Famiglia, we call it whānau here, is [where the two cultures are] very similar. (Male, up to 35 age range, Group 3)

The overwhelming uniformity in these responses can be attributed to a variety of reasons. Most participants demonstrated to have been exposed to the narrative of good Māori-Italian relations and/or the socio-cultural affinity between the two cultures. Older member of Group 1 had memories of relatives who had fought in the war and of the post-war period which they had passed on to younger members of the whānau. Furthermore, interviewees from Group 3, who lived in Wellington or nearby, were aware of, or participated in, Italian community events in the capital. Notably, a reunion of Stromboli families attended by 450 people, held in the Parliament Buildings in 2000, which led to an exhibition and a book (Page, 2000) and was followed by other books about Stromboli families (see Hindmarsh, 2004; Moleta, 2012), appeared to have triggered the participants' interest in their Italian genealogy, also making them amenable to being interviewed for this study.

Contextual flexibility: Why be Māori when you can be Italian?

Like previous findings that many individuals with mixed ethnic affiliations switch freely and easily between ethnic identities contingent on social situational demands, respondents reported emphasising their Italian or Māori heritage depending on such demands. This strategy presents more variety for the three groups, due to the variety of life situations and circumstances and to the subjective way individuals interpret and react to contexts.

The comments below are testimony to Goffman's (1959, 1963) interactionist understandings of identity expression which underline the tendency for individuals to publicly 'perform' selected identities to project a desirable image within the course of social interactions. Among Group 2, who felt stronger in their sense of Italianness owing to the still strong presence of their Italian fathers, the switching is performed consciously and playfully to obtain a certain effect:

[When I meet Māori people] I start talking like them. [... I use] different body language movements. [...] My wife thinks it's funny. She sees me changing my attitude if I have to when I meet different people. [... It's] like you are wearing three different hats. (Male, 36-55 age range, Group 2)

Italian and Māori are the same. [Whispering to the interviewer] I feel more Italian. Maybe because dad is still here. (Female, 36-55 age range, Group 2)

The last interviewee's need to hide, by whispering, that she feels more Italian reveals that she is aware of the importance of feeling Māori and living as one. Living in New Zealand, often close to their Māori families, respondents were immersed in a Māori cultural and social milieu. As such, some reported that this reality pushed their Italian side into the background, as not always relevant to their daily life. As expected, this perception and attitude was more prevalent among Groups 1 and 3, whose Italian ancestry went back various generations:

Māori [is the stronger identity] because it's where I live. [...]Māori is the culture that I live in. I guess we do a lot of European things. This is European, the way we live here, you know. I like them all really. I like to mix them all up actually. I probably do more things Māori because more things Māori are happening around me, do you know what I mean? And my family are doing more things Māori, so it's more about that [...] I mean if [...] there was a whole lot of Italians doing Italian things, I'd be getting involved, you know, but it's just what's available. It's like most people here are shearers and fisherman [...] because of where we live, but that doesn't mean that they can't be judges or whatever. You just learn to fit in within your environment. (Female, 36-55 age range, Group 1)

I normally answer [I am] Māori. because I think here in New Zealand if you start throwing things out like 'Oh, I am Italian', 'I am fourth-generation New Zealand Italian', they look weirdly at you. [If I were in Italy,] yes [I would emphasize the Italian connection...]. As much as I would like to have more of a connection with Italy, I feel like ... sometimes, I don't know, I think I have such a strong Māori background I just identify with what I've just [said]. But I would really like to learn more about my Italian culture. (Female, 31 years old, Group 1)

I was brought up very much more Māori, and that was all from mum [of Italian descent]. She was doing the kapahaka and all those things and made us go to Māori boarding school. [...] she identified and loved very much [Māori culture]. [... Dad] gave us the Māori blood but she demanded culture. [...] The biggest thing [about the boarding school] was it was

the one time in my life where I was not a minority. Everybody there was Māori. (Male, 36-55 age range, Group 3)

Entirely coincidentally, in 2013 the second author featured in the aforementioned television documentary *Why be Māori when you can pass for an Italian?*. In the programme Toi Iti travelled New Zealand and the Gold Coast of Australia talking to Māori, including scholars, about why those of mixed ethnicity would identify as Māori if they could be perceived as belonging to another ethnic group (Iti, 2013). Aligned with Goffman's idea that individuals manage social stigma by presenting selected aspects of their identities, this documentary highlighted the flexibility of ethnicity for those who affiliate with more than one ethnicity and the fluid way ethnicity is perceived and engaged with by Māori with multiple ethnic affiliations, particularly to distance themselves from unwanted negative perceptions of either identity groups.

This same pattern was evident among our respondents, who were acutely aware of discriminating and negative stereotyping about Māori in New Zealand and many of whom had observed acts of stigmatisation of other Māori people. While many appeared highly resilient and happily asserted a positive view of their Māori culture, the ability to identify as Italian, for many respondents, somewhat shielded against what they perceived as the negative stigma ascribed to Māori ethnicity. This is evinced in these statements:

Māori don't really get good press in this country at the best of times. Any story about Māori people is blown up on the news and yet any other ethnicities can do that and it's back-page news kind of thing. For me it was always quite special to have something else. (Female, 36-55 age range, Group 1)

[Being Māori] means family, it means loyalty, it means knowing where we come from, pride, sometimes shame [... due to] some behavioural manners of some Māori people, that I feel quite disappointed in, because they are Māori. I guess when one Māori lets you down, you feel they are letting everyone down, all of us down. (Female, 36-55 age range, Group 1)

I think I am proud of my connection. I think as a young man I thought it was cool to be Italian, it was a bit exotic. I think if I look at Europe or other parts of the world, I think of so many positive things about Italy. (Male, 36-55 age range, Group 3)

In keeping with his strategy of freely switching between identities (as seen earlier), one participant from Group 2 expressed the unusual perspective that his Māori blood conveniently shielded him from Māori racism towards non-Māori people:

In this country there is a lot of racism, especially with the Māori. To have some Māori inside you makes things a lot easier. [... With Māori blood] I've got all bases covered. (Male, 36-55 age range, Group 2)

As noted above, a key motivator for individuals to identify with social groups is to enhance self-esteem. Given those with dual or multiple ethnic identities have two or more groups to identify with, and the choice to do so flexibly, those who can identify with two groups or

more would naturally draw on those identities strategically. Although most participants spoke of being Māori as most salient to their identities, several emphasised that being part-Italian was special. Some participants said so explicitly, explaining that having two identities, two sources of belonging, and being able to walk in 'two worlds' was a source of personal strength and self-worth:

I'm very satisfied with what I am and who I am and I feel so much more fulfilled now that I have been able to put my arms around [my Italian family]. (Male, 83 years old, Group 1)

You have the genealogy and the blood connection there [Italy]. But obviously I don't speak the language. I don't live there. [...] I don't know if I feel less [Italian] but obviously I am in terms of not speaking the language and living there. [The connection] gives me a sense of cultural security, [...] a place of standing, like the foundation of belonging [...]. What [the Italian side]'s given me is, I feel I am able to straddle both worlds [...] I'm as confident here in the CBD or going to the Opera and ordering a latte. And I am familiar and fine doing that as well as being on the Marae and performing the karanga, welcoming people. Italy [represents] the international side. (Female, up to 35 age range, Group 1)

Living in New Zealand, being an Italian, you are nearly singled out, you are a special person. A lot of New Zealanders have respect for Italians. You feel different, you feel special, you're not just a normal New Zealander. [...] My name, everybody who comes through the door who I haven't met before: '[Italian name], you must be Italian, oh... wow'. They just start talking: 'I've been to Italy, I love [Italy]'. (Male, 36-55 age range, Group 2)

While almost all respondents believed the two cultures share a number of values and customs such as the worth of family, respect for the elders, and living off the land/nature, they also consistently expressed a belief in the fine attributes of Italian culture. With that foundation, some participants ascribed certain positive features of their lives and character, skills, and abilities to their Italian heritage. This emerges in the positive descriptions of Italian identity and the association of Italian identity with high culture, art, fashion, and beauty:

[My grandmother] always did things like embroidery [...] and we all do, all the family does [embroidery is not a Māori thing]. [Mum] learned from grandmother and all of us. [...] I think it is in the blood, it's like my Māori side. [... It's a] pride thing, it's blood. (Female, 55-70 age range, Group 1)

I am proud to be Italian. I love the Italians, Italians are beautiful. Yes, [being Italian] is exotic. Hey, everybody thinks: Oh...wow! (Female, 55-70 age range, Group 1)

[Italians are] adventurous people, very prosperous [...] think of the great mechanical side to Italy, its production side, and where it leads in the world, film stars, music, I think a lot about Michelangelo, because of art, arts, the structures, buildings. [...] Just being

part of the world's existence really, I always have to say I am Māori because I was born, that's the culture I came ... and lived and been in and my Italian side too ... just knowing that ... Italy proved to be part of this world. [It made] a huge contribution to this world. A huge empire, the Roman Empire. All of those things, and thinking that I have a blood strain in me that belongs to that... (Male, 55-70 age range, Group 1)

In Māori society women are considered lesser than males. We are not even allowed to speak in the Marae. Males are totally dominant, the female element is about support and subserviency. And I believe that the Italian side of me is about superiority, it's about knowledge, history, and strength. And when I disagree with my husband he often says to me: 'That's the Italian coming out in you'. Because I can swap my cultural subservience role in Māori to my Italian role, because I believe the Italian women have a sense of assertiveness that their culture and history has allowed them to gain, so I revert to Italian ancestry because I feel privileged that I can. (Female, 56 years old, Group 1)

For me what I see is like how we talk, talking over each other, and everybody has got an opinion, to me that's an Italian trait. Because you know like on my Māori side [...] they're very quiet. And on the Sciascia side they are always loud and talking, and they are leaders. I see them as leaders. And they think outside the square, made things happen in the community. [...] when we got to Italy and I saw [...] our people like people with power because they were always people that organised, people that made things happen [...] and they were judges, lawyers etc.. Ah ah... that's why [we] are like the way [we] are. I always saw that we were different, when my uncles [were] called [...] macaronis, so the Māori knew they were different. They had a different way of doing things. We say we are Māori because that's where we live. You relate to this place we live in. (Female, 36-55 age range, Group 1)

[Italians are] steadfast. I think of [...] their work ethic, their finances, they are pretty structured, they are very good at saving money, and self-insuring. [Dad told us] you need to work. If you want something, you need to do this. [...] stick to it, you can't just change your mind later, you need to be committed, solid. (Female, 18-35 age range, Group 2)

I identify with beauty as well [...] beautiful blue sea, the buildings and even the people. [...] Dad had very strong morals and beliefs and loyalty, and sense of self and sense of family, food, wine, expensive tastes. I am prone to something a little bit different. I usually don't like things that are run of the mill, because everyone could have them. [I like] something that stands out and usually costs more. (Female, up to 35 age range, Group 3)

I have morals and standards [...] A lot of it has to do with being Italian. (Female, 31 years old, Group 3)

Generally Italian culture was seen as not competing with Māori culture, but adding to and enhancing Māori

heritage and identity. The following excerpts go further, asserting that being Italian (as another or second ethnicity) can help Māori to reconnect with their Māori heritage and rebuild their Māori identity:

In my acknowledging of my Italianness [...] when I'm out teaching [...], I always acknowledge that I am Italian, half Italian, that my greatgreatgrandfather came from Italy [...] to help people who have any problems perhaps relating to being Māori, or whatever, just to understand that [...] if you know your genealogy, then all of that is part of what makes you. (Female, 55-70 age range, Group 1)

My mother has taught us that everything is about family. And everything you do is for your family. [...] It could be [a Māori thing]. I think it is both [Māori and Italian]. [But] I think ... especially getting to know Māori friends, that [our family] is quite different. I think [...] some people might think I go overboard and everything is for your family. [...] I don't know if it's because times are changing. I just see the difference. (Female, up to 35 age range, Group 1)

This latter excerpt hints at the possibility that family values are becoming diluted among Māori. The interviewee continues by reporting that Pākehā relatives do not have the same commitment to family as her own Māori family. This perhaps indicates that she sees Pākehā-Māori unions as responsible for this loss and a threat to Māori values and way of life, whereas she considers Italian-Māori hybridity as an antidote to such a threat. Although this comment is clearly an individual perspective, recent quantitative data do indeed indicate that, although Māori tend to be described as relationally orientated and collectivist, such attitudes and values are not held ubiquitously among Māori (see Houkamau & Sibley, 2019). We shall see in the next section that our respondents erect clear boundaries between themselves, as Māori and Italian, and Pākehā.

Distinct and better: in-group favouritism and distinction

SIT emphasises that because individuals want to develop and maintain social identities they will be strongly motivated to define group boundaries clearly to set themselves apart. This tendency was evident among our participants. In some cases, Māori Italians claimed their identities gave them more social value and meaning compared to Pākehā New Zealanders, who were seen as having 'no culture'. This was then contrasted with what they perceived to be a richer, distinctive Māori-Italian cultural mix:

I don't think I think of Italian as being Pākehā. I am more inclined to think [Pākehā] is a European. Pākehā, English. I think Pākehā as being the 'other' race of New Zealand. [...] Pākehā are the other race that lives in our country. Italians are Italian. [...] For me Italians are colourful [...] Yes, I think that's the right word [ethnic], rather than Pākehā. (Female, 70 plus age range, Group 1)

I connect to Italian more so than to English, because Sciascia was our surname. I guess if our surname was

Smith, I might feel different, I don't know. (Female, 36-55 age range, Group 1)

The Italians who came here struggled with the Europeans, you know, because we all have our own culture. The Europeans, [that is to say] the English, had no culture, whereas the Māori and the Italians had a culture. Dad's gang in the tunnels was made up mostly of Māori people [...] The English were stiff. They didn't know how to gel at work. (Female, 36-55 age range, Group 2)

I class Pākehā as white people from New Zealand. Pākehā actually means stranger [...] Pākehā don't really know where they come from. That's the beauty about being Italian or Māori, you know where you come from. (Female, 36-55 age range; Group 2)

I have never considered myself a Pākehā. I never thought [an Italian to be a Pākehā]. In my eyes Pākehā is a white person born in New Zealand. For me Italians are European. A Pākehā to me is like my stepfather [...] he is a Pākehā. He's got no culture. He was born in New Zealand. I don't know where his ancestors came from. (Female, 36-55 age range, Group 2)

I'd say I am Māori Italian Scottish Irish and very quietly I'd say English. I am proud of Scottish and Irish, for some reason the English doesn't really do much for me. Sometimes I don't even want to put it there for some reason, because of colonisation and things like that. I feel a stronger connection to Scottish and Irish probably because they were colonised and oppressed. [...] I am definitely Māori before I'm Kiwi. [...] There is a lot of things that I don't really relate to, like I think a lot of New Zealand families isolated and they don't support their neighbours, they don't really have connections to their culture. There is a lot of kiwi stuff that I just think is watered down British stuff. (Male, 36-55 age range, Group 3)

As noted, SIT provides clues as to why these respondents referred to Pākehā as being without culture: it may be seen as a way of differentiating their own identities in a positive way, as opposed to an actual social reality (see King, 1988, 1999 for a discussion of Pākehā culture in New Zealand).

DISCUSSION AND CONCLUSION

In New Zealand, Māori are the most likely to identify with more than one ethnic group and the numbers who do so have been growing each year. This reflects New Zealand's demographic transformation, which impacts on the construct of ethnicity. We confirm previous findings that Māori select aspects of their different ethnic identities and express them in various personal and social situations to meet social goals (Houkamau, 2006). This in turn confirms the implications of SIT for ethnic minorities, namely that the task of assuming a positive sense of identity that drives all individuals is more complex for these groups due to discrimination from the dominant group, but also because multiple identities provide tools to overcome the external negative categorisations (Houkamau & Sibley, 2010, 2014a, 2014b). Our data demonstrate that knowledge of their Italian heritage and alignment with the positive associations with Italy and

Italian high culture provided our respondents with a sense of pride and personal self-worth that added very positively on their sense of self as Māori. This inspired some to learn more about their Italian ancestors and culture, expressing the intention to travel to Italy, study Italian, and join in more local Italian events.

Some respondents emphasised that their Italian heritage afforded intellectual abilities and practical skills that enhanced what they had learnt from the Māori heritage or compensated for Māori lack of interest in those areas. Having goals and pursuing them with passion, aspiring to a good job and to a nice and clean house, and generally building a future for oneself were seen as ideals originating in the Italian heritage, which indirectly projected a view of the Māori lifestyle as inadequate and inferior. Many of them appealed to the Italian historical, artistic, cultural, and technological patrimony to elevate themselves, one even reproducing the colonial discourse of categorisation of indigenous cultures as 'primitive'. This shows how internal and external definitions are mutually implicated. In Jenkins' words (1994, p. 217), 'the very act of defying categorization, of striving for autonomy of self-identification, is, of course, an effect of being categorized in the first place. The rejected external definition is internalized, but paradoxically, as the focus of denial'. The association of Māori with the availability of Italian elements worked overall to enhance personal and social prestige and to resist definitions imposed by Pākehā colonialists, emphasising agency and encouraging many participants to take ownership of their lives. A second ethnicity reduces constraints and opens up the range of ideas by which Māori individuals can conceive of themselves and resist social stigma (Davis, 1975). While we cannot state that it has been their Italian heritage that has encouraged the pursuit of a good education, many respondents were clear that it had inspired a strong work ethic and thinking 'outside the box'. Certainly, all respondents, except one 18 year old, were employed and were in good occupations.

The respondents' ability to describe their identities positively, to counter stereotypes and stigma or to overcome discrimination, including within-group gender inequalities, was partly contingent on their relationships with others in their family and social networks. Thus, those with more positive role models were better placed to assert positive views of their own identities. These role models were more clearly and vocally identified with living first-generation Italian parents or with grandparents whom the respondents knew or had known personally. Yet the importance and value of even distant Italian ancestors were felt just as strongly by many, with their ancestors' legacy being recognised in their lives today, even when this legacy was felt as an Italian national one rather than personal or familial.

Respondents also spoke of being distinctive, as Italians or Māori Italians, and felt positive about that distinctiveness. The belief in a strong affinity and harmony between the two cultures and the prestige Italy and things Italian currently enjoy in New Zealand do indeed distinguish the Māori Italians from other mixed Māori groups. Joint Italian ethnicity elevates the Māori both in their self-definition and in the external definition by the dominant group. The findings of studies on other mixed ethnicities suggest that while tension from the Māori whānau ensued from essentialist notions of what it means to be Māori, tension from the non-Māori family depended on the social value the non-Māori ethnic group attributed to itself, which may in turn be a consequence of the esteem in which it was held within the social and cultural hierarchy and within the colonialist/racial Pākehā discourse. The Māori Jews, for example, suffered exclusion from the Jewish family who considered themselves superior to Māori, though a change is reported in relation to today (Ore, 2018). By contrast, Ip (2013) reports how, despite very good early relations between Māori and Chinese communities, today Māori-Chinese relationships are sources of tension within families and Māori-Chinese individuals experience anxiety due to the current anti-Asian backlash by Māori. Ip quotes a Māori-Chinese young woman saying that she felt 'like one side of me [was] attacking the other' (Ip, 2013, p. 4), a tension which contrasts starkly with the overwhelming harmony between Māori and Italian selves our interviewees reported. An important difference is very clear to see, namely that the Māori-Chinese community is subject to ethnic power relations in New Zealand today (Ip, 2013: 3) in ways that the Māori-Italian community is not. It seems that Italian ethnicity is held in high consideration among the Māori, who distinguish it from other minority immigrant communities. Māori Italians use their Italian ethnic affiliation to elevate themselves without at the same time aligning with the colonisers: not having been part of the colonising power, Italians are not currently seen as a negative reference group in relation to either Pākehā or other 'undesirable' minorities.

It is important to note the limitations of this study. The identities expressed by participants may have been influenced by the interviewer being Italian and not, say, Māori or Pākehā. This may have shaped the identities expressed, particularly the very positive presentation of their Italian identities and heritage. These stories and experiences are only glimpses into the participants' lives. In addition, small sample size limits generalisability beyond this Māori-Italian population. However, the data give a unique insight into how very socially contingent and constructed expressions of identity can be. Indeed, respondents spoke of flexible identities which allowed them to experience multiple selves in different contexts.

To conclude, our findings show that pejorative external categorisations of Māori and consequent negative self-definitions combine with positive external and internal categorisations of Italians to shape the ideas and ideals of the Māori Italians who participated in this study. While Māori was seen as the primary identity, Italian identity was a highly valued second heritage. The two cultures and heritages enhanced one another to equip individuals with psychological, social, and practical skills that enabled them to transcend Māori's disadvantaged position in New Zealand and, paradoxically, assert themselves as Māori.

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A journey of identity: A rangatahi treatment programme for Māori adolescents who engage in sexually harmful behaviour

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This process evaluation focused on a community treatment programme designed for Māori adolescents (rangatahi) who had committed sexual offences against adults or children. We used qualitative and kaupapa Māori approaches to interview 23 participants (rangatahi aged 15 to 17, family members, staff and stakeholders) and observe group therapy and outdoor wilderness therapy excursions over 10 months. Participants found the Māori beliefs and processes, woven into westernised therapeutic theories and techniques, enhanced treatment by emphasising values essential to positive adolescent growth, including whānau support, the maintenance of relationships (including effective group work), and the importance of a secure identity (including finding positive Māori identities and role models). The personal qualities of the kaimahi (Māori staff) and their responsiveness to the issues facing Māori youth and whānau of mixed ethnicity contributed to the programme's success. Participants called for more support for cultural initiatives with sexually abusive youth to reduce community risk.

Keywords: Adolescent Sexually Harmful Behaviour, Cultural Treatment, Process Evaluation.

Introduction

It is now widely recognised that a significant proportion of sexual offences are perpetrated by adolescents (Lambie & Seymour, 2006; Margari et al., 2015). In New Zealand, adolescents who engage in sexually harmful behaviours are thought to commit around 15% of sexual abuse in the community (Ministry of Justice, 2009; NZ Police, 2018). For instance, between 1994 and 2012, young people under the age of 17 years old made up 13% of all individuals apprehended for all sexual offences (Statistics New Zealand, 2013). Due to the under-reporting of sexual abuse, it is widely acknowledged that these rates are an underestimation of perpetration. In the United States, between 30% and 50% of all child sexual abuse cases are perpetrated by young people under the age of 18 years (Vandiver, 2006).

Adolescents who engage in harmful sexual behaviours have been found to be a highly heterogeneous and diverse population on a range of factors, including the age and sex of the victim, the psychological and developmental characteristics of the adolescent and their family, and the social system (Gamache, Diguer, Laverdière, & Rousseau, 2012). Young people who sexually offend have been found to be more likely to have experienced significant childhood trauma, childhood exposure to pornography and sex, and subsequently high rates of anxiety and low self-esteem (Seto & Lalumière, 2010). In their meta-analysis, Seto and Lalumière also found that they often experienced social isolation from same-age peers, as well as disengagement from school. Research comparing sex-only adolescent offenders to adolescents who had offended in a range of ways found that sex-only offenders had lower rates of antisocial personality, psychiatric issues and substance abuse (Pullman, Leroux, Motayne, & Seto, 2014). It should also be noted that the majority of adolescents with harmful sexual behaviours do not have deviant sexual arousal patterns (Ryan &

Otonichar, 2016). Overall, these findings suggest the absence of significant psychopathology in the majority of adolescents with harmful sexual behaviours, although research trying to establish indicators and typologies is ongoing (Fox & DeLisi, 2018).

The economic burden of sexual abuse (Dopp, Borduin, Willroth, & Sorg, 2017; Lambie, Geary, Fortune, Brown, & Willingale, 2007), together with research identifying the adverse effects of sexual abuse to both victims' and offenders' quality of life, has resulted in an increase in research and treatment services for adolescent sexual offenders (Bouman, de Ruiter, & Schene, 2008; Steptoe, Lindsay, Forrest, & Power, 2006), involving group and individual interventions (Worling & Langton, 2016). Group work has been shown to facilitate group cohesion, openness and accountability among adult sexual offenders (Billing, 2009); similarly, group work with sexually abusive adolescents is considered a key treatment modality (Edwards et al., 2012; Rich, 2003). An extension of group work is the use of outdoor wilderness experiences with sexually abusive adolescents (Somervell & Lambie, 2009; Geary, 2007), found to be beneficial because they enhanced interpersonal relationships, improved adolescents' views of themselves, the intensity of the experience facilitated engagement in the therapy process and, most importantly, they aided in disclosure (Somervell & Lambie, 2009).

Whilst some research has been conducted into the effectiveness of several mainstream adolescent treatment programmes in New Zealand (e.g., Geary, 2007; Somervell & Lambie, 2009), there is yet to be a study looking at the success of programmes specifically designed for Māori youth who have engaged in sexually harmful behaviour. From the still sparse general literature on the treatment of individuals of Māori descent, it is evident that Māori-centred therapies assume that strengthening an individual's cultural identity during

therapy will lead to improvements in overall wellbeing (Durie, 2003; Huriwai, Sellman, Sullivan, & Potiki, 2000; Moeke-Pickering, 1996; Stuart & Jose, 2014). Improved treatment retention rates and greater life satisfaction have also been shown (Huriwai et al., 2000).

In research on offending, Owen's (2001) study showed a successful treatment programme for Māori youth offenders included opportunities to rediscover identity, whakapapa (genealogy/lineage, Huriwai et al., 2000), te reo Māori (Māori language), tikanga (customary values, practices and protocol) and history (oral traditions and mythology, Cherrington, 2003). With adult Māori sex offenders, promoting kaupapa Māori principles and practices during treatment helped individuals develop a meaningful identity other than that of a sex offender (Billing, 2009; Tamatea, Webb, & Boer, 2011) and increased confidence in the ability to change (Billing, 2009). In a community sex offender treatment programme, having whānau (family) members present and participating in the programme significantly increased respondents' willingness to make positive changes in their lives, for both Māori and non-Māori (Billing, 2009; Geary, 2007).

The aim of the current research was to focus on the cultural practices and processes of a programme used to treat Māori adolescents who had engaged in sexually harmful behaviour. It aimed to explore in-depth what was working well and what needed improvement from the perspectives of the adolescents, family/caregivers and programme staff.

METHOD
The Rangatahi Programme

The rangatahi programme was developed for Māori youth (*rangatahi*) and facilitated by Māori staff (*kaimahi)* from a specialised Māori team that had been formed in recognition of the specific needs of indigenous clients, within a larger mainstream provider. Treatment for medium- to high-risk Māori males, aged between 10 and 17 years, for up to two years, aimed to prevent recidivism, and included individual and group therapy sessions, system reviews with the rangatahi/whānau/support people and attendance at an annual wilderness therapy camp. Programme workbooks from the mainstream provider were used to supplement the individual therapy sessions. Adolescents were allocated to the programme if their referral indicated they were of Māori descent, and after assessments of recommended treatment intensity and supervision needs.

The kaimahi used a range of mainstream (CBT, DBT, behaviour modification, family systems, psychodynamic and narrative therapies) and Māori therapeutic approaches. Mainstream psychological approaches were used to specifically focus on the young person's behaviour and sexually abusive behaviour. Māori therapeutic approaches included a core cultural framework, *Te Whare Tangata* (The house of the people), a cultural model the kaimahi created that was simple, addressed sexually abusive behaviour and acted as a foundation for other Māori models.

Te Whare Tangata uses the carved meeting house (the *wharenui*) as a model because it has relevance to all of the rangatahi (regardless of the tribal area they come from).

The wharenui is a powerful symbol of identity and community (Durie, 2001; Moko-Mead, 2002; O'Connor & Macfarlane, 2002). It is seen as the most important building within a marae setting and is often referred to as sacred because it is an architectural representation of the physical body (often that of an important tribal ancestor); practices appropriate to the boundaries of the body can therefore be related to the building.

The aim of Te Whare Tangata is to reconnect rangatahi and their whānau with traditional Māori values such as *whakawhanaungatanga* (process of establishing relationships, relating well to others; Love, 1999), *manaakitanga* (the process of showing respect, generosity and care for others), and tikanga. Parallels are drawn between the marae, these values, sexually harmful behaviour, victims, the rangatahi, their whānau, friends, and community. Teaching Māori values to the adolescents was important because most had little or distorted understanding of Māori worldviews, that could even support their sexually harmful behaviour. (See Ape-Esera, 2016 for more detail on the model and its development by kaimahi.)

Qualitative evaluation and Kaupapa Māori research

This research was a utilisation-focused, process evaluation, defined as, "an evaluation done for and with specific, intended primary users for specific, intended uses" (Patton, 1997, p. 23). For such an evaluation, the researcher needs to establish a working relationship with intended users early on, to determine what is needed from the research. Furthermore, understanding the breadth and depth of treatment processes, not just the outcomes, is important in building effective interventions with sexually abusive adolescents (Geary, Lambie, & Seymour, 2011).

As the research was specific to individuals of Māori descent (intended users), it was important to acknowledge how Māori culture and ideas were considered in a *kaupapa Māori* research framework, which has been defined as, "research by Māori, for Māori and with Māori" (Rangahau website, 2015). The first author is of Māori and Samoan descent. A kaupapa Māori approach considers Māori worldviews and ideologies, acknowledges Māori cultural, political, and social realities, and seeks to redress power imbalances and bring concrete benefits to Māori (Walker, Eketone, & Gibbs, 2006). It acknowledges that the term Māori is broad and diverse, including multiple realities, dialects, protocols and political and organisational representations (Barnes, 2004; Walker et al., 2006).

Māori consultation took place throughout (Durie, 2011), with efforts made to ensure kaimahi participated in the development and implementation of data collection procedures, and Māori experts/colleagues were consulted during data analysis. Care was taken to ensure participants' views were correctly represented and that final outputs were balanced and not harmful to Māori. The research process took much longer than expected as considerable time was spent reflecting and formally documenting the processes and perspectives obtained.

In addition, participation in a peer Māori and Pacific Island research group, and establishing a research support network comprised of Māori academics and whānau from

the Taranaki and Auckland regions, were important, with confidential discussions covering research methodology and analysis (not identifying individual participants), Māori models, tikanga, and emotional support to stay culturally and spiritually safe in the topic area.

Qualitative methods, including interviews and group observations, are valuable when conducting process evaluations because researchers can explore programme dynamics whilst gathering rich information about the programme's functioning (Patton, 1990), and allow participants' subjective experiences and cultural understandings to be captured. Using an inductive approach (Patton, 1997), aiming not to test a theory, but to generate new ideas from the data collected (Thomas, 2006), was appropriate, given that this evaluation incorporated kaupapa Māori concepts, and focused on a population with whom research is limited.

Data Collection and Analytic Approach

Data sources were face-to-face interviews and direct programme observations (group and wilderness therapy), with reference to documents (workbooks, policy and procedural manuals, pamphlets and brochures, and the agency website) as relevant. Ethics approval was obtained from the University of Auckland Human Participants

programme. The three programme staff (*kaimahi*) identified as being of Māori descent, and two had more than five years' experience working with sexual offender populations. The four key stakeholder interviewees were external agency staff who worked directly with rangatahi participants (e.g., social workers).

Interviews explored: 1) Perceptions and understanding of the programme; 2) Programme's strengths/benefits and weaknesses/detriments; 3) Views on whether the programme met their individual and cultural needs; and 4) Recommendations for future improvements. Interviews ranged between 40 and 120 minutes, were audio-recorded, electronically encrypted for confidentiality, and transcribed by an independent transcriber who was fluent in Māori and had signed a confidentiality clause.

Direct programme observations offered insight into the programme's physical and social environment, including how Māori ideologies were incorporated into the programme, whilst making the least disturbance to the participants' regular activities. Twenty-eight two-hour weekly group sessions were observed by the first author over 7 months, with notes written up directly after sessions. One wilderness therapy camp and one outdoor excursion were also attended, where the researcher was a

Table 1. Participants

Interviewees (*n*)	Characteristics
Rangatahi - 7 Māori – 2 Māori/European – 3 Māori/Pasifika – 2 Age 15-17	Previous Māori experience: None 2, Minimal 3, Moderate 1, Extensive 1. Time in programme: 6 to 18 months (12 months - 4). Living in residence 5; with whānau 2. Sexually harmful behaviour: Sexual offending against a child/children 5; against an adult 2.
Whānau - 9 Māori – 3 NZ European – 6*	Biological parents – 4 Foster parents/whangai – 2 Residential caregivers – 3
Kaimahi – 3 Māori – 3 (with a range of te reo Māori and tikanga experience)	One was also involved in the tāne (Māori men) programme. Two had more than 5 years' experience. Male 2; Female 1.
Key stakeholders - 4	External agency staff including from statutory child agency, residential services, sex offender therapists etc.

Note.*Those not of Māori descent were still supportive of their adolescent attending a treatment programme specifically designed for Māori youth.

Ethics Committee.

Interviews with 23 participants included both programme users and providers (7 adolescent clients, 9 parents/caregivers, 3 staff and 4 key stakeholders – see Table 1). Clients and caregivers had to have been involved in the programme for at least 6 months. The seven Māori adolescent clients (*rangatahi*) were aged 15 to 17 years, of mixed ethnicity, and most reported limited exposure to Māori culture prior to entering the programme. The nine parents/caregivers (*whānau*) had participated in family group conferences/review sessions of the rangatahi and included biological, foster/whangai parents and residential caregivers; those not of Māori descent were supportive of their adolescent attending a Māori

participant-observer, joining in with the group bonding activities such as rafting, which helped the adolescents feel more comfortable with the researcher's presence during the disclosure therapy activities. All the data collected during direct observations were regularly debriefed, cross-checked and validated for consistency by the Māori programme staff.

Thematic analysis was chosen as it helps to make sense of the meaning of the data, and is compatible with inductive approaches to research (Braun, Clarke, & Terry, 2014). The analysis followed Braun and Clarke's (2006) approach, which involved systematically working through the entire dataset, identifying repeated patterns and coding by hand, then developing themes, which were refined

further by three researchers systematically re-coding and debating, until a consensus on a theme was reached, a lengthy but worthwhile process to include different perspectives (Klein & Olbrecht, 2011). Hammersley (2008) refers to such strategies, and the cross-checking with staff during data collection, as a kind of triangulation to "check the validity of descriptive inferences" from data (p. 24).

ANALYSIS

Firstly, the perspectives of kaimahi (staff) and key stakeholders on what worked well and areas for improvement in the rangatahi programme are presented, followed by the views of the rangatahi participants and whānau/caregivers. The results outlined below represent a consensus amongst research participants, worked through as part of the reflective kaupapa Māori and process evaluation discussions.

A brief overview is presented in Table 2. Themes were developed from both group observation data and interviews. Anonymised, verbatim interview quotes (with "um"s removed for readability) are marked (K) for kaimahi, (KS) for key stakeholder, (R) for rangatahi and (W) for whānau.

What worked well: Kaimahi and stakeholder perspectives

The clinical practices that worked well were the use of Māori models of treatment, including working with whānau to attend to whānau issues which may be hindering treatment progress; modulated workbooks which provided structure for both staff and clients; and the positive Māori role-modelling of staff.

Māori models of treatment lead to better treatment outcomes

The kaimahi and key stakeholders reported that the programme was clinically effective because it was developed specifically by Māori for Māori, using Māori models of practice. "Māori staff have a greater understanding of these boys" (K). The clients' therapy and cultural needs were being met simultaneously:

I know that their delivery of treatment is not the same as the mainstream programme. It is culturally appropriate and more interweaved of those aspects of Māori practice. I think that we would expect that they are much more likely to have better outcomes under that model, that has been my experience anyway. (KS)

Working with the whānau is important

Kaimahi stated that the programme was clinically effective because therapy emphasised the rangatahi within their family system, an important aspect of a Māori framework, rather than working from an individual perspective. This helped attend to whānau issues, which may have been preventing treatment progress.

I think the strength is being able to guide our boys and their families through their hard times, now that seems airy-fairy but that's actually what we have to work with before we can even get to the hard stuff ... we can't work with a boy without the whānau...when [whānau] see we are here to tautoko [support] them, they start trusting us and are less resistant. (K)

Table 2. Summary themes of what worked well and areas for improvement.

Summary themes	Kaimahi and external stakeholders/referrers	Rangatahi and whānau
What worked well	- Māori models of treatment lead to better treatment outcomes - Working with the whānau is important - Modulated workbooks provide structure for kaimahi and rangatahi - Kaimahi role-model positive relationships	- Māori framework enhances experience - Kaimahi characteristics facilitate engagement - Positive experience of group work
Areas for improvement	- The kaimahi feel culturally undervalued - Clinical meetings need to be at home or marae - Experienced cultural supervisors and continuous cultural professional development needed - Need more people (Māori therapists, social workers, community kaiako/instructors); and more time (for induction, communication and discussion; and to develop more Māori treatment modules and resources).	- Group disclosure is challenging - More information needed for whānau throughout - Home-based meetings, resources for transport, resources for kaupapa Māori development/te reo etc

Modulated workbooks provide structure for kaimahi and rangatahi

The set programme modules (such as victim empathy or the cycle of offending) were helpful because the booklets were simple and visually appealing for the clients. In addition, staff indicated that the modules gave their therapeutic practice structure and simplified the process of monitoring a client's progress:

Having those modules set up for me, we don't follow it by the book but it's actually there so you can glimpse at it and work it to fit and actually know, yep, this boy's done this work...you got their goals and it's there, that's helped me. (K)

Kaimahi role-model positive relationships

A strength of the programme that was discussed by all of the key stakeholders was that the kaimahi demonstrated and reinforced positive male and female interactions, and modelled values such as co-operation and support:

They have a wonderful strength together. They complement each other really well and they support each other...the boys see it and can model it. (KS)

In addition to modelling positive relationships, staff referred to the programme employing older clinicians with diverse Māori backgrounds and how these characteristics facilitated the process of respect:

A person of an older generation which actually works ten times better than the Western concept that youth workers or the people working with youth should be young people ... brings in the values of respect. (K)

Areas for improvement: Kaimahi and stakeholder perspectives

While the Māori aspects were a strength, they were also a challenge, in terms of how staff cultural knowledge should be valued or how fully "kaupapa Māori" it was possible for the programme to be.

The kaimahi feel culturally undervalued

Kaimahi reported feeling overworked and undervalued in their role as Māori therapists, despite the commitment of the agency overall to work appropriately with Māori clients:

Knowing very well that a lot of the people in the other teams just cannot work with our people the way we do, so I feel that we're kind of undervalued. And I get that feeling of tokenism every now and then. (K)

They all possessed specialised cultural knowledge attained through living and working in Māori communities, rather than academia, that was not necessarily well-recognised or remunerated:

I think they need to acknowledge your life experience and your experience as Māori. You know the experience as a Māori being in this field of work and acknowledge that others might have three years doing a thesis whereas you and I may have three years just living it, so that needs to be acknowledged. (K)

The limited availability of Māori clinicians trained in the field of sexual offending contributed to high workloads and, at times, wilderness programme cancellations. In addition, kaimahi workplace responsibilities extended beyond the programme, as they frequently crossed paths with clients and whānau in their respective Māori communities outside of work hours. "We have to be accountable to our people, to the community, to our clients, and to our families" (K).

A significant programme issue identified by the kaimahi was that the *kaupapa* (topic, plan, purpose, agenda) of the rangatahi programme was unclear, in terms of goals, direction and how it differed from the mainstream adolescent programme. From using "Western models" initially, they had developed the *Te Whare Tangata* model to use alongside other Māori and non-Māori aspects. There were contradictory views among staff on the quantity and quality of Māori kaupapa that should be taught to clients. Most of the rangatahi had limited or no exposure to their Māori culture prior to entering the programme, many were of mixed ethnicity, and all had to operate in both Māori and non-Māori (*Pākehā*) worlds, so some kaimahi felt a mix was inevitable:

The boys don't know what their culture is... I think I've learnt not to be too heavy on them about their culture because they don't know, so we just take it a step at a time ... I love my Māori world but the reality is they also have to live in the Pākehā world ... They don't struggle living in it, they struggle being comfortable in it. In both worlds actually. (K)

In contrast, one argued that a fully Kaupapa Māori programme would allow rangatahi to build a stronger cultural identify and a better sense of self:

I feel that the more exposure they have to more cultural things, the better. Even though I know that the boys come from diverse backgrounds, I just believe that if we're gonna practise things Māori, let's do it good, let's do it well and expose them to it ... It's about building a strong cultural identity so they can stand strong in their own skin. (K)

Suggested improvements

The kaimahi stated that their treatment outcomes would improve if clinical meetings involving whānau were held at the clients' home or in a marae setting. They also felt their clinical practice and personal wellbeing would benefit from being given access to experienced cultural supervisors and continuous cultural professional development. More Māori male therapists and a Māori social worker were needed, and the kaimahi also suggested that *kaiako* (teachers/instructors) could be sourced from the community to teach traditional practices that aligned with a client's safety plan. Conducting a thorough induction process with new staff and reorganising team resources to enable greater communication and discussion were recommended. Finally, the kaimahi suggested that the programme could benefit from developing more Māori treatment modules and resources – which again would require more people and time.

What worked well: Rangatahi and whānau perspectives

Rangatahi and whānau focused on how the Māori framework enhanced treatment, how staff characteristics supported change (especially how crucial the

relationships between kaimahi and participants were), and how positive group work could be.

Māori framework enhances experience

Having a separate programme for rangatahi that incorporated Māori frameworks and philosophies was felt to be of benefit to this population. The rangatahi and their whānau reported that a Māori framework enhanced their treatment experience because it helped to decrease their resistance to the programme, including, for example, feeling less anxious about entering a "Māori" programme:

I guess knowing I was doing this programme made it a bit easier for me knowing that it was a Māori programme...like it would be easier to connect to Māori ways and they understand me. (R)

Another participant had been worried about "being in a group with Māori" because he had not been "brought up Māori" but had learned lots; similarly, a whānau member who had not been connected to their culture said, "The information we thought we knew about the marae was wrong. It made us feel good when we were told the correct information" (W).

The use of a Māori model and philosophies helped to strengthen participants' identity, wellness, sense of belonging and understanding around boundaries and consequences of behaviour. All of the rangatahi found the Te Whare Tangata model helpful and were able to correctly recount the symbolism behind it.

They drew up a whare and it was a representation of a person and they went through all the aspects and the values ... It showed what happens in and out of a whare like health, family, the community or a person. It related back to Māori cause it also went back to ancestry, history, you know, the gods and stuff. I realised that everything is kind of related on the same basic aspects and everything's done by values. (R)

Furthermore, they understood how the model related to sexually harmful behaviour. For example, one rangatahi reported that the model helped him to understand the boundaries that exist when interacting with females and children as well as the consequences of violating these boundaries.

The marae shapes a woman...that's why they say never to hurt a woman and that women are tapu [sacred] and so are children cause children come from women. That's why we are here cause we broke tapu. (R)

Emphasising the Māori concept of whānau and involving them in the treatment process was important to the rangatahi because they were able to showcase their personal achievements and at the same time get valuable feedback from whānau. System review meetings were viewed as an important place for the rangatahi to rebuild what had not always been functional relationships with their whānau.

I like doing work with my family and building a better relationship. The meetings have helped us talk like openly and more comfortably now. (R)

Some of the whānau reported that their sons' confidence had grown exponentially over their time in the programme, with one respondent attributing this change to finally embracing his Māori identity, a "side of him that's been pushed down in the past" (W). In contrast to most participants' views, one non-Māori mother felt that the therapist exploring her son's Māori father's side was introducing an aspect of cultural "difference" that her son had not had an issue with before (the father had died). Other whānau acknowledged their reluctance to be involved but that had shifted:

I was pretty rude when I first came here ... "Oh just hurry up and get that over and done with, I wanna get out of here." I don't think like that anymore cause I know deep inside this is helping my son, and helping me. It's a journey for both of us. (W)

Other Māori practices included *karakia* (prayer/incantation; Barlow, 1991) to open and close all sessions, which rangatahi understood as part of "making everything we do in here tika and safe" (R). Karakia were performed in both English and Māori and more importantly, whānau acceptance and participation in the process was never assumed. The kaimahi were aware that many whānau were not of Māori descent; therefore, it was important to invite participation rather than expect compliance in a process that participants described as safe.

Rangatahi appreciated that staff were Māori, feeling they were less likely to judge and more likely to understand them than non-Māori staff, as this participant, who had experienced both the mainstream and rangatahi programmes, pointed out:

The mainstream group have a different approach to things. I expressed myself in that group just like I expressed myself here but they didn't understand. They couldn't relate back to my cultural needs. I felt out of my comfort zone like we are two different groups of people ... the Pākehā Europeans ... often we are the low people but when it's Māori to Māori, it's equal respect. (R)

Kaimahi characteristics facilitate engagement

The personal attributes of the kaimahi (especially humour and straightforward talk) helped to put participants at ease and were crucial to motivating engagement with treatment. Rangatahi really valued their relationships with the kaimahi, whose use of humour and relaxed style made the rangatahi feel connected and motivated.

They're kind of more laid back and you could joke with them ... The work was laid back which was good because that helped me do my work, it helped me, cause that's the way I feel comfortable learning and working so it was easy for me. (R)

The kaimahi style eased potentially volatile situations, and helped rangatahi move into the more emotionally demanding work they needed to do.

My therapist, he's a crack-up ... he's awesome, O for Awesome... I think of him as a mate. (R)

Whānau too appreciated the personal qualities and skills that the kaimahi demonstrated:

They approach on a level that they're just ordinary people too without the big therapist type thing, they are very natural and yet where the rubber hits the road and they have to say, "Look no, this is what is," they do it but they've layered it in very carefully. (W)

The kaimahi were also seen as positive Māori role models, as well as using case studies of famous Māori to help rangatahi see that being Māori did not have to be bad. "I used to think that Māori people are always bad and that's the way you have to be" (R). Diverse cultural needs were also handled well by staff, according to most whānau:

I think being in a Māori programme helped him relax a lot more to be able to participate in the treatment. His therapist is a person who can understand my son's heritage because he's got two lines to sort of look at. On his Mum's side, he's Māori and on my side he's English. (W)

Having access to kaimahi of kaumātua status helped to reinforce the Māori cultural frameworks that were promoted in the programme, such as respect and perseverance. Some also commented that having Māori females involved was good in the "male-orientated" environment of the treatment centre, especially for female whānau.

Positive experience of group work

Participants spoke of positive experiences of group work. Groups built a sense of universality among the rangatahi, and the activities employed by the kaimahi, such as "blind trust" exercises, helped to challenge participants' preconceived ideas/assumptions and enhanced their sense of connection to other group members. Boys described the group wilderness camps as fun, building stronger bonds with each other, to make harder aspects like disclosures more effective:

Like on camp when we were going to do our disclosures, we had a bit of a fun time beforehand and then got into work instead of just getting straight to it. It gets me motivated to do the work. (R)

Whānau saw them as building life skills:

Every time they go out for their camps, it gives him life skills that he can use out here. (W)

Areas for improvement: Rangatahi and whānau perspectives

Rangatahi acknowledged that disclosures were necessarily challenging but suggested the language and pace of questioning could improve. Whānau wanted more information about the programme and improved access through home-based meetings and transport resources.

The rangatahi shared that the presentation of disclosures in a group setting was challenging. Sometimes when the kaimahi were attempting to explore the adolescents' attitude and beliefs, they had difficulties understanding what was being asked of them, because they had not been shown how to explore their emotions, or the depth of the questions progressed too quickly:

I started getting mixed up with their words cause I couldn't understand them properly. I just got angry and then just shut myself down. It was just sometimes too many words and too fast and I just get frustrated and I just think they're intimidating me. (R)

One concern expressed by Māori was that those considered as "outsiders to the tikanga of the programme" could impact on the treatment process. This included unknown professionals attending group or whānau sessions (such as lawyers or social workers), or

confidentiality when going into other tribal areas. Participants reported there were times when the kaimahi failed to inform them about professionals attending group/whānau sessions. At the outdoor wilderness camps, rangatahi reported they felt embarrassed disclosing personal information in front of unknown professionals who had arrived, and therefore hesitated with their disclosure. One stated he was conscious that he was in a different iwi [tribal area] at the camp and was concerned about the confidentiality of the information being shared with the unknown professionals in attendance.

Some whānau wanted more information about what the programme would involve (e.g., an "information pack"), how boys were progressing, and who was at system review meetings and why (e.g., when lawyers, social workers or residential care staff attended). This could help both to advance the transparency of the programme and maintain participants' "buy-in".

Increased resources for both rangatahi and whānau were recommended, including meeting Māori graduates of offender programmes, more kaupapa Māori learning (e.g., learning te reo Māori), employing a Māori social worker and providing an adjunct group for whānau members. Accessibility could be improved through home-based meetings (as also recommended by programme staff) or the use of satellite offices, or at least providing more consistent funding for rangatahi transport to attend weekly group and therapy appointments. The experience of a home-based review meeting was very positive for whānau:

We all talk more here than we did at [the office]. We had questions but we wouldn't ask; being in your own house, we could. I never used to look forward to programme meetings ... I didn't know what the programme was about until they came here ... them coming here and explaining themselves ... made us open up. (W)

Similarly, taking more information to the wider community would be vital, through for example running education days at tribal hui. This would encourage whānau to be involved and understand rangatahi in treatment, but would also share the preventative concepts and Māori frameworks across a wider tribal setting.

DISCUSSION

Process evaluations of Māori sex offender treatment programmes are sparse and limited to adult populations (Billing, 2009; Tamatea et al., 2011), or youth in mainstream programmes (Geary, 2007). The key findings therefore advance limited knowledge in this area and are discussed in relation to existing literature.

Culturally appropriate approaches with sexually abusive Māori youth are helpful for engagement.

The fundamental finding of this research was that, despite participants' differing levels of cultural knowledge and experience, the Māori model and practices integrated into the programme were understood and embraced by the clients. The programme utilised a holistic approach to offending, as the respondents were encouraged to attend to their sexually harmful behaviours whilst nurturing a positive cultural identity and core relationships.

The benefits of culturally focused treatment programmes when working with indigenous populations have been acknowledged (Durie, 2003; Huriwai et al., 2000; Stuart & Jose, 2014; Thakker, 2014). Yet, it is difficult to understand the specific clinical factors through which a culturally focused approach affects an individual's wellbeing (Houkamau & Sibley, 2010; Thakker, 2013). The rangatahi programme data offer some insight into the cultural processes and practices that were clinically helpful; namely, use of the Te Whare Tangata model; use of karakia; stories depicting successful Māori who had overcome adversity; the importance of whānau involvement; and tikanga practices that were tailored to the rangatahi.

The use of Māori models and practices in the rangatahi programme was apparent throughout data collection. Most of the rangatahi were able to accurately recount the Te Whare Tangata model's cultural symbolism and how it encapsulated sexually harmful behaviour, and whānau could relate to it. Māori academics argue that the use of the marae (which includes the whare) in this context is suitable and symbolic because it is a vital part of Māori culture (Durie, 2001; Moko-Mead, 2002). For disenfranchised or marginalised Māori, the marae setting can act to reinforce Māori identity and restore sense of purpose (O'Connor & Macfarlane, 2002).

The effectiveness of karakia in a clinical setting has never been proven by scientific research, but anecdotal evidence suggests that these methods have been helpful in increasing engagement and retention through greater cultural suitability and relevance among addiction service users (Huriwai et al., 2000), adolescent and adult Māori sex offenders receiving treatment in the community (Billing, 2009; Geary, 2007), and incarcerated Māori sex offenders (Tamatea et al., 2011). Programme participants found the use of karakia to open and close sessions helped make them "safe".

The use of stories depicting successful Māori who had overcome adversity was also used on several occasions to challenge clients' negative perceptions of Māori. The positive role models of the kaimahi themselves were also powerful. The rangatahi were encouraged to contemplate the idea that ethnicity does not dictate, conduct or predetermine future aspirations. Many of the respondents reported that these concepts were initially unfamiliar and difficult to comprehend; however, once accepted, their motivation to become a "good Māori" and finish treatment increased significantly. Cherrington (2003) suggested that using Māori mythology in a clinical setting is helpful because it is meaningful, promotes Māori identity through the acknowledgement of Māori ancestors, allows clinicians to creatively explain an individual's personality traits and integrate concepts such as grief, change, and loss. Māori mythology is particularly helpful when working with young people and their whānau because it gives clients exposure to Māori families who were not perfect but who pushed through adversity to succeed (Cherrington, 2003).

Family involvement in the treatment of sexually abusive youth has been widely discussed (Anaforian, 2009; Billing, 2009; Geary 2007; McNeill & Gallardo, 2009; Tamatea et al., 2011; Williams & Cram, 2012), including improved treatment completion if family is active in the treatment process (Worley, Church, & Clemmons, 2012; Worling & Curwen, 2000; Yoder, Hansen, Lobanov-Rostovsky, & Ruch, 2015). From a Māori cultural perspective, researchers such as Durie (2003) and Love (1999) would argue that whānau/family involvement should always be considered in the therapeutic context because the mana of an individual and their whānau are intertwined to the extent that they are inseparable.

The concept of whanaungatanga, which emphasises the sense of belonging as a result of relationships and kinship ties (Moko-Mead, 2002; Williams & Cram, 2012), was a consistent theme, which emerged throughout data collection. Specifically, the adolescents' relationship with family and their wider community were carefully woven through every facet of their work and in-treatment social interactions were dictated by the whanaungatanga process. Most participants reported an improvement in family relationships as a result of the programme and that having family involved and supporting the treatment process gave them the opportunity to showcase positive progress and rebuild family trust. The whānau respondents reported that their involvement facilitated processes such as forgiveness, acceptance and togetherness. These findings give credence to the theory that family are a fundamental resource that support change for Māori adolescents (Huriwai et al., 2000; Stuart & Jose, 2014).

Kaimahi identified the need to tailor cultural practices to the cultural understanding and tribal affiliation of the rangatahi and the whānau, rather than just to the tikanga of their organisation. Huriwai et al. (2000) reported that matching tikanga is an issue faced by many Māori mental health clinicians left contemplating which tikanga to expose clients to – that of the therapist, the client or the iwi in which the organisation sits.

Although the benefits of using a cultural approach were undoubted, working in a Māori programme also had challenges for staff. Expectations from whānau and their respective communities about their work, including to continue as therapists despite feeling undervalued and overworked, were high; similar to expectations noted among Māori counsellors working in mainstream mental health organisations (Love, 1999). Love (1999) added that Māori counsellors can also experience conflict as a result of differing interpretations of counsellor-client boundaries and professionalism when compared with non-Māori clinicians. Because of the type of work, therapists in this area may experience high levels of stress and burn out (Sandhu, Rose, Rosthill-Brookes & Thrift, 2012), vicarious trauma, and potentially be a risk to clients (Billing, 2009). Therefore, it is important that kaimahi have consistent access to resources that will extend and reinforce their knowledge base, as well as increased access to clinical and cultural support, as recommended also in community sex offender research by Lim, Lambie, and Cooper (2012) and Geary (2007).

Staff characteristics were essential to engagement. Staff attributes were identified as an important feature that positively impacted on the programme users' (whānau and rangatahi) experience in treatment.

A strong client-therapist relationship during treatment was also imperative, with many rangatahi perceiving the

kaimahi as role models for positive relationships. Similar client-therapist relationship needs were also reported among mainstream sexually abusive youth receiving treatment in the community (Geary, 2007) and a recent systematic review highlighted that good relationships between adolescents and treatment staff was a crucial element of treatment (Campbell, Booth, Hackett & Sutton, 2018).

A key characteristic of staff was their cultural responsiveness, as noted, being aware of the acculturation issues of rangatahi and whānau, including the challenges of mixed race. This accords with Tamatea, Webb, and Boers (2011), who acknowledged that sex offender treatment programmes should be adapted to accommodate the cultural needs of those who participate and failure to recognise an indigenous person's cultural affiliation and values may result in the offender feeling alienated and neglected (Huriwai et al., 2000).

Cultural matching of client to therapist was important. Rangatahi reported that seeing a Māori therapist reduced their anxiety because they believed that they would be less judgmental of their personal circumstances and also understood the "Māori way of being". This was also evident in Turner and Manthei's (1986) study where Māori adolescents preferred Māori therapists because they were impartial and more understanding of their circumstances. Better treatment outcomes for users have been reported (Tamatea et al., 2011; Brown, St Arnault, George, & Sintzel, 2009) as clients stay longer and improve faster because of similarities in cultural beliefs and attitudes (Ape-Esera, Nosa, & Goodyear-Smith, 2009; Zane et al., 2005). In previous sex offender research, Māori adolescent participants and their caregivers found the inclusion of Māori therapists "essential" to the client-therapist relationship and in turn the therapeutic success (Geary, et al., 2011). However, while ethnically matching Māori clinicians with Māori clients is ideal (Tamatea et al., 2011), it is often difficult to achieve because of the limited availability of clinically trained Māori clinicians (Geary, 2007). Furthermore, international research states that similarities in therapist/client understanding of problem behaviour, willingness and interest to explore healthier coping strategies, and having shared treatment goals and expectations may be more important than ethnic matching (Zane et al., 2005; Imel, Baldwin, Atkins, Owen, Baardseth & Wampold, 2011).

Rangatahi and whānau appreciated the relaxed therapeutic style of the kaimahi and use of humour. While some sex offender researchers advocate caution using humour in a clinical setting, most have proposed that the careful integration of humour can lead to increased client-therapist rapport and create opportunities for therapists to explore clients' deviant sexual desires (Eisenman, 2000). In addition, humour can be a helpful means for staff to cope with the challenges of working alongside sexually aggressive populations (Sandhu et al., 2012).

Rangatahi and whānau reported that kaimahi characteristics facilitated engagement. In making sense of this in observations and analysis, an unexpected finding was how the rangatahi drew strong parallels between the staff members and relatives, including respected kaumātua, aunts or uncles, who had positively influenced them. Because of this association in their private lives, they were mindful of their behaviour around the kaimahi of kaumātua status and were more relaxed around the other staff because they reminded them of aunties/uncles who were fun and put them at ease. Moko-Mead (2002) and Love (1999) would attribute these views to the whanaungatanga principle; in particular, the idea that non-kin people can become like family through shared experiences. Western models of counselling may see these associations as inappropriate and potentially the result of a breach in counsellor-client boundaries, while in the setting of the current study, it was found to be culturally appropriate (Moko-Mead, 2002; Love, 1999).

Group processes are effective.

Peer relationships within the treatment programme were emphasised and continually reinforced through weekly group sessions, presentations, role-plays, and outdoor wilderness experiences. The wilderness experiences were particularly popular, not surprisingly, given the importance of peer friendships among this age group, and evidence that shared group experiences facilitate disclosure and change in relation to sexually deviant behaviours (Billing, 2009; Rich, 2003). Groups provide a supportive environment where sexual offenders learn basic relationship, communication, and social skills (Rich, 2003; Somervell & Lambie, 2009), whilst safely focusing on issues most relevant to sexual offending.

Strengths and Limitations

Strengths of this research were that it emphasised the perspectives of service-users, which are often overlooked in adolescent sex offender treatment studies, and that most of the interviewees were Māori. All the participants who agreed to participate in the research from the start completed the entire research process, but a limitation of the research was that rangatahi who graduated or dropped out of the programme were not able to be included, despite efforts to interview them. Whānau refused participation for some because they had "since moved on with their lives"; for others, contact details were out of date. Also, despite attempts to engage the management, they chose not to respond; team leader/management perspectives may have added more to the research.

Concluding comments

This process evaluation of a rangatahi programme showed that, by carefully weaving tikanga Māori beliefs and processes with westernised therapeutic theories and techniques, the kaimahi were able to create a unique treatment environment that emphasised values essential to positive adolescent growth including whānau support, the maintenance of relationships, and the importance of a secure identity. Furthermore, the personal qualities of the kaimahi and their responsiveness to the issues facing Māori youth of mixed ethnicity significantly contributed to the programme's success.

The findings of this study are important because they help to give credibility to the use of cultural initiatives with sexually abusive Māori youth. This current study clearly illustrates that sex offender treatment programmes need to accommodate the cultural needs of those who participate and failure to do so may result in disparate outcomes for its users and increase the risk to the community.

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"It's an important thing and can change someone without you realising": New Zealand Students' Views of University Mental Health Services

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Students face significantly more psychological distress than the general public, yet the view of New Zealand students about their university mental health services is overlooked in research. Consequently, nine individual semi-structured interviews were conducted with students from different universities in New Zealand and analysed to explore views and experiences on service quality. Participants mostly described being satisfied with their university MHS, but many highlighted aspects that could be improved. Therapists' qualities and skills played a leading role in views on service quality. However, long waiting times for appointments and the lack of information provided about therapists and services were barriers to use. Advertisements were identified as a route to increase service awareness and reduce mental health service-use stigma.

Keywords: Consumer Perspectives, Students, University Mental Health Services, Service Quality.

Introduction

The problems university students present with at their university counselling centres are no longer predominantly about adjustment or career support but are multi-faceted (Benton, Robertson, Tseng, Newton & Benton, 2003). This reflects the co-existing nature of some disorders and the varying range of difficulties faced by students, including sexual trauma, identity difficulties and suicidality (Kitzrow, 2009; Pledge, Lapan, Heppner, Kivlighan & Roehlke, 1998; Sarmento, 2015). University mental health services (MHS) in New Zealand have students presenting with similar concerns as those overseas. They work with a range of difficulties including, but not limited to developmental and transitional issues, grief, learning difficulties, anxiety/stress, depression and traumatic incidents (Auckland University of Technology, 2017; Canterbury University, 2017; Massey University, 2017; Otago University, 2017; University of Auckland, 2017; Waikato University, 2017).

The psychological distress and symptoms presented by students before attending university worsen across their degree study (Bewick, Koutsopoulou, Miles, Slaa & Barkham, 2010; Cooke et al., 2006). University students have significantly higher levels of psychological distress when compared to the general public in most Anglo-American countries (Cvetkovski, Reavley & Jorm, 2012; Cooke, Bewick, Barkham, Bradley & Audin, 2006; Stallman, 2010; Storrie, Ahern & Tuckett, 2010). Although there is a lack of published prevalence rates for New Zealand, it has been reported that around 45% of students from one New Zealand University have described struggling with their emotional wellbeing (Hoffman, 2017).

The implications of untreated mental health difficulties for students are significant and can affect academic achievement, drop-out rates, concentration and output, as well as interpersonal relationships (Brackney & Karabenick, 1995; Hunt & Einsberg, 2010; Kitzrow, 2003; Svanum & Zody, 2001). The utilisation of campus MHS results in better student retention rates and stress reduction (Lee, Olson, Locke, Micheloson & Odes, 2009). This makes it important to consider the support that university students are receiving.

Barriers and attitudes to help-seeking

The attitudes of students towards help-seeking, as well as the barriers to the utilisation of MHS, have been explored in clinical, non-clinical and specific populations (such as those with disabilities or medical students) (Coduti, Hayes, Locke & Youn, 2016; Givens & Tjia, 2002; Russell, Thomson & Rosenthal, 2008). When engaging in help-seeking, consistent with trends in the general population, students often approach general practitioners rather than counsellors (Andrews, Henderson & Hall, 2001; Stallman, 2010). Students can be unwilling to seek support from a counselling centre due to their difficulties being deemed not serious enough to require such support (Megivern, Pellerito & Mowbray, 2003). Further, there is concern that they will be stigmatized for being in a state of emotional distress (Stanley & Manthorpe, 2001; Warwick, Maxwell, Statham, Aggleton, Simon, 2008).

Generally, factors identified as barriers to the use of campus MHS include the therapy models used (predominantly western models of therapy), cost, accessibility, a lack of knowledge around the services provided, a lack of perceived level of supportiveness by staff, and perceived stigma by family or friends regarding mental health disorders (Benton, Robertson, Tseng, Newton & Benton, 2003; Collins & Mowbray, 2005;

D'Amico, Mechling, Kemppainen, Ahern & Lee, 2016; Eisenberg, Hunt & Speer, 2012; Leong & Lau, 2001; Sontag-Padilla et al., 2016; Vivekananda, Telley & Trethowan, 2011; Yorgason, Linville & Zitzman, 2008).

Mental health services and effectiveness

There is a rising demand for MHS in universities (Ketchen Lipson, Gaddis, Heinze, Beck & Eisenberg, 2015). However, limited data from several unidentified universities in New Zealand suggests that only 5.2% of enrolled students receive counselling (Stallman, 2012). This is similar to findings in other Anglo-American countries, where students do not utilize on-campus MHS (Eisenberg, Golberstein & Gollust, 2007). There is a lack of available information on how university counselling centres in New Zealand are coping. In terms of funding support, most New Zealand universities allocate money to their counselling centres from student levy fees, which each student pays upon enrolment (Auckland University of Technology, 2019; Canterbury University, 2019; Massey University, 2019; Otago University, 2019; University of Auckland, 2019; Waikato University, 2019). Although some universities provide student levy allocation information publicly online, the percentage allocated towards MHS specifically is not always clear. In example, in 2016 Massey University allocated 39% of student levy fees to health and counselling centres (Massey University, 2016). Whereas, Victoria University of Wellington specified that, in 2017, counselling services were allocated 11.3%, and health services 16.8% of student levy fees (Victoria University of Wellington, 2017).

Definitions of quality in health services are influenced by different policies worldwide (Ferlie & Shortell, 2001; Choudhry, Fletcher & Soumerai, 2005). The term 'quality' concerning MHS is made up of two factors: A focus on the client and obtaining a positive result from using the services and a practitioner-orientated aspect, which emphasises the importance of evidence-based knowledge (World Health Organization, 2003). Focus is often placed on 'indicators' of quality as a framework for service quality. This includes ease of access (including appointment times), the service process (including appropriate mental health disorder-specific care), and explicit changes found from service outcome measures administered (Shield et al., 2003; Valenstein et al., 2004).

The research on university MHS effectiveness has tended to consider effectiveness through the use of various outcome measures. For example, Connell et al. (2008) studied counselling service effectiveness with United Kingdom university students using the Clinical Outcomes in Routine Evaluation and Assessment measures (CORE). Counsellors and clients completed the measure at the start and end of therapy. Overall, there was an improvement seen in more than half of the students who accessed the counselling services. This improvement was influenced positively by whether there was an agreed therapy termination plan (a set number of sessions). Similarly, in another study (Murray et al., 2016), the CORE-OM was used to assess engagement with student counselling services and the effectiveness of such services. More than half of the students who initially presented with severe distress showed clinically

significant improvement, although around 2% of students got worse.

In the Connell et al. (2008) study, the timing of when the therapist versus client completed the measures is not clear. When students dropped out of therapy, a final measure was not completed. Consequently, regarding those who dropped out, it is not clear whether counselling was effective, and they stopped attending as they no longer needed support or dropped out because they were not getting the support needed (Connell et al., 2008; Murray et al., 2016). The results, therefore, risk response bias in favour of successful instances of therapy being reported, as they are essentially based on MHS staff responses. A lack of exploration around what students found useful from university counselling services is a common limitation in research evaluating university MHS effectiveness.

When assessing the effectiveness of some studies, which consider university student populations, focus predominantly on the effectiveness of the psychological treatment rather than the counselling centre (Monti, Tonetti & Bitti, 2013). The number of sessions offered in such studies is also much higher than the range of sessions offered at university counselling centres in New Zealand, which is generally set at six (Destefano, Mellott, & Petersen, 2001). When considering effectiveness, attention has also been placed on the working alliance between clients and counsellors. More specifically, the positive and/or negative influences the working alliance can have on therapy outcomes and effectiveness (Ackerman & Hilsenroth, 2003; Martin, Garske & Davis, 2000).

Studies exploring health service user perceptions regarding quality or effectiveness are often in primary health settings with specific populations (for example, those who are terminally ill) (Al-Momani, 2016; Khamis & Njau, 2014; Mohebifar, Hasani, Barikani & Rafiei, 2016; Papanikolaou & Zygiaris, 2014). Research specifically considering psychological distress and quality of care from patient perceptions, are often based in medical practice settings (Gask, Rogers, Oliver, May & Roland, 2003; Johnston et al., 2007; Nolan & Badger, 2005; Pollock, Mechanic & Grime, 2002; Rogers, May, Oliver, 2001).

Studies around university MHS quality has focused on: What services are provided, accessibility, the services that have been found to work, funding, the skill level of practitioners, as well as the ratio of practitioners. However, to date, most research in this area has only been conducted with university staff members (such as lecturers or counsellors) and directors, rather than with tertiary students (Guienee & Ness, 2000; Hunt, Watkins & Eisenberg, 2012; Jaworska, De Somma, Fonseka, Heck & MacQueen 2016; Stallman, 2012; Stone, Vespia & Kanz, 2000). The view of campus counselling service users is really important to learn about, as a client's view can differ from that of a clinician's view or understanding (Sofaer & Firminger, 2005).

Research of the experiences of students attending an educational based counselling service has focused on those who have accessed secondary school-based counselling (Shi, Liu & Leuwerke, 2014). Generally, secondary school students see the services as helpful in

different areas of their lives (including behavioural, emotional and interpersonal outcomes) (Lynass, Pykhtina and Cooper, 2012). However, research is needed for the specific experiences of tertiary students, as the needs and concerns of students at a university level are arguably different from those at secondary schooling (including differing adjustment concerns and differing levels of support systems). Furthermore, age difference results in different developmental concerns (Parker, Summerfeldt, Hogan & Majeski, 2004).

The limited studies that have focused on the experiences of tertiary students have mostly considered students' experiences with general university services (including, but not strictly limited to counselling services) in Anglo-American countries. Findings are not explorative and only briefly note that students are generally aware of such services, are satisfied with them and, at times, do engage with them (Russell et al., 2008). To date, there has been no research on the views of domestic students around university MHS engagement.

Current study

The purpose of this study is to explore the views of New Zealand based students around service quality of campus MHS. Therefore, the main research question is: What are the views and experiences of students who have accessed a New Zealand University MHS? Some supporting key questions include: What are their thoughts around local campus MHS after attendance? Also, in what ways may their experiences have increased or decreased the likelihood of them accessing other mental health/general health services in the future?

This study seeks to address the gap in research around the views of New Zealand tertiary students' MHS use. This will allow for the identification of areas specific to the needs of a New Zealand student population. Most studies considering the quality of care perceptions have focussed on views of clinicians or used closed-ended questions (survey formats or psychological measures). A qualitative method will allow for a more detailed exploration of what service users find important.

METHODS
Participants and Recruitment

Recruitment was through posts on public New Zealand wide Facebook groups, mass email lists (for example, university graduate email lists) and posters around two university campuses. Interested participants contacted the researcher through email and were then provided with an information sheet and consent form. Participants who agreed to continue on to the interview set up an interview time and date with the researcher through email. There were nine participants aged 18 and over (Table 1). All were current or past domestic students of two New Zealand universities (last year of attendance being within the last three years) and had previously attended a university MHS for at least one session.

Procedure

Interviews were one-to-one and semi-structured, ranging from 20 minutes to an hour and a half. These were held in a private room at a library or via Skype. Before beginning the interview, the main sections of the

information

Table 1. Participant Demographical Information

Characteristics		Count (N)
Gender	Female	9
Age	18-24	5
	25-34	1
	35-44	3
Ethnicity*	New Zealand/European	7
	Maori	3
	Chinese	2
	Niuen	1
	Burmese	1
	Scottish	1
	Irish	1
Qualification level	Bachelor degree	6
	Postgraduate diploma	1
	Doctorate	2

*Note. Some participants identified with more than one ethnic group.

sheet were once again discussed with participants. Participants all signed a consent form and completed demographic information. All interviews were audio-recorded with permission. As the focus was on the students' experience, interview questions were not theoretically grounded but open-ended and general. This was to encourage the participants to direct the conversation to the areas they wanted to speak about. The initial question set given to the first three participants was found to be unclear. The wording of some initial interview questions was changed, producing a new adapted set. This was clearer and allowed for more personal interpretations by the rest of the participants.

This project was reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 17/14 (Appendix A). Participants were provided with a list of helpline contact details (e.g., Lifeline, Depression Helpline, Health and Disability Commissioner) at the beginning of the interview. This acted as additional support should the participants wish to discuss their experiences in a therapeutic context. The data was anonymised with pseudonyms being used when reporting participants' experiences in this study. Identifying information about the universities or where participants sought and received MHS was removed.

Data Analysis

Thematic analysis was chosen as the method for data analysis as it allowed for the exploration of the specific research question and the views of participants (Braun & Clarke, 2006). Braun and Clarke (2006) provide a six-step guideline so that the process of thematic analysis is clear and thorough. In line with their guidelines, all nine of the recorded semi-structured interviews were first personally transcribed. Participants were sent the transcripts for their review and approval. Step one involved creating notes on what stood out with transcripts each re-read several times. In step two, initial coding was inductive-based, whereby codes were kept as close as possible to the participants' experiences and focussed on their answers (rather than the questions asked) (Clarke & Braun, 2013). In step three, themes that emerged from the codes were placed together in groups. During step four, each theme was reviewed,

edited and refined. This process was repeated several times resulting in eight over-arching themes being merged into five. In step five, the themes were defined and, in the final step, analysed with the results and discussion section written. Sub-themes often vary in their distinctiveness, although the overall themes identified are distinct (Maguire & Delahunt, 2017).

There were various considerations made in order to aid with the credibility of this study (Golafshani, 2003; Shenton, 2004). One form of triangulation is the comparison of participants' experiences with each other so to verify the experiences (Shenton, 2004). That is, although each participant's experience is unique, it was found that by the ninth interview, there was a significant degree of overlap in what participants were describing. The credibility of this study was also addressed through encouraging honesty; in each interview, participants were encouraged to be as up-front as they wished (Shenton, 2004). The researcher also being a student aided this by not being affiliated with any mental health services at universities. Further, participants had the chance to go through their transcripts afterward, although no amendments were requested (Patton, 1999). The dependability of this study is supported through the detailed methodology provided (Shenton, 2004).

ANALYSIS

Three over-arching themes were identified in relation to the accounts provided about university MHS by students who were service users (Table 2).

Accessibility of university MHS, an over-arching theme, was the most discussed area by participants from the two universities. In the first theme, barriers, many felt service access was difficult and intimidating. Therapy misconceptions, a sub-theme, pulled together participants' acknowledgments that stereotypes or common misconceptions about therapy had initially shaped expectations. The influence of stereotypes on what therapy might be like was present for participants regardless of their educational background.

...Even with study, I still thought it would be someone behind a clipboard going, 'ok, well tell me what's going on'... [Ashley].

Participants identified areas of apprehension before session attendance, which generally reflected a lack of information around university MHS. There was concern about what disclosures might be required in counselling session discussions.
...I thought it would be invasive... I didn't want to talk about my childhood or all those other things... [Isabelle].

Similarly, a fear concerning what remained confidential when engaging with their university MHS was common. Participants wanted confidentiality to be respected because of apprehension around the consequences of others knowing what was spoken about.
...it was really important that confidentiality was maintained, cause she likely knew a lot of the people I was talking about [Paige].

Some participants had high positive expectations regarding attendance outcomes. A face-to-face session meant that concerns would be alleviated instantly and that they could then go on with their lives.
...To put it very black and white, I felt bad and I wanted them to make me feel good.... I thought I would be in a stronger place and I would be able to just do the all-nighters that you were supposed to do [Isabelle].
Although participants were hopeful that they would gain instantaneous relief; there was the eventual insight that an instant fix might not be the case, regardless were not put off therapy.
...I just need to make it to that two-week mark and then I will be ok. Um, obviously, that's not how it works and that's not how it happened [Kate].
Participants felt there was a lack of information provided by their university MHS, as identified in the sub-theme: low publicity. Some were unaware of the free counselling service at both universities or the number of sessions provided, which was also a pattern observed

Table 2. Summary of over-arching themes, themes and sub-themes.

Over-arching Themes	Themes	Sub-themes	
Accessibility of the university mental health service	● Barriers	i.	*Therapy misconceptions and expectations*
		ii.	*Low publicity*
		iii.	*Stigma*
		iv.	*The appointment*
	● Advertising	i.	*Multiple faces of access*
		ii.	*Efficiency*
Perceptions of service quality	The role of the counsellor	i.	*The ideal therapist*
		ii.	*Therapist: The experience*
The influence of university mental health service	Attendance and new knowledge		

within their peer groups. This was an area that participants wanted more information around.

I didn't know a lot… I didn't know it was free until I went. I just know it was there because it was called health and counselling [Kiana].

Participants reported that some universities did not provide information about the therapists at their mental health centres anywhere. The result was a distinct sense of vulnerability about disclosing personal information to a stranger.

…Had I known who I was having the appointment with, I would have been like, 'oh ok, I'm talking to blah, blah' and like, become comfortable with the fact that I'm going to be speaking with this person [Ashley].

A few participants stressed needing something serious or severe to trigger the use of the university MHS. This 'required extremity' was an obstacle to service access as those who feel they do not meet the prerequisite might not approach the service, even when support is needed.

…My feeling is that, I think that, that people would think that you need to have a massive serious problem to go and see a counsellor [Emily].

Stigma was a key sub-theme raised and seen as a barrier. Concerns about the attitudes individuals have towards mental health meant trepidations about using the MHS at their university.

…I thought that my lecturer would make opinions based on me asking for help [Isabelle].

The service met this desire some participants had to blend in, allowing for more comfortable MHS use. Participants from one university highlighted the location of the service, specifically the waiting rooms as positive in reducing fears of stigma.

…The receptionist was kind of like going to GP appointment… it felt pretty normal... if someone was sitting in the reception and waiting, they wouldn't have even known I was going in for a counselling session, which was quite nice [Hannah].

However, with the merging of health and mental health centres, only one reception desk is available. Participants felt that reception staff should acknowledge that students coming in for different services have different needs. Treatment of students by receptionists can influence ease of accessibility and comfort for service users (Mowbray et al., 2006).

The sub-theme, the appointment, comprised the many ways participants attempted to access MHS at their universities and their struggles with this. Participants often had to play an active role in learning about the service and finding out about access pathways. For most, the first point of access was through the Internet.

…I googled it. I found it on the [name of university] website [Kate].

Opinions around the use of online platforms to learn more about university MHS varied depending on what university the participant attended. Participants from one university found access to be more difficult with limited

availability of information online. However, participants from another university found the experience positive to reasonably neutral.

I think the websites probably ok, I mean in terms of their- people look for it [Paige].
…Finding phone numbers, um, finding a website which had that questionnaire, like all of those things were easy to access [Emily].

Both the universities that participants attended required completion of a questionnaire online before offering their MHS. There were varied reactions to and feelings about the perceived purpose of this questionnaire. By some, it was seen as an attempt to identify students who might need immediate support. A few found the questionnaire to be frustrating and as a 'task' required to get support from the service. For others, it had a negative personal impact.

…Made me feel a bit stink, because I was like, well obviously I'm not resorting to alcohol, I haven't been abused, I'm not suicidal and I thought... it was kind of like they were asking, 'well if you got these specific things, go talk to someone' and I was like, well I'm not really feeling any of that, so maybe I don't need the counselling service? [Hannah].

Participants were frustrated about trying to make an appointment with MHS. Setting appointments was not always a clear or easy process.

…It's also very confusing, cause sometimes you make an appointment with your counsellor for your sessions and then other times they book you at the front desk; and then other times the front desk will book you in without talking to the counsellor and the counsellors already booked you in, so you end up with two different appointments or that will happen, but you end up with no appointments …I feel like, that I got so mucked around with [Kate].

The tussle in trying to secure regular appointments with no success was indicated as a pressure that staff was also aware of.

…when I reach out to make [an] appointment, um, the receptionist will also make a joke about it. They'll say like, 'oh no, there won't be any appointments available.' So, it's this... understanding within the service that the counsellors have a lot of clients and it's pretty rare to ring up, say on a Monday and expect to see someone that week [Emily].

Many students grappled with the limited number of counselling sessions available. Through a yearly session number limit, many faced the struggle of having to decide when their distress required support or if they were able to go on without MHS input for the time being. Some felt like the need for additional sessions outside of the set limit must mean that there is something wrong with them.

I was told you've got...like nine free sessions, but it was like, 'oh ok, am I meant to have only nine breakdowns?' [Ashley].

Others felt it became risky to open up and speak about what is going on clearly, as they would not receive long-term support.

I found it pretty hard that they would number the amount of sessions that you would typically attend for...so being aware that I only had like three or four more sessions, was quite, um, hard for me to relax and be forthcoming [Isabelle].

In the second theme, Advertising, advertisements were portrayed as invisible, although useful in different ways. Often it was commented that university MHS advertisements were restricted to the health centres at universities and therefore not visible to the general public. Many wanted their university MHS to move away from this. Adverts were seen to be in specific places due to associated stigma.

It wasn't something that was widely shown around university, oh you know 'you could go see somebody if you're feeling down'... [Ashley].

Adverts were also seen as a potential action against stigma by allowing a conversation point and reducing the views around the 'types' of people or problems MHS are for.

I think the more it's talked about the less the stigma becomes... I think one of the biggest steps we can take is making sure people are talking about and know about these services, and that it's available for all types of problems not just specific ones [Hannah].

Similarly, clear and openly placed advertisements about university MHS were seen as an advantageous way to help vulnerable persons recognise available support.

...People with severe mental health problems might be too overwhelmed to like seek help, maybe it would not make it seem as overwhelming to seek help if it was more just made really clear [Kiana].

This study explored what participants thought about the quality of the service provided at their university MHS. The overarching theme, Perceptions of Service Quality, comprises what participants felt reflected service quality. Participants indicated areas not related to the therapist that they felt made a service effective. This included accessibility and the approachability of service. Participants felt that a good quality university MHS would be accessible and affordable, especially when considering whether they would re-engage with the MHS.

...I think from the front of house, there needs to be a start there for that person to feel safe [Ashley].

Embedded within the 'role of counsellor' theme, participants described various preferred counsellor qualities and skills as a vital aspect of what makes up good service. This description of what was sought in a therapist encompassed the sub-theme, the ideal therapist. Emphasis was on the counsellor's various skills, values and characteristics. It was primarily desired for therapists to be open-minded and non-judgmental. Further, participants highlighted a need for genuineness and sincerity from a therapist. The ability for a therapist to be able to distinguish between empathy and sympathy and be present with the client in an empathetic manner was identified as necessary for an effective therapist.

I don't appreciate that [sympathy], I don't want somebody that was there to cuddle me. I wanted the

emotional support, but yeah, not feel like they felt sorry for me [Isabelle].

Some participants with a background in Psychology indicated that at times they could predict where the therapist was going in the session and that they would then attempt to interrupt this process. They indicated that they desired their therapist to confront them about such attempts gently.. The importance of a therapist's theoretical knowledge and training was also stressed. However, one participant strongly emphasised the therapist having lived knowledge in addition to having had more direct experiences of mental health difficulties.

...I think they need to have lived with mental health themselves, that's regardless of whether that's them having gone through it personally themselves or their partner or something [Kate].

The sub-theme, Therapist: The experience, brings together participants' descriptions of their experiences during their sessions. Participants felt that their therapists were non-judgmental.

...Treats you unbiased, that they speak with an open-mind and that from this side of the couch, I don't feel like I'm being judged [Ashley].

Participants also found their therapists to be empathetic, sincere and understanding and found it useful when their therapists would listen and give them the space needed to vent at their own pace. However, there were different experiences of how 'heard' participants felt. One participant spoke about how the therapist would not really listen to the feedback provided. This meant she ended up being pushed into agreeing with what was done.

...'Tell me if this isn't working' ...anytime I did, he got really defensive. So I ended up sitting there going, 'oh no, this was great, I'm getting exactly what I want and what I need' even though it wasn't [Kate].

There were also comments about collaborative work in looking for a solution to certain difficulties by therapists with participants. Participants indicated that the therapists guided them rather than told them what to do. Many participants described the importance of rapport or a sense of connection with their therapist.

[Referring to first counsellor] was really nice, I just don't feel like I connected with her and so that kind of made the counselling a bit unsuccessful...I felt like she didn't understand... what's it's like at this age growing up in New Zealand [Kiana].

Participants' descriptions and examples of the verbal support received from their therapist reflect the use of normalisation, affirmation and validation (Bedi et al., 2005; McLeod, 2013; Slattery & Park, 2011).

...The counsellor reassured me that what I was feeling was normal, and that was a big thing for me, cause I was like 'oh maybe it's just me, maybe I'm just being a little weird...She reassures me...she's always kind of like, congratulates me in a way, she's like, 'you know, you're actually doing a good job' and for me that makes me feel good [Hannah; an example of normalisation and affirmation].

...When I was really hesitant to ask for an extension, they would say, 'you have no idea how many students ask for an extension, this is one of the forms I used the most at this service, so I'm telling you, you're not an anomaly and they aren't gonna think you're getting favouritism or anything like that... [Isabelle, an example of normalisation and validation].
...My sort of right to be able to spend that hour talking about my life [laughs] and just sort of actually really assuring me that I'm fully kind of entitled to that [Paige, an example of validation].

Many participants felt that their therapist provided them with various tools that they could use outside of therapy when needed, including breathing techniques, practical resources and reading materials. This was described positively and found to help participants cope outside of sessions and reduce distress.
...Coping mechanisms: sleeping well, breathing out, that sort of stuff and I remember that was met. I walked out knowing what I can do, not completely healed, but knowing that [there] was other ways of going about trying to get myself of where I was [Ashley].

Within the overarching theme, The influence of the University MHS, participants described how attending the counselling sessions resulted in various conclusions drawn about the university MHS. In the theme, Attendance and new knowledge, attention is drawn to how influential the service was on views and future recommendations to others. There were varying views on the overall experience with participants' university MHS. Through attendance at their university MHS many learnt about what counselling offered students and what was specifically available at local university MHS. One participant, who had attended independent counselling before, highlighted the welcome cultural support available at one university.
...They met my needs really well. Especially in terms of being Māori. I initially met with somebody that I... wasn't comfortable with...and I said that and they moved onto a Māori counsellor and I feel that was just so much a benefit [Isabelle].

Another participant who had attended two university MHS found that a holistic approach to MHS, expected with more culturally aware services, was not provided.
...The idea of your health, your mental health in a wider context...I don't think they hold that view [Kate].

It was highlighted repeatedly by all participants that they were generally happy to access MHS in the future.
...Wherever I move to, I'm definitely going to look for someone that I can, would be able to talk to... [Hannah].
...Thanks to the help I've got... I'd definitely be more willing to look for help [Brianna].

For those who were not completely happy, future engagement with that specific university MHS was unlikely:
...Pushed off, that's how I felt. So, I wouldn't want to engage with them again. I wouldn't want to go back. I just had such a horrible experience ...I would

recommend it to other students because there is pretty much nowhere else to go and pretty much no other option [Kate].

Others would be encouraged to use the service due to external mental health services being regarded as expensive and thus unaffordable for students.

DISCUSSION AND CONCLUSION

University MHS are generally seen as plausible and attractive support networks for students, with external services often regarded as unaffordable (Macdonald, 2018, July 19). However, there were many barriers to the service. Many participants were wary of university MHS use due to a lack of knowledge around services, which is access obstacle for tertiary students more generally (Flisher et al., 2002). As reflected by participants in this study, a concern around what remains confidential also hinders tertiary populations MHS attendance (Chew-Graham, Rogers & Yassin, 2003).

The lack of advertisements, although not explicitly stated as a barrier, can be interpreted as such since adverts were seen as the gateway towards initially learning about university MHS. Clear and openly placed advertisements about university MHS were seen as an advantageous way to help vulnerable persons recognize such available support by participants. One study has previously found that sometimes individuals can struggle in identifying their concerns (as related to mental illness) and clear adverts can aid in identification (Flisher et al., 2002)

Stigma, a commonly identified barrier for tertiary-level students (Corrigan, Druss & Perlick, 2014; Yorgason, Linville & Zitzman, 2008), was mentioned in this study by participants about several aspects: It was predominantly seen as a barrier with concerns expressed about what others might think of mental health service use. Participants found that their misconceptions served to work as a hurdle in accessing university mental health services. The influences of the media on how therapy is seen by society, primarily through inaccurate or dramatized representations in film, are well known (Bischoff & Reiter, 1999; Gabbard, 2001). Participants' comments in this study often reflected distorted images of therapy from wider contexts, such as movies, which fostered them feeling intimidated prior to attendance of their first counselling session.

Interpretations of counselling based on stereotypes and misconceptions were not always a barrier to accessing university MHS. Some students expressed the belief that attending therapy would lead to an 'instant cure,' which increased the desire to attend, making it beneficial to service access. Therapy as an 'instant cure' has been highlighted previously by services as being a common occurrence, while counsellors have recognised it as misconception or stereotype that many clients entertain (Much, Wagener & Hellenbrand, 2009). Although participants in this study realised that there would be no instant cure, this did not seem to hinder further service use specifically. Stigma was also raised in conversations for change, where reduced stigma was considered an outcome of increased services advertisements around the campus. The use of various media is a tactic often used to combat

stigma by encouraging conversation around a stigmatised topic (Clement et al., 2013).

A frequent requirement for access to university MHS in NZ is the completion of an online questionnaire on the respective university's website. Despite views that the questionnaire allowed for an indication of risk or was a screen for better support, it served as a barrier to access. For some participants it created anxiety that their concerns were not 'severe' enough for support, as students had to choose from a list of significant concerns such as alcohol abuse or suicidal ideation. Remarks also indicated a sense of vulnerability amongst participants when disclosing recent personal concerns through such an online questionnaire form.

Internet use to learn about mental health and the options available to seek MHS access is not uncommon (Powell & Clarke, 2006) and was found to be the key pathway to accessing university MHS identified by participants in this study. Accessing the university website to gain information about services was considered beneficial by some as it was easy to access and a discrete way to search for support. This is similar to overseas reports by young people finding that accessing information via the internet reduced the fear of facing stigma (Horgan & Sweeney, 2010).

One of the most agreed upon barriers were the long waiting times for appointments. Prior research has emphasized the struggle of university mental health centres worldwide in dealing with high demands for service use by students with complaints about long-waiting periods (Kitzrow, 2009; Macaskill, 2013). Such difficulties with waiting times suggest that university staff struggle to manage the high demand for service access by New Zealand students.

The term MHS 'quality' was seen to reflect the presence of various components within a service, including positive improvement using evidence-based knowledge (World Health Organization, 2003) and fast appointment times (Shield et al., 2003; Valenstein et al., 2004). Participants' comments on what they felt made a service 'good quality' also reflected the importance of evidence-based practice and good service, such as fast appointment times. However, predominantly, 'quality' for participants was perceived as the presence of certain qualities in a counsellor. Counsellors needed to be unbiased, open-minded, relatable, skilled and experienced. Although theoretical knowledge and training were important, so too was lived knowledge and understanding. The qualities desired by participants matched qualities fundamental to person-centred therapy; this included empathy, unconditional positive regard and congruence (Rogers, 1957; McMillan, 2004).

Participants also noted the importance of 'a connection' with the therapist for therapy. Research has found certain components to increase the relationship between a therapist and client, the therapeutic alliance, including collaboration, gentle challenging, empathy, warmth, friendliness and affirmation (Ackerman et al., 2003; Babatunde, MacDermid & MacIntyre, 2017; Bor & McCann, 1999; Bedi, Davis & Arvay, 2005; Manthei, 2007; Leach, 2005). In this study, a 'connection' consisted of therapists having shared knowledge with clients or communicating an understanding of where the participant

is coming from. Most participants interviewed indicated that they had had a good connection with their therapist. A good therapeutic alliance is important, as it is linked to clients judging the service to be of good quality and is linked to successful therapy outcomes (Noser & Bickman, 2000; Safran & Muran, 2000). Therapists in this study were described as providing other components linked to positive therapeutic alliance, including validation, affirmation and normalisation; skills and qualities also identified as promoting the therapeutic alliance (Leach, 2005).

Participants in this study all had differing views about what was most effective in their session (for example, the use of session plans). This divergent emphasis highlights the differing nature of the client's needs (Bohart & Tallman, 1996). For most participants, their experience with their therapist was predominantly positive and they would use such services again. Such commentary is similar to findings from previous studies, concluding that prior experience with a service influences the likelihood of attending MHS again (Kahn & Williams, 2003).

There were some limitations in this study. Unavoidably, the research process was influenced by the researcher's background knowledge. More specifically, a lack of experience in qualitative interviews meant being strongly focussed on remaining neutral and non-leading during the initial interviews, which was not always possible. This also meant certain comments by participants were not thoroughly explored. In later interviews, this was addressed and the focus was placed on the rapport with participants and more thoroughly exploring areas participants highlighted. Consequently, this might have impacted the data as some participant's experiences and views were explored more deeply than others.

Participants were also all female, which may reflect higher MHS use found amongst women (Cheung & Dewa, 2007). However, an all-female sample can have implications for the transferability of this study. There is the possibility of self-selection bias, with participants choosing whether or not they want to engage in this study (Nilsen et al., 2009). This might reflect the higher positive responses around university MHS.

Implications

This study provides an understanding of student views of their university mental health service. It also tentatively (considering limitations) offers an indication of what domestic New Zealand students find to be hindrances and supports and provides insight into what is important for students around service quality. We conclude with the following recommendations - key areas highlighted by participants as requiring addressing by university mental health services:

- Provide advertisements, which include students' views about the MHS, highlighting benefits and addressing common concerns.
- Increase advertisement visibility in different areas of university campuses.
- Provide MHS information at the beginning of the academic year.
- Clarify the process for setting up appointments and self-referring to the university MHS.

- Provide therapist profiles in order to decrease the views of therapists as 'complete strangers'.
- Clarify how many sessions are offered per year

- Describe the general purpose of the referral questionnaire to avoid student anxiety around whether their concerns are 'serious' enough for support.

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Mental Health of Trans and Gender Diverse People in Aotearoa/New Zealand: A Review of the Social Determinants of Inequities

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The effects of health inequities on transgender (or trans) and gender diverse populations have been well documented internationally. Studies that compared the mental health of trans and gender diverse populations to cisgender populations found significant inequities for mental health problems. There has been very little research on this topic, however, from Aotearoa/New Zealand. We conducted database search in the PsycINFO, as well as manual searches for published grey literature in Aotearoa/New Zealand to identify theoretical and empirical literature on social determinants of health and related frameworks to explain the effects of social environments on health inequities experienced by trans and gender diverse people. We also complement international studies by considering Māori and Pacific trans and gender diverse identities and the ramifications of colonisation on the mental health and wellbeing of these populations.

Keywords: Transgender, Gender Diverse, Mental Health, Social Determinants of Health.

Scope of Research

This review examines mental health and wellbeing, and the social determinants that lead to mental health problems among transgender and gender diverse (TGD) people in Aotearoa/New Zealand. We provide an overview of existent transgender and gender diverse health research in Aotearoa/New Zealand and some recommendations for enhancing research design with this population. We used the PsycINFO database to locate relevant mental health research in Aotearoa/New Zealand. Due to the limited amount of local research about indigenous TGD people's health, we searched for international literature that has examined this topic. We also searched the international literature for theories that explain the high prevalence of mental health problems among TGD people.

The database search was based on publications from database inception until June 2019, using the search term keywords, transgender, trans, and gender diverse, and mental health keywords such as depression, anxiety, and mental health problems. Lesbian, gay, bisexual and transgender (LGBT) studies that did not examine TGD people as a separate category were excluded, as previous research has demonstrated TGD and LGB people do not have similar experiences related to gender identity and expression (Tan, Treharne, Ellis, Schmidt, & Veale, 2019). We also explored published grey literature such as reports and conference papers through Google Scholar to provide a comprehensive overview of TGD mental health in Aotearoa/New Zealand.

Introduction

The demographic makeup of Aotearoa/New Zealand is specific to this country, and this has a particular effect on the ways in which mental health is understood. Nearly three-quarters of the Aotearoa/New Zealand population (74.0%) identify with one or more European ethnicity, followed by the indigenous Māori who comprise 14.9% of the national population (Statistics New Zealand, 2015). Aotearoa/New Zealand is also home to Asian people, who comprise 11.8% of the population, and various Pacific people, who make up 7.4% of the population, and are Samoan, Cook Islands Māori, Tongan, Niuean, and other Pacific ethnicities (Statistics New Zealand, 2015). Since the colonisation of Aotearoa/New Zealand by Pākehā (European) settlers during the nineteenth century, the social and cultural status of indigenous Māori have been severely affected, with detrimental impacts on their wellbeing (Hutchings & Aspin, 2007). The process of colonisation has involved degrees of assimilation into Pākehā settings, and a commensurate loss of Māori cultural knowledge. One of the outcomes of colonisation is the marginalisation of the diverse expressions of gender which were specific to Māori culture, but were understood as 'perverse' by many Pākehā missionaries and other colonisers (Hutchings & Aspin, 2007; Kerekere, 2017).

In Aotearoa/New Zealand, there are many ways of understanding gender diversity including Pākehā, Māori, Pacific and Asian ways. Pākehā perspectives of gender diversity are based on the western understandings of gender identity (i.e., the internal sense of individuals toward their experience of gender) and include those who identify under the umbrella terms of transgender or gender diverse. Transgender (or trans) denotes people whose gender identity does not correspond with the gender typically associated with the sex assigned to them at birth (American Psychological Association, 2015). Transgender people may identify as neither men nor women (e.g., non-binary); both men and women (e.g., bigender); as moving between binary genders (e.g., genderfluid); or as no gender (e.g., agender) (Adams et al., 2017; American Psychological Association, 2015).

Gender diverse is a broader term which includes people who identify as transgender or any of the other identities that we describe in the following section. In this review, we use the abbreviation TGD to refer to transgender and gender diverse people.

There is little research into Asian understandings of gender diversity in Aotearoa/New Zealand, but more research has been conducted on Māori and Pacific understandings that are unique to our region.

Māori and Pacific Gender Diversity in Aotearoa/New Zealand

All colonised states have a specific and unique history of colonisation, and Aotearoa/New Zealand is no exception. European settlement of Aotearoa/New Zealand occurred throughout the 17th and 18th centuries, and the Treaty of Waitangi was signed between the representatives of the British Crown and some rangatira (chiefs) in 1840 (King, 2003). Given the distinctive colonial context of Aotearoa/New Zealand, Burford, Lucassen, and Hamilton (2017) urged researchers to reflect on the "history of indigenous inhabitation, settler colonisation and the migration of peoples from the islands of the South Pacific, and among other migrant groups" (p. 213). For TGD research to be relevant to Aotearoa/New Zealand, Māori and Pacific understandings of gender diversity need to be central to this work.

Diversity in gender identity, gender role (i.e., social roles associated with gender in a culture), and gender expression (i.e., the presentation of an individual to reflect aspects of gender identity or role) have always been part of Māori society (Hutchings & Aspin, 2007). Although many details were lost as a consequence of colonisation and the imposition of binary western gender frameworks onto indigenous understandings of gender (Feu'u, 2017; Hutchings & Aspin, 2007), there are various sources (e.g., oral accounts, archival material and carvings) that provide evidence of the existence of gender diversity within pre-colonial Māori culture (Kerekere, 2017). For instance, there is a Māori traditional narrative of an ancestor, Tāwhaki who was on a journey when he encountered Tongameha, a tipua (spiritual force who had the ability to change form and gender in remarkable ways). The ability of tipua to embody both female and male, and alter gender provides a sense of cultural resonance for contemporary Māori TGD people (Feu'u, 2017; Kerekere, 2017). Feu'u (2017) also brought up accounts from James Cook's crew members on the Endeavor voyage, who commented on the striking beauty of Māori "maidens", although they soon realised these maidens were whakawahine (Feu'u, 2017), a term that literally translates as "like a woman". Contemporary usage of this term denotes a person assigned male at birth with the wairua (spirituality) of a woman (Kerekere, 2017).

There are many instances of gender diversity among Pacific populations in Aotearoa/New Zealand, such as Samoan fa'afāfine, Cook Islands Māori akava'ine, Tongan fakaleiti, and Niuean fakafifine (Brown-Acton, 2014). As Samoans are the largest population of Pacific origin in Aotearoa/New Zealand (Statistics New Zealand, 2015), the Samoan fa'afāfine are relatively common within Pacific TGD populations. Fa'afafine literally translates as "in the manner of a woman", and fa'afāfine are

traditionally identified by virtue of their propensity for feminine labour (Schmidt, 2017). Contemporary fa'afāfine represent a broad range of gender expressions that sometimes (although not always) encompass more western aspects of trans and gender diversity and/or might be understood as 'gay men', while still aligning themselves with the traditional identity of fa'afafine (Schmidt, 2017). While globalised discourses of gender and sexuality diversity have been actively utilised by fa'afāfine in constructing their identities, they have also led to a range of stereotypical representations of fa'afāfine within both popular and academic texts (Schmidt, 2017), and Farran (2010) noted similar ramifications of colonisation and globalisation on gender diverse people across other Pacific cultural contexts.

Māori and Pacific TGD people ascribe to various identities — some affiliate with terms of their specific cultural context, others align only with Pākehā TGD identities, and others encompass both their own cultural backgrounds and western models within their identities (Adams et al., 2017; Brown-Acton, 2014). Māori and Pacific terms often carry historical, political and social connotations that are not necessarily interchangeable with Pākehā terms, which are reflected in the range of identifications adopted by Māori and Pacific TGD people in Aotearoa/New Zealand (Feu'u, 2017). The uniqueness of Māori and Pacific gender diversity, and the specific social outcomes wrought by colonisation and westernisation mean that considering the mental health and wellbeing of TGD people in Aoteaora/New Zealand necessitates awareness and consideration of the additional marginalisation faced by people with these identities.

Mental Health in Aotearoa/New Zealand

Mental health can be defined as a state of wellbeing which allows people to "realise their abilities, deal with life's challenges and stresses, enjoy life, work productively and contribute to their communities" (Brunton, 2018, p. 1). Those who experience mental health problems face psychological and emotional reactions that may affect their ability to perform daily routine activities (Brunton, 2018). Various surveys have been developed to examine the health and wellbeing of Aotearoa/New Zealand populations. The 2015 New Zealand Mental Health Survey is a population-based study of 1,377 adult participants from the general Aotearoa/New Zealand population. It found that 9.3% and 6.5% of Aotearoa/New Zealand population reported symptoms of depression and anxiety respectively (Hudson, Russell, & Holland, 2017). Mental health problems can have life-threatening consequences, with Aotearoa/New Zealand studies (e.g., Beautrais, 2003) finding that mental health problems are associated with an increased risk of developing suicidal ideation and attempting suicide.

The Aotearoa/New Zealand National Health Committee (1998) posited a need to examine upstream factors influencing mental health, which comprise determinants of health that are social (e.g., accessibility to health services), cultural (e.g., connectedness to cultural group) and economic (e.g., socioeconomic status). The Committee highlighted the importance of investigating health within a social context, as social environments

comprise upstream factors that exert predominant influences on health and are often beyond the control of individuals (Blane, 2006; Jayasinghe, 2015). Hence, a holistic health model should contemplate social determinants of health as a collection of intermediary factors that intertwine with social systems (e.g., education system), social norms (e.g., racism), and social structures (e.g., policy) in generating health outcomes (Jayasinghe, 2015).

TGD Mental Health and Social Determinants of Health

Recent published review studies in the Europe and North America found that TGD people manifest higher rates of various mental health problems when compared to general population prevalence figures. For example, Millet, Longworth, and Arcelus (2017) conducted a systematic review of the prevalence of anxiety symptoms and disorders among TGD people across various countries in the regions of Americas, Europe and Asia, and found that the prevalence of anxiety disorders among this population may be as high as 68.0% compared to the 18.1% found in general population surveys. Public health literature correlates the relative susceptibility of minority populations (TGD populations in this instance) in manifesting mental health problems with their marginalised social positions (Brunner & Marmot, 2006).

These review studies have generally not taken into consideration issues of ethnicity and indigenous backgrounds. Burford and colleagues (2017) noted the importance of acknowledging the ramifications of colonisation in taking into account the wellbeing of gender diverse people who are marginalised in contemporary westernised society as well as the ethnic and cultural differences among Aotearoa/New Zealand populations in gender diversity research. Such acknowledgement promotes the inclusivity of Māori and Pacific populations, and this in turn fosters their mana (authority, influence, and power).

Historic colonialism has resulted in destruction of Māori communities and Māori becoming disconnected from their land (Durie, 2011; National Health Committee, 1998). Deleterious effects of colonialism on the wellbeing of indigenous populations are outlined in the Indigenist Stress-Coping Model (Walters & Simoni, 2002). According to this model, indigenous people experience heightened levels of life stressors (e.g., historical trauma) that in turn affect health negatively. Reid and Robson (2007) attributed the high prevalence of mental health problems among indigenous Māori populations to their loss of mana, rangatiratanga (autonomy), and sense of belonging.

When gender diversity is examined in health-related research, it is clear that TGD people are at risk of a range of health inequities when compared to cisgender people (Pega & Veale, 2015). Health inequity refers to those inequalities or disparities in health outcomes, which are "deemed to be unfair or stemming from some form of injustice" (Kawachi, Subramanian, & Almeida-Filho, 2002, p. 647). In order to understand the fundamental causes of mental health inequities for TGD people, we need to examine the circumstances in which people live and work—the social determinants of health (SDHs)

(Brunner & Marmot, 2006) and refer to theoretical frameworks that explain the roles of social determinants in causing health inequities that TGD people experience. Pega and Veale (2015) argued that gender diversity has been neglected as a social determinant of health and that health inequities specifically affecting TGD people arise as the result of cisgenderism. Cisgenderism is a form of structural marginalisation of TGD people through a process that privileges cisgender people by reinforcing the understanding that there are only two valid genders (i.e., woman and man) and that people's gender must align with expectations of their sex assigned at birth (Riggs, Ansara, & Treharne, 2015). Consequently, cisgenderism causes the delegitimising of TGD identities and genders. The privileging of cisgender people situates TGD people in a lower social position and causes TGD-related negative experiences, such as discrimination, rejection, and victimisation at individual, interpersonal, and structural levels (Pega & Veale, 2015; Testa, Habarth, Peta, Balsam, & Bockting, 2015). These negative experiences also limit TGD people's ability to access other determinants of health including education, employment, social programmes, and healthcare services.

Existing TGD Mental Health Research in Aotearoa/New Zealand

The Youth'12 study (Clark et al., 2014) is the only research based in Aoteaora/New Zealand to investigate TGD people's health inequity with comparisons to cisgender populations. Youth'12 is the third of the Youth2000 series of population-based surveys that focused on the health and well-being of secondary school students in Aotearoa/New Zealand. It included the question "Do you think you are transgender? This is a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl (e.g. Trans, Queen, Fa'faffine, Whakawahine, Tangata ira Tane, Genderqueer)". In response, 1.2% of the sample responded yes to the question, and a further 2.5% reported being not sure about their gender.

Youth'12 found an almost 4-fold increased risk of depression among TGD students (41.3% vs 11.8%), an almost 2-fold increase in non-suicidal self-injury (NSSI) risk (45.5% vs 23.4%), and an almost 5-fold increase in risk of a suicide attempt in past 12 months (19.8% vs 4.1%) when compared to cisgender students (Clark et al., 2014). TGD students were significantly more likely than cisgender students to experience external stressors including being physically harmed (49.9% vs 32.5%) and bullied at school (17.6% vs 5.8%), and internal stressors such as being afraid of someone hurting them at school (53.5% vs 39.8%). TGD students also reported being significantly less likely to experience protective factors, such as getting along with family members (63.9% vs 81.5%), enjoying the school environment (74.1% vs 90.4%), and feeling connected with friends (63.9% vs 81.5%) (Clark et al., 2014). This decreased access to protective factors is important for TGD youth, as studies have shown that family acceptance and social support aid in reducing the risk of manifesting mental health problems (e.g., Veale, Peter, Travers, & Saewyc, 2017).

However, there is a need to interpret the results of Youth'12 on TGD students with caution. Although

Youth'12 was a product of its time, its transgender question defined TGD people based on their sex assigned at birth, referring to TGD youth as a girl who feels like she should have been a boy, or a boy who feels like he should have a girl. This narrow conceptualisation of "transgender" could present TGD identities as arbitrary choices, and fail to include students whose gender is outside the binary of boys and girls. It is unclear what effect, if any, this had on TGD participants' responding.

It is also possible that some cisgender students may have responded yes to the transgender identity question because of misunderstanding of the question or not answering the question seriously, and it would have only taken a small proportion of cisgender students to endorse this question to meaningfully dilute the transgender sample. Pega, Reisner, Sell, and Veale (2017) also raised concern about the usage of the one-question method (i.e., asking if one identifies as transgender) in a population-based survey, because it runs the risks of undercounting TGD people whose gender is different from their sex assigned at birth but who only identify themselves within the gender binary framework. Hence, the current best practice in population-based surveys includes using the two-question method, which involves collecting both sex assigned at birth (i.e., female or male), and current gender identity (in a way that is inclusive of non-binary genders). This allows for the responses for these two items to be cross-classified to determine TGD identity (Pega et al., 2017; The GenIUSS Group, 2014).

TranZnation was an Australian-based TGD health study that has included 24 TGD participants from Aotearoa/New Zealand (Pitts, Couch, Hunter, Croy, & Mitchell, 2009). New Zealand participants in this study comprised less than 10% of the total sample, and the researchers did not report separately on data from this group. TranZnation found an approximate 6-fold increase in depression among TGD people (36.2% vs 6.8%) in comparison to the Australian general population. TGD people who had faced a greater number of different types of stressors (e.g., verbal abuse, physical attack, and sexual assault) were found to be more likely to exhibit depressive symptoms.

Theoretical Frameworks in TGD Mental Health

There are competing theoretical frameworks to explain these mental health inequities, one that suggests that being TGD is psychopathological (i.e., psychologically disordered and inferior) and another that focuses on the stigma and minority stresses that TGD people face.

Psychiatric diagnoses related to being TGD have existed in the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) since the 1980s (American Psychiatric Association, 2013; Drescher, 2014), reflecting the idea that being TGD is mentally disordered (Zucker, Lawrence, & Kreukels, 2016). Because mental health problems tend to co-occur, the belief that this pathology can explain the increased prevalence of mental health problems among TGD people was widely taken for granted without much consideration of the role of cisgenderism as a social determinant of mental health inequities (Schulz, 2017). The existence of psychiatric

diagnoses is a form of social determinant of inequities affecting TGD people, as these diagnoses serve as gatekeeping criteria and compel this population to undergo extensive assessment and referral prior to obtaining medically necessary healthcare services (Schulz, 2017). During this process, TGD people may risk exposing themselves to mental health professionals who are not equipped with sufficient level of TGD healthcare knowledge, or worse, who utilise the pathologisation perspective to invalidate lived experiences of a TGD person (Schulz, 2017).

TGD populations mobilised to criticise this pathologisation for its lack of conderation of the role of cisgenderism as a social determinant of health; they also noted that this pathologisation leads to harmful stereotypes about TGD people and advocated the end of the pathologisation of TGD people (Suess, Espineira, & Walters, 2014). While the pathologisation explanation for mental health problems in TGD people is still taken seriously by some (Zucker et al., 2016), as more researchers and health professionals listen to the views of TGD people, this approach is becoming less accepted. Professional organisations such as the World Professional Association for Transgender Health (WPATH, 2018) and the American Psychological Association (American Psychological Association, 2015) have publicly affirmed that being TGD is not pathological. In June 2018, the World Health Organization (2018) announced that Gender Incongruence will be moved from the mental health to section of the ICD to a new section called Conditions Related to Sexual Health.

One of the most widely adopted theories to explain health inequities that TGD people experience is the Gender Minority Stress Framework (GMSF; Testa et al., 2015), which is an adaptation of Minority Stress Theory (Meyer, 2003). The GMSF focuses on the impact of cisgenderism on the mental health of TGD people (Tan et al., 2019). This framework proposes that TGD people experience risk factors (that create adverse experiences and increase vulnerability to negative mental health outcomes) and protective factors (that buffer risks and promote health and wellbeing). Risk factors that TGD people face include distal (external) minority stressors (e.g., TGD-related discrimination and non-affirmation of identity), which lead to the development of proximal (internal) minority stressors within TGD people (e.g., internalisation of negative societal attitudes about one's own TGD identity and TGD people as a social group). Testa et al. (2015) proposed that the negative impacts of minority stressors can be mitigated when TGD people are exposed to protective factors, such as education, access to affirmative healthcare services, and social support (e.g., TGD community organisations and family support).

Numerous studies have found correlations between distal and proximal stressors and mental health problems (e.g., Veale et al., 2017). When put together, Testa et al. (2015) postulated a plausible chain: cisgenderism causes TGD people to experience distal stressors; some, or all of these distal stressors lead to proximal stressors that affect TGD people internally, and the accumulation of these stressors contribute to heightened levels of stress among TGD people. In this instance, stress is displayed through the over-activation of fight-or-flight responses. The

physiological changes associated with the dysregulation of flight-or-flight responses resonate with the symptoms of mental health problems (Brunner & Marmot, 2006).

Intersectionality can be used in relation to the Minority Stress Theory to investigate the experiences of TGD people with multiple and intersecting identities, who have distinctive individual and collective experiences (Parent, DeBlaere, and Moradi, 2013). In Aotearoa/New Zealand, this includes understanding the experiences and needs of TGD people of a range of ethnic groups, including Māori and Pacific TGD people. Intersectionality is used to explore how multiple and overlapping structural marginalisations (e.g., racism and cisgenderism) shape the experiences of TGD people with multiple and intersecting marginalised identities (Crenshaw, 1991; Parent et al., 2013). Overlooking intersectionality in mental health research would lead to a lack of a full understanding of the experiences of those most negatively affected by more than one form of marginalisation (Blane, 2006).

TGD Mental Health and Ethnicity

Because no research has yet examined differences in TGD people's mental health in Aotearoa/New Zealand on the basis of ethnicity, here we review international research on this topic. The 2010 U.S. National Transgender Discrimination Survey was a community-based survey that recruited 6,450 TGD people (Grant et al., 2011). A higher prevalence of suicide attempts was reported among non-white TGD people (categorised as aboriginal American Indian, Asian, Latino and Black) when compared to white TGD people (54.0% vs 38.0%). Significance test was not carried out for this comparison, however. The 2009 U.S. National College Health Assessment-II was a population-based survey that recruited 111,415 students, of whom 174 identified as TGD (Lytle, Blosnich, & Kamen, 2016). In a comparison between non-white and white TGD people, the former group was significantly more likely to engage in NSSI (38.0% vs 27.8%), develop suicidal ideation (35.2% vs 31.1%), and attempt suicides (29.6% vs 10.0%). A Canadian community-based study, TransPULSE Ontario, recruited 398 TGD people, of whom 32 identified as indigenous (Scheim et al., 2013), and this study found indigenous TGD participants reported high rates of lifetime suicidal thoughts (76.0%) and lifetime suicide attempts (48.0%).

An additive approach is commonly used in relation to the Minority Stress Theory to explain mental health outcomes of those with multiple marginalised identities (Meyer, 2010). This approach treats marginalised identities as independent of each other, and sees social inequality increasing linearly with each additional marginalised identity (Parent et al., 2013). Intersectionality, however, extends on the additive approach, recognising not only the independent effects of minority identity statuses (e.g., being indigenous and TGD) but also the combinative and interactive effects of minority statuses in shaping the experience of a person (Parent et al., 2013). Intersectionality is used to provide explanations for the impacts of multiple and overlapping structural marginalisation (e.g., racism and cisgenderism) in constructing the experiences of those with multiple

marginalised identities (Crenshaw, 1991; Parent et al., 2013).

Two studies have explored intersectionality quantitatively among TGD people. Jefferson, Neilands, and Sevelius (2013) adapted scales measuring experiences of racism and cisgenderism to explore the combined effects of these experiences on trans women of colour and found that combined discrimination related to the likelihood of depression. Scheim et al. (2013) reported only one-fifth of indigenous TGD people in TransPULSE Ontario had parents who embraced their TGD identity. Many indigenous TGD participants, however, were found to develop a strong sense of their indigenous identity, with 56.0% reporting high levels of spirituality and 19.0% having sought cultural or tribal leaders for mental health support (Scheim et al., 2013). A positive integration of indigenous identity and culture has been linked to buffering effects on the impacts of minority stressors, as well as those related to ramifications of colonialism (Chae & Walters, 2009).

Other Trans and Gender Diverse Research in Aotearoa/New Zealand

Three further studies in Aotearoa/New Zealand have examined the experiences of distal stressors among TGD people. The Human Rights Commission's Transgender Inquiry was conducted in 2006 and 2007 to investigate the discrimination experienced by TGD people in Aotearoa/New Zealand (Human Rights Commission, 2008). Based on the accounts of over 200 TGD people, the inquiry reported multiple forms of discrimination that affected TGD people, ranging from individual (e.g., low self-acceptance of their own TGD identity), interpersonal (e.g., facing rejection from peers at school), to structural levels (e.g., difficulty in changing name and gender details on legal documents). The inquiry also identified notable gaps and inconsistencies for TGD people in the provision of health services and accessing gender-affirming services.

In 2015, the Hohou Te Orongo Kahukura: Outing Violence community-based survey was launched to explore the prevalence of intimate partner and sexual violence among rainbow communities (Dickson, 2017). Out of 149 TGD participants, 53% reported being subjected to physical violence by partners, 40% received threats of sexual assault, and 17% experienced gender-affirming resources (e.g., hormones and clothes) being thrown away. Despite facing physical violence threats, TGD participants reported reluctance to seek assistance as 35.0% did not believe that they would be treated fairly and 16.0% were worried about prejudiced nature of specialist violence services. When asked to elaborate on the barriers of seeking assistance in comment boxes, non-binary people raised the issue of cisgenderism, suggesting that most professional organisations were operating within a binary gender framework.

The Auckland District Health Board initiated a project in 2011 to examine the experiences of rainbow communities in accessing mental health and addiction services in the Auckland DHB region (Birkenhead & Rands, 2012). In qualitative interviews with four TGD people, participants reported TGD-specific barriers in accessing appropriate mental healthcare, including stigma

about TGD identities, lack of professional understanding about TGD issues, and an insufficient number of clinicians who were experienced in working with TGD people.

Future Directions for TGD Research in Aotearoa/New Zealand

Our review has identified a need to account for plural and intersecting identities in future research with TGD people in Aotearoa/New Zealand. Standard western definitions of mental health and understandings of mental health problems are inadequate to the Aotearoa/New Zealand context. During Te Ara Ahu Whakamua, a hui (conference) held in Rotorua in March 1994, more than one thousand Māori health, community, and tribal leaders gathered alongside tauiwi (non-Māori) health leaders, to assess the state of Māori health and propose a strategic direction for Māori health (Rochford, 2004; Te Puni Kōkiri, 1994). The hui was marked as an important indicator of implementing the principles of Treaty of Waitangi into practice in Māori health, and Māori people were consulted to advise on health needs and the direction of health services. They came to an agreement that Māori health should constitute:

a strong sense of identity; self-esteem, confidence and pride, control of his/her own destiny, leadership, intellectual, physical, spiritual, and whānau (extended family) awareness, personal responsibility, respect for others, knowledge of te reo (the Māori language) and tikanga (custom), economic security, and solid whānau support (Rochford, 2004, p. 46)

This definition of Māori health reflects the need to recognise health in a holistic manner and as a state of balance including the self, others, and the environment. Māori models of health should be viewed as complementary to the western biomedical paradigm, as the latter has often neglected the ways in which health is interconnected and interdependent with other components of well-being (e.g., spirituality, whānau support, and cultural connections) (Durie, 2011; Rochford, 2004). Kaupapa Māori health frameworks, in which people are embedded in their social worlds and natural environments, are more consistent with the Minority Stress Theory, which focuses on social stressors, than the pathologisation understanding that only focuses on the individual as a discrete entity.

Durie (1985) developed a Māori model of health, Te Whare Tapa Whā, which conceptualises four dimensions of Māori health that interconnect with each other and are interdependent. These four dimensions comprise taha wairua (spiritual health), taha hinengaro (mental and emotional health), taha tinana (physical health) and taha whānau (family and social health). Future TGD mental health research is needed to investigate the interconnection of dimensions of wairua, tinana and whānau in relation to the hinengaro (mental health) of TGD people. The roles of spiritual and family health acting as protective factors for mental health among indigenous TGD people were documented in the TransPulse Ontario study (Scheim et al., 2013).

The recent published guidelines for gender-affirming healthcare in Aotearoa/New Zealand recognise the negative repercussions of the heavy reliance on pathologising diagnoses among health professionals in granting TGD people access to healthcare services (Oliphant et al., 2018). The guidelines use Māori health frameworks, Te Pae Māhutonga and Te Whare Tapa Whā, to inform the provision of culturally competent, as well as TGD-competent healthcare services. For example, health professionals are encouraged to facilitate autonomy to TGD people in making decisions about their own care, as well as to connect mental health with other components of health as part of the holistic healthcare delivery. The guidelines also highlight the need to avoid pathologising TGD people as being mentally disordered, as this approach negates the minority stress results from everyday distal stressors that TGD people experience.

To ensure that indigenous conceptualisations of health are accounted for comprehensively in psychological research, researchers need to consider how they are collecting data. Bethune et al. (2018) discussed the importance of using self-reported health to examine the health outcomes of indigenous populations, as this allows participants to incorporate multiple dimensions of health when considering satisfaction with their lives. In Aotearoa/New Zealand, self-reported health is necessary for researchers who may wish to incorporate the four Te Whare Tapa Whā dimensions into their conceptualisation of health. It is also important to consider which topics are focused on. Contemporary TGD mental health research often takes a deficit approach, which emphasises the relative vulnerability of TGD people in manifesting mental health problems. Brough, Bond, and Hunt (2004) suggested a focus on deficits may obscure investigation into the strength of populations and their resilience in sustaining mental health and wellbeing. Durie (2011) encouraged an examination of indigenous resilience that centres on the potential of indigenous people to overcome the effects of racism and colonialism through the formation of collective bonds with whānau and communities, and engagement with te ao Māori (Māori worldview), for example through fluency in te reo and connection to whenua (land).

Quantitative research that employs categorisation to classify gender and ethnicity run the risks of overlooking the breadth of diversity within the TGD populations and rendering indigenous concepts of gender invisible (Adams et al., 2017). For instance, the term transgender has been criticised for its inadequacy in representing the deeper underlying meanings of the Māori and Pacific gender diverse identities (Brown-Acton, 2014; Kerekere, 2017). Durie (2011) pointed out that adoption of an indigenous identity assists people in conveying a sense of connectedness to their indigenous identity and wider indigenous communities. Kerry (2018) conducted unstructured interviews with indigenous TGD people in Australia and reported that those who affiliated with indigenous identities have an improved sense of self, spirituality, mental health and wellbeing. Cisgenderism was found to generate stigma towards TGD people, which detached TGD people from their indigenous communities, consequently hindering them from adopting indigenous identities (Kerry, 2018). The strength of quantitative approaches in generating data from a larger population can be complemented with qualitative approaches which better encapsulate the nuanced

differences of experiences among TGD people across a range of diverse backgrounds. These can include TGD people with disabilities, non-binary people who situate their gender within a gender spectrum, and Māori and Pacific TGD people who have gender diverse identities that are relevant to their cultural backgrounds.

We recommend community-based participatory research (CBPR) approaches for TGD health research. CBPR emphasises conducting research with a community rather than on a community (dickey, Hendricks, & Bockting, 2016). TGD people in Aotearoa/New Zealand who have knowledge and interest in advancing the health of TGD populations should be invited to participate as research team members to provide input on research design. In doing so, it would be optimal to include TGD people with a diverse range of intersecting identities. Other than allowing the research to benefit from extensive TGD in-group knowledge, partnership with TGD people also enhances the efficacy of the research through the provision of opportunities for marginalised voices to have space in research (Adams et al., 2017).

Conclusion

International literature has documented the relationships of social determinants of health and mental health of TGD people. This article extends the existent literature in some important ways. We found that existent research on TGD people's mental health in Aotearoa/New Zealand has focused on TGD youth, and that the limited research that currently exists shows that TGD people have a high prevalence of experiences of distal stressors and mental health problems. We suggest psychologists and researchers working in TGD health in Aotearoa/New Zealand to ensure they are accounting for Māori and Pacific notions of gender diversity and indigenous understandings of mental health as interconnected with other dimensions of health. Psychological and research instruments should avoid utilising problematic juxtapositions that pathologise TGD people (e.g., attributing TGD identities with mental health problems).

While the Gender Minority Stress Framework has been commonly used to elucidate the effects of cisgenderism on TGD mental health, we proposed a need to complement this framework with the use of intersectionality. Intersectionality plays a crucial role among psychology practitioners and researchers in Aotearoa/New Zealand to meet the diverse needs of TGD people across ethnicities, genders, abilities, and other areas of need. In particular, a TGD-competent psychologist workforce requires a comprehensive understanding the nuanced differences among people with intersecting identities to fully understand and formulate their mental health problems and presenting problems. This will allow psychologists to take into account the impacts of colonialism and racism for indigenous Māori, Pacific and other TGD tauiwi of colour in Aotearoa/New Zealand.

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"So that's where I've probably formed those perceptions from":

A focus group study of lesbian, gay, bisexual, pansexual, transgender and queer individuals' perspectives on chronic illnesses

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This study investigated how lesbian, gay, bisexual, pansexual, transgender and/or queer people (LGBPTQ) perceive HIV/AIDS and rheumatoid arthritis as examples of chronic illnesses. HIV/AIDS continues to be the focus of most LGBPTQ-specific health psychology research. Little research has compared LGBPTQ people's perspectives of HIV/AIDS with other chronic illnesses. Thirteen focus groups were conducted with 50 LGBPTQ individuals in Aotearoa/New Zealand. Inductive thematic analysis led to development of three themes: stereotyping of chronic illnesses by LGBPTQ individuals; ways of differentiating HIV/AIDS from other chronic illnesses; and inadequacies of sexual health education for LGBPTQ people. These findings contribute diverse perspectives to the health psychology literature on chronic illnesses and have implications for sexual health education in Aotearoa/New Zealand that currently lacks inclusivity for LGBPTQ individuals.

Introduction

Research has indicated that lesbian, gay, bisexual, pansexual, transgender and/or queer (LGBPTQ) individuals have a higher prevalence several different chronic illnesses compared to their cisgender heterosexual counterparts (i.e., people who are not transgender and identify as straight), but little is known about the psychology of how those illness are perceived by LGBPTQ people. HIV/AIDS is the most salient example of a chronic illness which is associated with the LGBPTQ community and is stigmatised for both LGBPTQ and cisgender heterosexual individuals alike (Aspin, Penehira, Green & Smith, 2014; Boehmer, 2002; Henrickson & Fisher, 2016; Mundt & Briggs, 2016; Persson & Newman, 2008; Seacat, Hirschman & Mickelson, 2007; Treharne & Adams, 2017). This stigma is centred on the perception of HIV/AIDS as a preventable illness associated with unsafe sexual behaviour (Boehmer, 2002; Persson & Newman, 2008; Seacat et al., 2007). On the other hand, rheumatoid arthritis (RA) is an autoimmune disease which does not have the same association with the LGBPTQ community (McGavock & Treharne, 2011). While the risk of RA may also be minimised by certain behaviours, past research from Aotearoa/New Zealand suggest that whilst RA is stigmatised in terms of its perceived association to old age and disability, it is not stigmatised to the same extent as HIV/AIDS, which is perceived to be associated with being gay, using intravenous drugs or being promiscuous (McGavock & Treharne, 2011). Investigating LGBPTQ people's perceptions of these two chronic illnesses as pertinent examples is an important expansion to the

existing psychological literature on HIV/AIDS among cisgender heterosexual individuals in Aotearoa/New Zealand (Henrickson & Fisher, 2016; McGavock & Treharne, 2011).

People who identify as LGBPTQ have been marginalised in the majority of health research. For example, Boehmer (2002) analysed 20 years of public health research, revealing that just 0.1% of all articles listed in the Medline database focussed on LGBPTQ people. The available research tends to focus on sexually transmitted infections, with 52% of the articles on LGBPTQ people's health being specific to HIV/AIDS (Boehmer, 2002). Of this research, 80% of these articles only included gay men, indicating a lack of inclusivity of people with other diverse sexualities and gender identities. Furthermore, the US Institute of Medicine (2011) reported that the existing literature has tended to either categorise all LGBPTQ people as 'non-heterosexual', or disproportionately focus on certain subsets of LGBPTQ people (e.g., gay cisgender men) or subsets of healthcare (e.g., HIV/AIDS, cancer).

The existing health research with members of LGBPTQ communities is primarily centred on HIV/AIDS as a sexual health issue and a moral issue, particularly as stigmatising beliefs about sexuality impact on the perceptions of HIV/AIDS (Seacat et al., 2007). There are some notable exceptions to this predominant focus on HIV/AIDS, including research on a range of chronic illnesses other than HIV/AIDS among LGB individuals by Jowett and Peel (2009) and among gay men by Lipton (2004) as well as research on gay men's perspectives on

attaining health by Adams, McCreanor and Braun (2013). The selective focus of past research is generally at the expense of investigating LGBPTQ individual's perspectives on other specific chronic illnesses, such as the autoimmune health condition rheumatoid arthritis (RA). RA does not have the same recognisability as HIV/AIDS among the general population (McGavock & Treharne, 2011), despite affecting an estimated 1% of the population worldwide (Gibofsky, 2014). Research by McGavock and Treharne (2011) with illness-free heterosexual individuals has found that HIV/AIDS is perceived as more 'serious' than RA. Furthermore, participants perceived there to be more behavioural responsibility if a person was diagnosed with HIV, relative to being diagnosed with RA even when participants were provided with evidence about smoking and high coffee consumption as behavioural risk factors for onset of RA.

HIV/AIDS affects an estimated 3,500 of the population living in Aotearoa/New Zealand and affects more men who have sex with men, although subpopulation prevalence estimates are hard to determine (New Zealand AIDS Foundation, 2017). Aspin et al. (2014) reported that the number of infections of HIV in the Māori population is relatively small. However, research has indicated that Māori women have a higher rate of HIV infections than non-Māori women (Shea et al., 2011). Furthermore, Pākehā men have been found to have better health outcomes if diagnosed with HIV due to a shorter average delay between infection and testing (Dickson, McAllister, Sharples & Paul, 2011). In contrast to the low prevalence of HIV/AIDS in Aotearoa/New Zealand, RA affects an estimated 89,000 people in Aotearoa/New Zealand. RA is more common in women than men, and to a greater extent among Māori women than non-Māori women (Ministry of Health, 2016).

There is some evidence of a higher prevalence of several chronic illnesses among members of LGBPTQ communities compared to cisgender heterosexual individuals, namely HIV/AIDS, cardiovascular disease and chronic fatigue (Cochran & Mays, 2007; Fredriksen-Goldsen, Kim, Barkan, Muraco & Hoy-Ellis, 2013) but no published evidence of differences in the prevalence of RA. Research has also demonstrated that people with diverse sexual identities generally rate their own overall health as worse on average compared to cisgender heterosexual individuals (Lick, Durso & Johnson, 2013; Fredriksen-Goldsen, Kim & Barkan, 2012). These health inequalities are sometimes inappropriately interpreted as indications of inherent pathology or 'risky' behaviours (Fredriksen-Goldsen et al., 2013), which may contribute to stigmatising beliefs about certain illnesses. More recent explanations focus on the stress for LGBPTQ individuals that is inherent in living in heteronormative and cisnormative societies (Riggs & Treharne, 2017).

HIV/AIDS is the most salient example of a chronic illness with health inequalities for LGBPTQ communities. However, perceptions of risk for HIV among subsets of the LGBPTQ populations are not reflective of this. Despite the higher prevalence of HIV/AIDS among gay and bisexual men and other men who have sex with men in Aotearoa/New Zealand (New Zealand AIDS Foundation, 2017) and other locations,

research has demonstrated that up to 89% of gay men rate their risk of contracting HIV as less than other gay men (Gold & Aucote, 2003). This effect was sustained even among gay men who had engaged in unprotected sex in the past six months. This suggests an 'unrealistic optimism' effect, wherein people have the tendency to predict that their own futures will be better than others who are in a similar position (Gold & Aucote, 2003). The original research on unrealistic optimism has indicated that the less experience an individual has of a 'hazard' (such as contracting an illness), the less likely they are to believe it will occur in their future (Weinstein, 1987). Furthermore, unrealistic optimism tends to increase as people perceive the preventative measures of a hazard to have improved (Weinstein, 1987).

The geography of HIV/AIDS raises important questions about the unrealistic optimism effect in locations with lower prevalence of HIV/AIDS like Aotearoa/New Zealand. The introduction of antiretroviral treatment for HIV/AIDS is directly attributable to the lower mortality and morbidity rates in both industrialised and developing countries (Palella et al., 1998). The success of these medications in industrialised countries has led to HIV becoming conceptualised, with some trepidation, as a manageable chronic illness (Russell et al., 2007). However, the prevalence rates of HIV/AIDS are higher in developing countries (with a gross national income categorised as 'low-income' or 'lower middle income'; United Nations, 2014). The World Health Organization (2015) estimates indicate that almost 70% of all people with HIV/AIDS live in the sub-Saharan region of Africa. This is the only area where mortality rates due to communicable disease (particularly HIV/AIDS and malaria) are estimated to be greater than mortality rates due to non-communicable chronic illness (de-Graft Aikens et al., 2010).

The emphasis on the prevalence of HIV/AIDS among gay men may have diminished the focus on other chronic illnesses within LGBPTQ communities (Lipton, 2004). In research by Axtell (1999), lesbian and bisexual women described navigating different identities as their gender, sexual orientation and/or social class conflicted with their identity as it related to their health/ability. A further qualitative study by Jowett and Peel (2009) sought to identify the relevance of sexual identities to people's experiences of chronic illnesses other than HIV/AIDS. Some participants felt more accepted by the LGBPTQ community, whilst others reported greater feelings of isolation, or that they did not fit the stereotype of their sexual identities. Comparing HIV/AIDS with RA may provide insight into how members of the LGBPTQ community frame chronic illnesses in relation to their sexual identity.

As well as expanding the focus of LGBPTQ health research beyond HIV/AIDS, it is also important to acknowledge and explore stigmatisation of HIV/AIDS in relation to sexuality and geography. Recent research has addressed how specific factors might interact to perpetuate stereotypes of HIV/AIDS, with the findings suggesting New Zealanders hold stereotypical beliefs of HIV/AIDS relating to ethnicity and geography (Henrickson & Fisher, 2016). However, past literature has not identified whether LGBPTQ New Zealanders hold

similar stereotypical perceptions of HIV/AIDS. Henrickson and Fisher (2016) examined the encounters black African migrants living in Aotearoa/New Zealand have had with the healthcare system. Participants reported negative experiences with health professionals who do not specialise in HIV/AIDS. These health professionals often made stigmatising assumptions that black African people's ethnicity was a proxy for risk of HIV/AIDS rather than enquiring about sexual history. Many participants reported a variety of poor practices by healthcare professionals, including: unnecessary precautions being taken with HIV-positive patients; breeches in doctor-patient confidentiality; lack of explanations and empathy; and incorrect information being provided. Henrickson and Fisher (2016) concluded that the stigmatisation of HIV/AIDS in Aotearoa/New Zealand has allowed for little progress within healthcare.

Past literature has not addressed how LGBPTQ New Zealanders compare HIV/AIDS to another chronic illness. While there are fundamental differences between HIV/AIDS and RA, they share commonalities in that both are stigmatised, and the media portrayal has shaped the beliefs held among both non-LGBPTQ individuals (Henrickson & Fisher, 2016; McGavock & Treharne, 2011) and LGBPTQ individuals (Gold & Aucote, 2003; Graham, Treharne, Ruzibiza & Nicolson, 2017; Seacat et al., 2013). The present study explored the following research questions using HIV/AIDS and RA as specific examples of chronic illnesses:

1. How do LGBPTQ individuals perceive chronic illnesses such as HIV/AIDS and RA?
2. To what extent do the perceptions of HIV/AIDS and RA reflect stereotypes about population groups based on identities and geography?

METHODS

Participants

In total, 50 participants took part in the study across 13 focus groups; 29 participants identified as cisgender women, 18 as cisgender men, two as gender-fluid, and one as transgender and female. Of these participants, 11 identified as lesbian, 16 as gay, 16 as bisexual, five as pansexual and two identified their sexual orientation as queer. Of the 13 focus groups, the initial eight were single gender groups (i.e., all female participants or all male participants), predominantly to allow LGBPQ women to have space to discuss issues specific to them without the discussions being dominated by men. The latter five groups were mixed gender (i.e., including some female, male, gender-fluid and/or transgender participants). The participants' age ranged from 18-71 years, with a median of 22. Most participants were younger than 30 but two 71-year-old women participated in one focus group with rich information about social change that was very relevant to this analysis. The majority of participants (88%) identified as New Zealand European/Pākehā, two of whom also identified as Māori. One other participant identified as Māori only, one as African, one as Asian, one as Chinese and one as European.

Procedure

The recruitment process included posters advertising the study, which were placed around the local university campus, and shared to relevant organisations, email lists and groups on social media. Snowball sampling was also utilised by having participants recommending the study to others who may have been interested. Participants who expressed an interest in the study were emailed information sheet outlining the aims of the study. They were also emailed a list of topics which had been compiled by the researchers in the initial phase of planning the study. The focus groups were conducted in a relatively quiet and private research office on the university campus. Upon arrival, participants were asked to complete a consent form and a demographic questionnaire. As compensation for any expenses related to participating in the study, each participant was given a $15 supermarket voucher prior to the focus group beginning. The focus groups were facilitated by four researchers (three gay cisgender men and one gay cisgender woman). Each focus group had between two and four researchers present as part of an educational process in addition to providing practical support for the lead facilitator of the group in question.

The researcher leading the focus group reiterated the purpose of the study and the guidelines for the focus group during an introduction. Participants were informed that the focus group would last approximately an hour and a half, but that they could leave early if they wished. They were assured that their statements could be withdrawn or clarified after the focus group, although none chose to do so. Additionally, researchers reminded the participants that they were under no obligation to answer any specific questions. Prior to starting the questions, the researchers introduced themselves by outlining their sexualities and gender identities, with participants asked to do the same afterwards. The focus groups were audio-recorded with permission from the participants and subsequently transcribed.

Ethical approval was granted by the Department of Psychology at the University of Otago and endorsed by the University's Human Ethics Committee.

Data Analysis

The audio recordings were transcribed by a professional transcriber and then checked for accuracy by at least three of the researchers. The anonymity of the participants was protected by removing names and specific places. At this point, participants were contacted and told they could check the transcripts if they desired, though none took up this offer.

The data were analysed inductively at a semantic level (Braun & Clarke, 2006). The aim of the analysis was to provide a detailed account of participants' perceptions of HIV/AIDS and RA, and how these perceptions are formed and perpetuated. The six steps to thematic analysis outlined by Braun and Clarke (2006) were used as a framework for the analysis, which was led by the first author under the supervision of the second author as part of a wider project (Graham et al., 2017). The first author had not attended any of the focus groups and the second author led the facilitation of 10 of the 13 focus groups. This provided a level of distance from the data for the first author and this was reflected on throughout the analysis and writing process following the processes for ensuring quality of qualitative research described by Treharne and

Riggs (2015). The second author supported the analysis and writing by attempting to clarify any details that were unclear from the transcripts and commenting on each step of analysis and writing as an insider to the data collection and the community in question. Step one of the analysis involved multiple readings of each transcript whilst simultaneously listening to the corresponding audio recording to become familiar with the data. Pertinent features of each transcript were noted and used as the starting point for coding in step two. The coding process was completed by listening to the audio recording and reading the associated transcript once again. When data related to the study aims arose, they were written down along with a summary of how the discussion had arisen. These notes and associated quotes were subsequently organised under code headings, which were refined by working through the entire dataset systematically. Step three involved the combining of codes with common characteristics into candidate themes, which were discussed among the authors. In step four, the quotes relating to candidate themes were arranged in a way which presented the theme most coherently. The transcripts were re-read, and the organisation of themes readjusted so as to form the most coherent depiction of the whole dataset in relation to the research questions for the present analysis. In step five, core elements of the reviewed themes were identified and used to name themes and subthemes before further discussion among the authors. In step six, the themes and subthemes were critically examined in developing the final description of the results with final discussion among the authors to refine the overall narrative of the findings in relation to the research questions. Within the quotes that demonstrate the resulting themes, ellipses (…) are used to indicate short pauses, nonverbal features such as laughter are noted in round brackets, and clarifications or masked information are noted in square brackets.

ANALYSIS

Three themes were formulated from the analysis: 1) Stereotyping of chronic illness by LGBPTQ individuals, 2) Ways of differentiating HIV/AIDS from other chronic illnesses, and 3) Inadequacies of sexual health education for LGBPTQ people.

Theme 1: Stereotyping of chronic illness by LGBPTQ individuals

The first theme addresses the ways participants drew on social stereotypes of chronic illnesses. This is highlighted through two subthemes describing stereotypes about who is most likely to have HIV/AIDS or RA that also drew on some comparisons to other illnesses.

Subtheme 1.1: Stereotypes of who gets HIV/AIDS

Participants were forthcoming with their own perceptions of HIV/AIDS. Predominantly, individuals tended to automatically associate the disease with people living in Africa. Furthermore, there was never an identification of a specific country within the African region:

"Also everyone knows someone who's had cancer. Multiple people have had cancer usually and I have

never to my knowledge met anyone with HIV/AIDS." (P2, Group 6)
"Yeah, me neither." (P3, Group 6)
"You just don't, I mean honestly when I think of HIV/AIDS, I think of people in Africa." (P2, Group 6)

This generalised view was not exclusive to location; it carried over to perceptions of which groups of people were most at risk of HIV/AIDS. When encouraged to discuss who might be most at risk of contracting the health condition, several participants drew on stereotypes held by wider society:
"First off probably injecting, drug users." (P3, Group 7)
"Yeah." (P1, Group 7)
"Yeah I would agree." (P4, Group 7)
"Drug users, gay men." (P2, Group 7)

"... someone with HIV, it might be assumed that they caught it… by being promiscuous." (P3, Group 2)

On the other hand, several participants brought up various older news stories that had been covered by the media in Aotearoa/New Zealand, wherein prominent cases of people with HIV/AIDS had challenged the beliefs of who could be affected by the health condition. One example mentioned was the case of Eve (Hunt, 2013). Participants recalled that she was a child who had been refused entry to preschool due to being HIV-positive:
"… it had always been widely perceived as a gay disease and sort of this young girl was like blue eyes and blonde hair and sort of completely sort of shifted sort of, the sort of ideas of what HIV really was." (P1, Group 2)

Subtheme 1.2: Understanding of RA is limited

A common thread in much of the discussion regarding RA was participants' acknowledgement of their lack of prior knowledge of the condition and the way its symptoms may progress. Despite this, a recurring stereotype centred on the idea that elderly women were the primary sufferers of RA:
"And when I think of arthritis, I don't think of like young women… I tend to think of older women." (P2, Group 7).

In addition to this age and gendered stereotype, participants were sometimes dismissive of the symptoms of RA or minimised its debilitating nature. This served to demonstrate the way in which understanding of RA was more speculative compared to the participants' knowledge of HIV/AIDS:
"... I'm feeling like a hot bath would take care of a lot of it [the symptoms of RA]." (P2, Group 10).

Theme 2: Ways of differentiating HIV/AIDS from other chronic illnesses

The second theme addresses the way participants perceived chronic illnesses and differentiated the two illnesses that were the focus of the study. This came about through two subthemes describing the sensationalism and dehumanisation of HIV/AIDS compared to RA.

Subtheme 2.1: HIV/AIDS is sensationalised

When talk of the differences between HIV/AIDS and RA ensued, participants often identified that media stories of HIV/AIDS received far greater coverage than stories of RA:

"... my perception of them is that HIV/AIDS is a lot more serious but I guess that's just because of what, like the media, there's a lot more about HIV/AIDS than there is about arthritis I think so that's where I've probably formed those perceptions from." (P2, Group 7).

Across almost all the groups, participants were quick to explain that not only was HIV/AIDS covered more extensively by the media, but also that it is sensationalised. Participants' comments on this topic revealed the contrast between the perceptions of stories of HIV/AIDS and RA:

"... as you said, it's [HIV/AIDS] sensational." (P1, Group 1)
"All the stories in it so or like just going back to what we were talking about, like you know stories in the news, they always seem to be quite depressing, like they always put a very negative spin on it and it is an illness but you know, they just, yeah and I think people like see it, like I feel like the reason celebrities wouldn't want to say 'Actually I'm HIV-positive' because people just see it as a dirty disease sometimes, like I got it through sex, 'Oh you're a slut' so whereas if you had like asthma or a cancer or something, everyone's like 'Oh poor you, that sucks' even though they're probably still having sex." (P2, Group 1)

"It's [RA] not a very interesting disease that would be in the media..." (P3, Group 7)

This contrast was further strengthened by questions which encouraged the participants if they could name a celebrity who had been diagnosed with either illness as a way of determining familiarity of the illnesses. Several participants could name or describe a person who had been diagnosed as HIV-positive. This trend, however, did not continue when asked to name a person diagnosed with RA:

"Ah isn't there like some basketball player or something, what's his, do you know his name?" (P2, Group 5)
"Magic Johnson?" (R2, Group 5)
"Yeah there you go." (P2, Group 5)

"... can you think of anyone famous with rheumatoid arthritis, anyone in the news?" (R1: Group 7)
"No." (P1, Group 7)
"No." (P4, Group 7)

Subtheme 2.2: Having HIV/AIDS dehumanises individuals more than RA

When asked to compare the differences between living with HIV/AIDS and RA, participants tended to bypass the symptomatic aspects of each health condition, and instead acknowledged the underlying societal stigma of HIV/AIDS to be the biggest differentiating factor from RA:

"So umm comparing rheumatoid arthritis to HIV, what do you think the differences would be like living with them, if that makes sense, like." (R1, Group 7)
"There's no stigma with RA." (P3, Group 7)
"Yeah?" (R1, Group 7)
"Mmm." (P1, Group 7)

"There isn't that stigma towards rheumatoid arthritis..." (P1, Group 6).
"Yeah there isn't a stigma." (P3, Group 6)

Participants were generally in agreement over which types of stigma were associated with HIV/AIDS. These ranged from negative connotations of HIV/AIDS stereotypes, the possibility of being contagious if suffering from HIV/AIDS, or even it being part of a wider stigma associated with all sexually transmitted diseases:

"... Although common knowledge about how people get HIV people do think drug users and gay sex pretty much and both of those things a lot of people are anti so you would get that stigma as well." (P1, Group 6).

Some participants postulated that people may hold certain prejudices against individuals with HIV/AIDS, but not individuals with other chronic illnesses, due to a perceived lack of preventative measures taken by the person with HIV/AIDS. Furthermore, participants hypothesised that people with HIV/AIDS were judged to a greater degree than individuals suffering from other illnesses which could also have been prevented:

"... it's a... different level of sort of judging someone on their life choices... I think there is a sort of dehumanisation which is going on with HIV/AIDS." (P1, Group 12).

While participants acknowledged that societal stigma about HIV/AIDS existed, some participants also actively rejected these perceptions. This also held true when potential stigmatisation of RA was debated:

"... in some people it's still a thing like that like it [HIV/AIDS] only comes from like certain sexual things which is a bit stupid really." (P1, Group 8)

"... maybe they [people with RA] get stigmatised by people thinking that they're being more of a wuss like 'Oh he can't be that sore', that would be dumb..." (P4, Group 12).

Theme 3: Inadequacies of sexual health education for LGBPTQ people

The final theme addresses how LGBPTQ-specific information is crucial for sexual health education in schools, explained through discussions of HIV/AIDS perceptions. The inadequacies of current sexual health education programmes for LGBPTQ people were highlighted through two subthemes describing how sexual health education is heteronormative and unrealistic optimism about HIV/AIDS risk that appears to arise from inadequate sexual health education.

Subtheme 3.1: Sexual health education is heteronormative

When discussing participants' perceptions of HIV/AIDS, the conversation often shifted to the sexual health education programmes within Aotearoa/New

Zealand schools that most participants had experienced a few years prior. The general consensus was that sexual health education programmes were inadequate when participants were in school, regardless of an individual's gender and sexual identity. One participant went so far as to say that *"There's no proper sex ed."* (P1, Group 8). Further discussion revealed that the sexual health education was presented with the assumption that students are heterosexual. It was also noted that there was a passive acceptance of this exclusionary assumption:

"... I was never taught at any kind of sexual education ever that two females could have sex... I kind of turned a blind eye at the time to the fact that it wasn't being mentioned but for the longest time" (P2, Group 13)
"Exactly, exactly the same." (P3, Group 13)
"My first encounter within high school [...] I'm talking about sex education, dental dams were mentioned on a sheet and I actually asked the teacher what were they and she was just as puzzled as the rest of us" (P1, Group 13)

In most focus groups, participants pinpointed a lack of adequate sexual education aimed specifically at LGBPTQ people. Moreover, this required participants to seek additional information that was of greater relevance to their sexual identity:

"... sex ed was very heteronormative... I looked up like actual useful sites on how it all works... But like I had to do all the research myself coz they just don't tell you anything." (P4, Group 11).

Subtheme 3.2: Unrealistic optimism about HIV/AIDS risk

The lack of information provided to people with diverse sexual and gender identities in school highlighted discrepancies in knowledge of LGBPTQ-associated aspects of sexual health, especially regarding HIV/AIDS prevalence in Aotearoa/New Zealand. Many participants shared the sentiment that they were less at risk of contracting the health condition *because* they lived in Aotearoa/New Zealand:

"... I don't think me or anyone here is really like that in – risk of getting AIDS or HIV like it's probably a bit of a naïve view but like this is [city name], you know New Zealand (laughter), shit doesn't go down here" (P1, Group 5).

The AIDS Epidemiology Group (2013) reported 170 new cases of HIV/AIDS in Aotearoa/New Zealand in 2012. When participants were asked what they know about how many people contract the HIV each year, answers tended to be underestimations by an order of magnitude. One such example arose later in the same discussion as the above quote:

"I hope it'd be pretty low, maybe I dunno, 20 [in all of Aotearoa/New Zealand] you know, hopefully less than that but it's just a guess" (P2, Group 5).

These extracts demonstrate that participants viewed HIV/AIDS as something they were removed from and unlikely to encounter in Aotearoa/New Zealand. Participants' framing of HIV/AIDS reflected an unrealistic effect about their risk of contracting the illness.

Despite the frequency with which the participants drew upon stereotypes of sexuality related to HIV/AIDS, they tended to exclude themselves from these generalisations.

DISCUSSION

The first aim of the present study was to explore how members of the LGBPTQ community perceive HIV/AIDS and RA, while the second aim was to examine the extent to which the perceptions of HIV/AIDS and RA reflected stereotypes of population groups based on identities and geography. We found that participants held pervasive stereotypical beliefs about both HIV/AIDS and RA and participants identified the enduring stigma associated with HIV/AIDS as its major difference from RA. One of the reasons participants held stereotypical beliefs about both HIV/AIDS and RA was due to lack of knowledge about either condition. With regards to HIV/AIDS, this highlighted the need for adequate sexual health education that is inclusive of LGBPTQ people.

Past research has found that heterosexual New Zealanders explained their perceptions of HIV/AIDS and RA through a number of commonly-held assumptions (McGavock & Treharne, 2011). In particular, HIV/AIDS was found to be deemed far more related to risky behaviours, while RA was perceived to be less 'serious' (McGavock & Treharne, 2011). These assumptions are mirrored in the present study, particularly with regards to the theme 1; it was apparent that LGBPTQ individuals held perceptions of HIV/AIDS and RA which were embedded within stereotypes of each illness. Participants in the present study tended to frame HIV/AIDS synonymous with Africa, and when considering communities within Aotearoa/New Zealand, participants labelled certain groups of people as being more susceptible to HIV/AIDS, specifically: gay men, drug users, and sexually promiscuous people. With regards to RA, participants did not relate it to one region or regional group over another. Instead, LGBPTQ individuals perceived RA almost exclusively as a condition which affected elderly women. Similarly, participants in both studies described that whilst the media perpetuated much of the stereotypes participants held, it could also challenge these beliefs if expectations were contradicted. Future research could explore what happens when these perceptions are deliberately challenged, and assess whether beliefs about chronic illnesses can change after exposure to sources that diverge from the dominant sensationalised discourses that appear to persist in popular media (for an example related to HIV/AIDS, see Persson & Newman, 2008).

Additionally, theme 2 highlighted that LGBPTQ people drew upon negative stereotypes of HIV/AIDS when explaining their perceptions of the health condition. It also indicated that the participants were, to some extent, aware of the effects that such assumptions had; namely, that individuals with HIV/AIDS are dehumanised far more than individuals with RA. When participants contrasted their perceptions of HIV/AIDS against their understanding of RA, the lack of knowledge about the health condition in conjunction with the stereotype of elderly women was reflected by participants minimising both its debilitating nature, and their own risk of being diagnosed. Furthermore, participants recognised that the media portrayal of HIV/AIDS is sensationalised, especially when compared to RA. This is likely to have influenced the development of the stereotypes outlined by LGBPTQ individuals.

The second aim of the study was addressed by the discussion pertaining to theme 3. Experiencing sexual health education with the underlying assumption of

heterosexuality led to a lack of understanding of illnesses associated with the LGBPTQ community. Participants' underestimated both the number of people in their city with HIV/AIDS, and the overall prevalence rate in Aotearoa/New Zealand. Compounding this, participants drew upon stereotypes of HIV/AIDS by frequent mentions about Africa specifically and yet vaguely. This distinction of location also served to minimise their individual risk of contracting the illness, thereby perpetuating the unrealistic optimism demonstrated by participants in relation to HIV/AIDS.

Participants in the present study noted that they did not have detailed knowledge of HIV/AIDS, and most participants were unfamiliar with RA. The stereotypical perceptions about HIV/AIDS reproduced by participants in our study were similar to those held by some health professionals in previous research. For example, Henriskson and Fisher (2016) found that health care professionals with little experience or specialised training of HIV/AIDS engaged in stigmatising and judgmental behaviour with black African migrants living in Aotearoa/New Zealand while health professionals with more experience and knowledge of HIV/AIDS did not. In our study, participants were united in their belief that the illness affects people from Africa. This was further reinforced by discussions theme 3, wherein a lack of specialised knowledge created perceptions firmly embedded in this stereotype of the health condition. This has implications that increasing people's knowledge about HIV/AIDS may assist in reducing stigmatising beliefs and stereotypes in Aotearoa/New Zealand. Similarly, the majority of participants had limited understanding of RA and its debilitating nature. When describing their perceptions of the health condition participants tended to be dismissive of the symptoms and stigmatise individuals diagnosed with RA. On the other hand, the few participants who had first-hand knowledge of RA were able to describe the condition in detail without relying on broad stereotypes of the illness.

There are four core limitations to the present study. Firstly, using focus groups as the method of data collection has both advantages and disadvantages. Hearing social discussions about perceptions of chronic illness brings an extra depth to the data that individual interviews would not provide; however, group discussions can bring tensions or could have masked differences of opinion. The groups involved a mixture of friendship groups and people who did not know each other, which could have made it hard for some individuals to contribute but also provides a useful reflection of the range of 'natural' conversations about a topic. Secondly, this article describes a secondary analysis of one aspect of a wider focus group project and the first author did not contribute to the running of focus group. There were points in the focus groups where follow-up questions pertaining to the aims of the current study would have been useful; however, the focus group data were suitably rich and relevant to address the specific aims of this article. The analysis was led by the first author who had not attended the focus groups with support from the second author who had lead the facilitating of 10 of the 13 focus groups. Both authors collaboratively reflected on what they brought to the research as insiders or outsiders to the data collection process and the communities in question in the research, which that enriched the analysis. These reflective processes involved discussions in meetings and regular journaling, as described by Treharne and Riggs (2015) in their summary of ways to ensure quality in qualitative research. Thirdly, the sample was predominantly comprised

of younger LGBPTQ individuals who were open about their sexuality and active within the LGBPTQ community. Therefore, findings may not transfer to the wider LGBPTQ community of Aotearoa/New Zealand or other countries. However, the sample did include several people who were not 'out' about their sexuality in all areas of their lives. Lastly, only three participants in the present study identified as Māori. Given the disparity in health outcomes between Māori and non-Māori for both HIV/AIDS and RA (Dickson et al., 2011; Ministry of Health, 2016; Shea et al., 2011), future kaupapa Māori research could explore implications of the present research with focus groups of people who are of Māori descent. This would provide a more comprehensive understanding of the different factors that feed into perceptions of both HIV/AIDS and RA in Aotearoa/New Zealand.

An important implication of the present study is that the sexual health education programme presented within Aotearoa/New Zealand secondary schools seems to exclude the needs of LGBPTQ people. Our findings support the argument that sexual health education programme should be expanded to be inclusive of people with diverse sexual and gender identities. However, it must be recognised that school curricula, particularly in relation to LGBPTQ education, are reflections of wider social norms (Elia & Eliason, 2010). Assigning blame at the level of schools fails to address the concomitant and prevailing societal hegemonic views of LGBPTQ inclusivity (see e.g. Amnesty International, 2018; Riggs & Treharne, 2017). Therefore, adaptations to sexual health education programmes must also include the resources, training, and follow-up required to explore whether such programmes meet their intended aims.

The findings about unrealistic optimism in the present study expand upon those demonstrated by Gold and Aucote (2003) as the sample in the present study incorporated diverse sexual and gender identities, rather than focussing exclusively on gay cisgender men. It should be acknowledged that different subgroups of the LGBPTQ community may have disparate concerns pertaining to HIV/AIDS; in particular, the experiences of levels of stigma and risk for gay men is likely to be very different to women who identify as lesbian (Gold & Aucote, 2003). Similarly, the risk of women being diagnosed with RA is much higher than men (Ministry of Health, 2016). Future research should further explore the intersectionality of risk perception within LGBPTQ communities. For example, when considering HIV/AIDS or other sexually transmitted infections, examining the interplay between sexuality, sexual practices, perceived risk and statistical prevalence could help develop a greater understanding of the various factors that may influence the unrealistic optimism effect. Another avenue of future research is examining the perceptions of chronic illnesses in other countries, to provide a comparative sample for the findings of the present study. For example, in South Africa the causal link between HIV and AIDS was denied until the turn of the century (AVERT, 2016). Subsequent government funding and resources has seen the antiretroviral treatment programme in South Africa become the largest in the world (AVERT, 2016); it would be fascinating to examine how people in South Africa perceive HIV/AIDS in the wake of such a dramatic change.

The present study demonstrates that the LGBPTQ community hold pervasive stereotypes of both HIV/AIDS and RA; these reflect a lack of understanding of both health conditions, and particularly an underestimation of the risk of HIV/AIDS. There is a place for future research which

examines whether these stereotypes can be changed through presenting instances of popular media which may defy expectations Further to this, future research should explore risk perception of health conditions within LGBPTQ communities outside Aotearoa/New Zealand, as well as comparing other health conditions outside of HIV/AIDS and RA. The findings of the present study indicate a need for improved sexual health education in nations like Aotearoa/New Zealand; at present, the discussions in the focus groups indicated that such education is presented through a heteronormative lens, and does not adequately present information which may counteract widely-held stereotypes of conditions such as HIV/AIDS. This aspect of education is particularly relevant for people with diverse sexual and gender identities, and future queer expansion to sexual health education has the potential to assist in decreasing the marginalisation of the LGBPTQ community.

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Spirituality and religion in clinical practice: The experiences of psychologists in the integration of spirituality and religion in therapy in Aotearoa New Zealand

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While there are well-documented links between spiritual or religious beliefs and psychological wellbeing, many clinicians may not to address spiritual and religious issues in therapy, and there is some ambiguity around the practicalities of integrating spirituality and religion in psychological practice. The present study aimed to gain a better understanding of this issue and explored the experiences of clinical psychologists in integrating clients' spirituality and religion into their practice. A thematic analysis of six interviews with clinical psychologists in Aotearoa New Zealand identified themes around techniques, meanings, barriers and the importance of the integration of spirituality and religion in clinical practice. It is hoped that the findings will prompt more in-depth discussion and research regarding spirituality and religion in clinical practice.

Keywords: Spirituality, Religion, Psychological Practice, New Zealand.

Scope of Research

Religion is generally defined as an organised system of beliefs, practices, rituals and symbols intended to promote connection to the sacred or transcendent and is usually enacted as part of a community (Koenig, McCullough & Larson, 2001). Spirituality is less clearly defined but also relates to people's sense of a connection with a universal force or divine presence and as giving purpose and meaning to people's lives (Everts & Agee, 1995). While there is some overlap between religion and spirituality, and religion may be a structure for spirituality, spirituality may be considered a broader term and exist independently of religion (Rose, 2001; Cashwell & Young, 2011; Vieten, Scammell, Pilato, Ammondson, Pargament & Lukoff, 2013).

The potentially positive effects of both religion and spirituality on people's wellbeing, mental health and quality of life have been acknowledged across different age and cultural groups, including in Aotearoa New Zealand (Chai, 2009; Chai, Krägeloh, Shepherd & Billington, 2012; Gardner, Krägeloh & Henning, 2014; Hsu, Krägeloh, Shepherd & Billington, 2009; Koenig, 2009; Koenig, McCullough & Larson, 2001). For example, religious and spiritual beliefs have been linked with having a sense of meaning and hopefulness (Bein, 2014), may serve as psychological resources for coping with stress (Koenig, 2009; Heydari-Fard, Bagheri-Nesami, Shirvani & Mohammadpour, 2014), and have been associated with greater optimism and lower levels of depression in both younger and older adults and different cultural groups (Levin, 2013; Krause, 2015). In Aotearoa New Zealand, O'Brien et al. (2013) reported that high school students with high levels of spiritual beliefs were 1.5 times less likely to report high levels of depressive symptoms than students with low levels of spirituality, and Hsu et al. (2009) similarly found a significant correlation between spirituality and quality of life in young adults. Such research highlights the potential significance of religion and spirituality for wellbeing and thus underscores the need to consider their integration into therapy.

Indeed, spirituality and religion are important to many people in Aotearoa New Zealand. Over half of the population identify with at least one religion (Statistics New Zealand, 2016), and while Christianity remains the most common religious affiliation, a greater diversity of faiths is reported, as indicated by the steady rise in the percentage of people affiliating with other religions such as Sikh and Hinduism. Additionally, over half of the indigenous Māori population (the tangata whenua or indigenous people), 83% of Pasifika and 70% of Asian peoples report a religious affiliation (Statistics New Zealand, 2016).

For Māori spirituality is considered one of the four cornerstones of hauora (Māori health). Tāne Ora Alliance (2016) go as far as suggesting that wairua (spirituality) is the most significant requirement for wellbeing for Māori, being intimately connected with issues of empowerment, threatened identity and life purpose (Abbott & Durie, 1987).

It is thus likely that mental health professionals will work with clients in clinical practice for whom spirituality and religion are important components of their identity and culture (Aten & Hernandez, 2004). The ethical codes of many countries including the US, UK and Aotearoa New Zealand specify that psychologists respect, and are responsive to, people's worldviews in therapy (American Psychological Association, 2002; New Zealand Psychologists Board, 2009; New Zealand Psychological Society, 2002; The British Psychological Society, 2009). This implies a need for psychologists to consider how to acknowledge and include people's religious and spiritual beliefs in the therapy setting, especially given research which suggests an association between

spirituality/religion and mental health.

International research however, suggests that while an interest in spirituality and religion has recently emerged in psychological practice (Atan & Hernandez, 2004; Eck, 2002), negative attitudes towards spirituality and religion including their lack of relevance or benefit to mental health have persisted (Azar, 2010; Delaney, Miller & Bisonó, 2013). Furthermore, spirituality and religion are rarely included in clinical practice, and are generally absent in training (Begum, 2012; Delaney et al., 2013; Florence, 2009; Mueller, 2012). Begum (2012), for example, found that trainee clinical psychologists received little education and guidance on the topic both academically and in supervision, and that a large body of psychologists do not address nor explore spiritual and religious issues in their practice.

In this study the experiences of six psychologists who themselves identified as spiritual and/or religious were interviewed regarding their integration of spirituality and religion in clinical practice in Aotearoa New Zealand. The study aimed to explore how these psychologists regarded the role of spiritual and religious beliefs and how they worked to include them in therapeutic work. It is hoped that this study will promote further discussion around the relevance and integration of religious and spiritual beliefs and practices in therapeutic interventions.

METHODS

Participants

Six clinical psychologists located in the Auckland region were recruited for this study. All participants were female and worked in either the District Health Board and/or private practice. Five identified as Christian, and one as spiritual drawing on her Māori culture. Participants were assigned pseudonyms to ensure confidentiality.

Procedure

Participants were recruited through networks. Psychologists who indicated interest in the study and gave permission to be approached were contacted by the first author through email. The location of interviews was a private meeting room at the Auckland University of Technology or their workplace, whichever was most convenient for the participant. Data were collected via semi-structured interviews of approximately an hour in duration. Semi-structured interviews were selected as they involve open-ended questions that can facilitate new or unanticipated experiences and meaning (Willig, 2013). While the process is systematic, there is freedom to digress and explore topics spontaneously initiated by the participant (Berg, 2009). Interviews explored participants' thoughts about and experiences of integrating religion and spirituality into their clinical practice. Interviews were audio-recorded and transcribed verbatim.

Data Analysis

Data was analysed using Braun and Clarke's (2006) well-established interpretative thematic approach following a six-phase process that identifies, analyses and reports themes across a dataset as follows: 1) familiarisation with data, 2) generating initial codes, 3) identifying themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the report. Strategies such as triangulation, thick description and reflexivity were implemented to ensure the rigour of this research (Braun & Clarke, 2006). This study was approved by the authors' institutional ethics committee (AUTEC 16/110).

ANALYSIS AND COMMENTARY

The main themes identified in psychologists' talk about integrating spirituality and religion into their clinical practice were: meanings and importance of religion and spirituality for practice, integrating religion and spirituality into practice, and barriers to implementation.

With regards to the first theme, participants spoke of the meaning of spirituality and religion for themselves and for their clients. Participants often used the words 'spirituality' and 'beliefs' interchangeably, with Sybil commenting that "*spirituality and religion are all the same thing*" although she did go on to elaborate that, "*they're all about the same relationship with God.*" Alternatively, they associated spirituality with multiple beliefs, with Diana commenting that "*spirituality could include specific religious beliefs*", or they described spirituality as a broader belief system. Sybil described how spirituality is "*so broad and unique from person to person,*" Anne that it is about "*the bigger picture in terms of the spirit world and the spirit realm*" and for Diana spirituality could also include meanings around nature, music and culture.

While Christianity was seen as stemming from European colonisers, spirituality was seen as encompassing traditional Māori beliefs, which were described as fundamental to Māori culture. Juliet, for example, commented that,

"*Spirituality .... meant more than just religion, more than a single god, and (was) much more around gods who were acknowledged and practised… [Spirituality] just comes if they are Māori… I think it's really easy for Māori because it's embedded into our culture.*"

Māori spirituality was held to encompass the concepts of whakapapa (genealogy), ancestors and nature. As Juliet said,

"*There's a way of being held by an essence of your ancestors… The spiritual stuff about the way we thought about it as Māori was much more about balance and harmony with nature and it makes sense in terms of our whakapapa.*"

Sybil emphasised the importance of religion and spirituality, commenting that, "*the Māori and Pacific community… have worked so hard to have recognition of the fact that spirituality and religion are really closely intertwined with culture and that they're very significant in people's lives.*"

Some participants described spirituality as relevant to every individual, irrespective of particular religious beliefs. Diana described it as, "*a crucial part, especially if one comes from a more holistic approach*" and Laurel as, "*at the centre of every human being.*" Laurel went on to discuss the centrality of spirituality in her own life:

"*[Spirituality] means everything. Spirituality, for me being a Christian, is my relationship with God. And*

it's everything. It contains every other aspect of my life rather than being another aspect of my life. So it's the core of who I am and gives meaning to everything I do."

Since participants regarded therapy as a space in which to explore *identity*, and particularly in the case of loss and grief, existential issues, participants felt that was important to address spirituality and religion in therapy. For example, April said,

"There's a lot of questions, too, that come up around death. You know, people are facing their own mortality; not just people who might be unwell, but when you start looking at yourself and doing therapy, often you end up with existential type of questions, and so I really enjoy having those conversations with people… a lot of people are interested in spirituality."

Likewise, Juliet described how *"[Spirituality] often comes up when young people lose a parent. They talk about where they've gone and a belief about wanting to believe they're being held somewhere. A belief that they might be watching them have a good life."*

Participants believed that spirituality and religion could not only have positive psychological outcomes for clients but might even be pivotal to their recovery. Laurel commented that,

"I've worked with clients whose spirituality has been the most crucial factor in their recovery. And I've had clients who have increased their connection with God and that has been the exact thing that has gotten them better."

And Sybil spoke of a client, where, *"It was like once she reconnected with God, a whole lot of other things seemed to fall into place a lot faster in therapy."*

Finally, participants shared their experiences in therapy when their inclusion of spirituality and religion had had a positive impact on the therapeutic relationship. For example, Laurel shared that,

"It can allow the client to feel understood, empathised with, they know that you get it. And that's a huge part of the therapeutic relationship."

On the other hand, two participants discussed how self-disclosure of personal beliefs needed to be carefully managed, seeing this as potentially detrimental to the therapeutic relationship if the therapist and client held different views. Laurel commented how,

"It can be a barrier if your beliefs are different… I had a client who took offence to the fact that I was wearing a cross and didn't want to work with me. Also, you've got to be careful in what you say. Sometimes, our view of the world can leak through little things that we don't think have a meaning. So, that same client was offended because… I questioned if things can happen for a reason and for her that was a value statement and it was completely against her view of the world. She didn't like that, and she chose to not work with me anymore… It was the only time that has ever happened to me. So, in my nine years, I've had one experience like that. But it just shows that it could happen."

The therapeutic relationship may thus be strengthened or weakened depending on the beliefs of therapists and clients and how these are valued and incorporated in therapy.

Participants shared a broad range of experiences around the integration of religion and spirituality into therapy and discussed particular ways in which this could be achieved. This included the integration of spirituality and religion into several modalities such as cognitive-behavioural therapy (CBT), acceptance and commitment therapy (ACT) and dialectical behavioural therapy (DBT).

Moriarty and Hoffman (2007) suggested that there is considerable congruence between religious scripture and CBT. This was highlighted by one participant who noted that the Bible was a very powerful source to 'find truth' and could be a tool to challenge negative thoughts since for Christians the Bible is God's Word and has absolute authority. As regards CBT, several participants described how cognitive restructuring and challenging dysfunctional thoughts with positive, helpful beliefs that are aligned with a client's spirituality or religion may be useful in therapy. For example, Diana shared that:

"Some people who have strong religious kind of beliefs might feel really guilty about certain things. And then, to try to understand why they feel guilty and linking it back to what they actually believe more on a religious level can actually help them just to get that clarity. For instance, why they feel so guilty and then it's about asking them 'Okay in terms of your beliefs what would be helpful in this situation?' When people feel guilty… 'Could someone who has similar beliefs to what you have… What would they recommend you actually do?'"

Acceptance and Commitment Therapy (ACT) was similarly described as a modality that fit well with acknowledging the role of religion and spirituality, since it provides a context for clients to discover what is most important to them by exploring their values, and spirituality may be one of these. Diana commented that,

"[Values] is a concept I find very helpful in therapy, especially when people struggle to make decisions, or their feelings, or relationship issues. Just to talk a bit about 'Okay, what are their underlying beliefs?', 'What are their drivers in life, really?'. It helps people to get a better sense of what is really important and what would be really helpful in this situation."

Regarding DBT, another participant discussed the modality's congruence with spirituality and religion, particularly considering the role of mindfulness and the 'wise mind' (Linehan, 2015):

Laurel: "So, the wise mind, Christians call the voice of God. It's that voice within that when you're still and quiet, tells you what is the thing that is going to be effective for you. So, it ties (in) very well… Mindfulness is about being present, being in the present moment; that's part of spirituality and Christian spirituality, being in touch with creation and appreciating what's around you and being grateful for things."

Participants also suggested several more generic ways in which psychologists could integrate spirituality and

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religion into therapy. This included undertaking comprehensive assessments of clients' spiritual and religious beliefs in order to gain a broader understanding of the individual. As Laurel commented,

"It all starts from a better, more thorough assessment, so having part of the assessment that explores spirituality. 'Does the person have a spirituality?', 'How important is it to them?', 'What part of life does it contain?', 'How would they like it integrated in therapy?'"

This was seen as relevant to therapeutic work:
Diana: *"It's hard to work with something if you don't really acknowledge it or believe in it…"*

And creating a climate in which clients felt free to explore these issues in therapy:
Anne: *"Clients generally are pretty good at reading us as clinicians, and if they perceive that the clinician would be open to that, then they would share it. But if they perceived they wouldn't."*

One participant described incorporating Maori practices into her therapeutic work. This included the concept of whakapapa:
Juliet: *"It's more about spirituality and the essence of that and being able to help clients to see that they were and are descended from these godly beings and they will have those godly qualities, all those nice qualities and they'll also have some of the not-so-nice qualities. And, so, really for me, it's about a balancing up of which of those ancestors are you most listening to and I've used it almost like a self-analysis. If I'm working with young people, 'Which of the gods from your area, Ngāpuhi or wherever do you know about who were either acknowledged for those qualities or who have a particular relevance for you?'"*

The involvement of kaumatua and kuia (Māori elders) for specific spiritual practices was further identified as a way of integrating Māori spirituality into clinical practice.
Juliet: *"We have had kaumatua and kuia who have lifted tapu off clients, sexually-abused clients... They wanted a name-lifting ceremony and we have been able to provide that with kaumatua and kuia who've got those specific spiritual skills to be able to do that part of the process... There would be a lot of ceremonial stuff around karakia and lifting off the tapu from the abused young person."*

Furthermore, Prayer or karakia was identified by most participants as a method of healing that incorporated spirituality and religion into therapy.
Juliet: *"I've had young kids write their own karakia for certain bits where they felt they needed more strength… It creates what we call whakawātea, that space… a clean, cleansing space where you can bring into it what you need to bring into it and the end it will be clean and cleansing again."*

Laurel: *"Being able to relate with them on that level and to tap into that spirituality and to pray together and to bring the power of prayer into the therapy session."*

Finally, participants also identified bringing in religious works, such as biblical Scripture into therapy as another technique to integrate religion and spirituality into clinical practice. Sybil described using Scripture to discuss certain issues and find truth, saying that
"Using Scripture as source of finding truth; because, for a Christian, if you genuinely believe the Bible is God's Word, then it has so much more authority than any thoughts or any kind of evidence you can come up with yourself or that other people in your life come up with, so it's a very powerful source."

However, despite its many advantages, participants identified a number of barriers to the integration of spirituality and religion in clinical practice, such as a lack of training, as indicated by Laurel:
"One thing that struck me… is just how much more need there is for training on integrating spirituality in clinical practice and how much our clients need it. I think there was a research by [the organisation] that asked something about that and showed that people really wanted their spirituality integrated."

Other barriers also included resistance, shame and anxiety regarding spirituality and religion from both clients and psychologists. Indeed, most participants identified resistance to spirituality and religion within mental health settings and communities, and spoke of how this could cause difficulties for both clients and psychologists.
Juliet: *"For some reason, spirituality is less tolerated than other issues. Abuse, trauma all seems to be tolerated. Even anger, discontent, all of those kinds of stuff, but I think spirituality is less well acknowledged."*

Participants also expressed the belief that there are prevailing negative attitudes about spirituality and religion among mental health professionals themselves:
Anne: *"That does disappoint me when you hear that someone will present a case in a team environment and they'll say 'Oh, you know the client said that God wants him to change schools or God wants him to go to another church' and people will sort of go 'pff'… which is a shame."*

Juliet: *"Pākehā people are pretty used to karakia and stuff, but other people (practitioners) coming into New Zealand are often like 'I don't believe in God', 'I don't have to listen to this' and 'I think it's unfair that your religion should overtake my lack of religion'. So, we've had some interesting discussions… often filled with tension and difficulties."*

Anne commented how such negative attitudes could lead to a pathologising of clients' religious or spiritual practices:
Anne: *"It used to really irritate me that often mainstream psychiatry and psychology would see that as evidence of disorder if somebody wanted to carry their Bible with them; that meant they were unwell. Or, if somebody had a particular Scripture that they wanted to read, over and over again, that meant that they were unwell and we need to up their medication or we need to think about other options… I think, too*

often, very unwell clients wanting to draw close to God is seen as an illness as opposed to wellness."

Such negative perceptions were often seen as a barrier to individuals expressing their beliefs in therapy, and to a lack of focus on or only token attention to these issues. Anne commented that *"a client's faith may be just mentioned in their notes at the beginning of an assessment and that's about it."* Similarly, Juliet said:

"The spiritual stuff is often the stuff that's left behind. Even though for Māori we have great models which says it's there, but I will tell you that a lot of Māori clinicians leave it out because either they don't believe it themselves or they are worried that it might be off-putting for the young person."

Likewise, Sybil commented:

"We don't often initiate those conversations, like a lot of people don't actually ask, so, some clients then would probably feel they're not necessarily allowed to talk about it… I think it will probably be in their best interests to start doing it more routinely because you don't know what you're missing otherwise."

Negative perceptions thus created anxiety from both clients and psychologists in relation to talking about spirituality and religion in therapy.

Laurel: "There can be a lot of fear in practising Christian spirituality or integrating a spirituality… People are really scared of prayer or asking those questions because they may impose values or they may do the wrong thing."

April: "When you choose a therapist you want to choose somebody who you feel you can be yourself with, and I think a lot of clients are probably a bit anxious about their faith and whether it's going to be respected and not dismissed."

What was interesting is that some participants spoke of counsellors as being *"much more accepting than psychologists"* about religion and spirituality in general. Juliet even noted that:

"There are Christian counsellors, and they've got their own association in New Zealand, and they have their own conferences and stuff. Counsellors do a lot of talking about stuff like that."

Participants however, also expressed some caution in regards to integrating spiritualty and religion into therapy. As April commented, there was awareness that, *"while faith and belief can be a very wonderful and powerful strength for people, it can also have its restrictions."* For example, participants identified a need for discernment to determine what is a spiritual experience and what may be part of clients' mental health issues (e.g. psychosis).

Juliet: "I think that the concern is when they're very unwell that the way in which they're hearing or feeling spiritually or religiously is very skewed and that it can actually be harmful for them."

April: "Being able to be discerning about when somebody's faith or the way their faith is being practised is actually problematic, when to challenge it and when to support it, and to be able to have confidence in that discernment."

Participants also highlighted how clients may present with spiritual and/or religious beliefs that may be dysfunctional or unhelpful for their recovery, and how they needed to challenge such beliefs in therapy.

April: "Sometimes, I find that religion can be used very powerfully as a defence. People build up all sorts of mechanisms to defend themselves. I'm thinking of a woman I saw years and years and years ago who… it was almost like her faith… she used her faith, unconsciously, as a way of almost not taking responsibility… It was a barrier. It was a way that perhaps was even harder for me to challenge because then here's me put in the position of challenging God, not challenging her defences… I gently and persistently try to challenge my clients around their beliefs and about being authentic and about really connecting with their own sense of self and meaning."

Sybil: "Their relationship with God is marked by this big struggle because they don't have a sense of His love or acceptance… So, with a couple of clients, that's been a big part of our work has been looking at who God is, where those views have come from and how their experience of God actually relates back to their parents…"

Sybil then shared how this type of work in therapy could result in clients reconnecting with their faith which in turn could lead to positive changes in their mental health.

DISCUSSION

Participants in this study supported the integration of religious and spiritual beliefs and practices into therapy. Participants shared examples of working with clients whose faith had led to improvements in their wellbeing or had even been pivotal in recovery. The integration of religion and spirituality was also seen as helpful in therapy because of its applicability to addressing loss, grief, guilt and existential issues. During times of loss and death, clients may explore the meaning of life and the afterlife (Walsh, 2004). Some may find comfort in greater meaning (e.g. they are part of God's greater plan) whereas others may question, distance or even abandon their religious beliefs (Marrone, 1999; Walsh, 2004). In either case, practitioners need to understand their clients' spiritual or religious beliefs about adversity and death, because these may be instrumental in helping clients cope and make meaning out of such experiences (Frame, 2003). By not exploring spiritual and religious beliefs, therapists may be overlooking a helpful source of counselling support and a critical part of a client's worldview (Begum, 2012; Everts & Agee, 1995). Further, participants in this study pointed to the positive impact of acknowledging and involving spirituality and religion on the therapeutic relationship, which may be fundamental for successful outcomes in therapy (Young, Dowdle & Leach, 2009). Understanding and accepting a client's spirituality and/or religion may develop empathy which strengthens the therapeutic relationship (Bohart, Elliot, Greenberg & Watson, 2002; Horvath & Bedi, 2002).

However, despite the participants in this study acknowledging the role of spirituality and religion, they

discussed that many psychologists do not bring spirituality and religion into therapy, either because they do not hold spiritual or religious beliefs themselves, are worried about the clients' reactions, or face organisational prejudice. This is reinforced by Begum (2012) and Delaney et al. (2013) who reported that many psychologists do not assess nor explore their clients' spirituality or religion in therapy. Findings from the UK (Begum, 2012; Mueller, 2012), US (Delaney et al., 2013) and Aotearoa New Zealand (Florence, 2009) suggest this is a global concern in the psychological field of clinical practice. The ethical principles of respect and responsible caring as set out in the NZ Code of Ethics (New Zealand Psychological Society, 2002), however, imply that psychologists should be responsive to their clients' cultural and social needs, which may include spiritual and religious needs. This would however, imply a need not only to be open to including religious and spiritual beliefs into practice, but also potentially to have some degree of knowledge about clients' beliefs and practices, which in itself may present a challenge.

Participants experienced and/or witnessed further challenges such as anxiety, resistance and negative attitudes that hindered the integration of spirituality and religion in clinical practice. As was the case in Florence (2009) and Young et al.'s (2009) studies, who reported that Christian clients fear their faith may be pathologised by non-Christian psychologists, participants suggested that clients were hesitant about disclosing their faith because they did not know if it would be acknowledged and validated. Researchers have noted negative attitudes towards religion since the early days of psychology when it was generally believed to be pathological and problematic (Azar, 2010; Bartholomew & O'Dea, 1988; Gerson, Allen, Gold & Kose, 2000). While there is emerging interest in research on religion and spirituality in the psychological field (Aten & Hernandez, 2004; Eck, 2002), resistance and shame in this regard may still be prevalent in current psychological practice.

In contrast, one participant suggested that counsellors talk more about spirituality and religion than psychologists. This reflects current literature on spirituality and religion in clinical practice which is dominated by studies from the field of counselling. Certainly in Aotearoa New Zealand, counsellors have shown more interest in this area than psychologists, facilitating presentations and annual conferences related to this topic (Everts & Agee, 1995; New Zealand Christian Counsellors Association, 2019). Similarly, the US discipline of counselling among other health care fields have established training, research and competencies on spirituality and religion much earlier than has the psychological field (Vieten et al., 2013). There has been a relatively recent growing emergence of psychological studies on spirituality and religion in the literature (Aten & Hernandez, 2004; Eck, 2002), perhaps reflecting a move away from more medical models of understanding wellbeing to more holistic models.

Participants unanimously agreed that there is a lack of training in this area of clinical practice, a finding mirrored by UK and Aotearoa New Zealand unpublished studies on psychologists and psychotherapists which indicated an absence of training and confidence in this area (Begum 2012; Florence, 2009; Mueller, 2012). This may present an ethical concern for psychologists regarding competence.

It is important that the integration of spirituality and religion is client-led however, because the definition of spirituality may be subjective and, as one participant stated, it is dependent on the clients and their needs. Indeed, the present study identified multiple meanings of spirituality held by the participants and their clients which reflected the numerous definitions cited in the literature. It is also possible that a client may be religious but not wish to explore faith in therapy or, alternatively, a client may not be religious but would like to explore spiritual or religious content. Psychologists should acknowledge and accept clients' religious and/or spiritual beliefs (Waller, Trepka, Collerton & Hawkins, 2010) and engage in comprehensive assessments to gain a holistic understanding of the client as well as to decide the extent to which religion and/or spirituality are integrated into therapy.

The present study suggests various psychological interventions and techniques that therapists may employ to integrate spirituality and religion into clinical practice. Participants discussed the relevance of religion and spirualty for use in modalities such as CBT, where key constructs and beliefs fundamental to their religious perspective could be used to challenge clients' negative or dysfunctional beliefs. This is supported by Aten and Hernandez (2004) and Eck (2002) who recommended using spiritual and/or religious interventions to address dysfunctional thoughts. The synchronicity between other modalities such as ACT and DBT and religious/spiritual beliefs was also noted.

Religious and spiritual practices may also lend themselves to being successfully integrated into theory. A Māori psychologist in the study shared how conversations about whakapapa, myths and stories in relation to self-analysis could be incorporated to enhance practice, particularly with Māori clients. This is reinforced by Hopkirk and Wilson (2014) who noted that spirituality is vital for Māori and can assist in therapy. The participant also commented on the relevance of involving kaumatua and kuia with specific spiritual skills in her treatment with Māori clients. Similarly, Ybañez-Llorente and Smelser (2014) recommended consulting with religious and/or spiritual leaders when clients experience distress in relation to religious or spiritual issues.

Māori services in New Zealand, as pointed out by one participant, tend to have processes that involve spirituality because for Māori spirituality may be embedded into Māori culture. It is possible that spirituality may be more easily integrated into therapy for Māori than other groups, and psychologists may employ specific practices to ensure spirituality is acknowledged for Māori clients. However, this does not imply that spirituality is necessarily well-integrated into therapy for Māori clients by psychologists. One participant shared that despite having helpful Māori models for practice, *"a lot of Māori clinicians leave it out because either they don't believe it themselves or they are worried that it might be off-putting."* Therefore, the lack of integration of spirituality and religion by psychologists applies to both Māori and non-Māori clients.

Karakia (prayer) and religious scripture were the most common practices discussed by participants as ways of integrating spirituality and/or religion into therapy. Prayer was used for strength, healing and to open and close therapy sessions. Similarly, Knabb (2012) has pointed to the value of centring prayer for Christians in remission, and Bennett to karakia for Māori clients (Bennett, 2009; Bennett, Flett & Babbage, 2008). Religious scripture was seen as another tool useful to explore religious perspectives on certain issues. Aten and Hernandez (2004) likewise have recommended religious scripture for cognitive interventions which can provide comfort and relief. While there is little research on the topic of scripture and therapy, the present study indicated that religious scripture may be useful in therapy. However as one participant noted, using scripture as a tool required in-depth knowledge which would limit this practice to those with the knowledge. Nonetheless, where psychologists lack knowledge in particular religious scripture but wish to use it in therapy for the benefit of their clients, it could be helpful to consult with a religious leader of the clients' faith, similar to the use of involving kaumatua and kuia for Māori clients.

Clinical implications

This study is consistent with the observation that psychologists may not integrate spirituality and religion into their clinical practice despite their perceived usefulness and significance. Stigma around spirituality and religion needs to be addressed in order to facilitate the discussion of spiritual and religious content in therapy. As reflective practitioners, psychologists may need to consider their own spiritual and religious beliefs and practices and their impact on their work. Training providers, psychological associations and accrediting bodies such as the New Zealand Psychological Society and the New Zealand Psychologists Board need to give consideration to acknowledging the role of spiritualty and religion, and ensure that psychologists are trained and competent to integrate these into their practice or able to draw on appropriate support services to help them do so. Additionally, action needs to be taken to promote the acceptance of religion and spirituality in mental health services. This could include displaying informative posters that welcome religion and spirituality in therapy in waiting rooms, thus encouraging clients to share their religious and/or spiritual beliefs in therapy. Mental health services should also emphasise to their staff the need for respect and sensitivity around individuals' religious and spiritual beliefs and offer continued professional development to ensure these areas are sufficiently addressed. Finally, services could also partner with spiritual or religious advisors to provide informational and instrumental support to mental health professionals. However, it is important to recognise that there are many important areas for these services to explore such as gaining a deeper understanding of Māori culture and their currently active discussions and efforts with limited resources are acknowledged.

Study limitations and future research

As this study was a small scale qualitative study, the data is likely representative of the six participants interviewed rather than of the wider population of psychologists. The participants were those who themselves held spiritual or religious views, and most research suggests a lack of religiosity amongst psychologists (Bergin & Jensen, 1990; Delaney et al., 2013; Rosmarin, Green, Pirutinsky & McKay, 2013). Participants may have chosen to take part in the study because they are spiritual or religious and wanted to discuss their ideas in this area of research. Additionally, psychologists who are neither spiritual nor religious may not have participated in this study because they did not have much experience integrating religion and spirituality into clinical practice. As one participant suggested, non-religious psychologists may not see the significance of integrating religion in therapy. And as mentioned earlier, Delaney et al. (2013) found that many non-religious psychologists do not believe religion can be beneficial to mental health. Nonetheless, it would be important to explore the experiences of non-religious psychologists in this area.

Target areas for future research include further exploration of the interaction between clinician spirituality, client spirituality and therapeutic intervention using a larger and more representative sample. Additionally, the study may benefit from a comparison sample of counsellors as there may be a difference in approach between psychologists and counsellors and the field of counselling has a longer history of acknowledging the role of religious and spiritual beliefs and practices on mental health and including these in counselling interventions.

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Emotional wellbeing as perceived and understood through the lenses of SEL and PYD: A qualitative commentary and suggestions for future research in Aotearoa New Zealand

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Aotearoa New Zealand statistics for the wellbeing of children and youth, in school and beyond, are a major concern. The Education Review Office (ERO) has prioritized the improvement of wellbeing as a school-based outcome for all children, especially Māori children whose wellbeing is lower than the mean. New Zealand schools are free to choose how they do this. From the vast range of wellbeing-promoting programmes available, not all of which meet the criteria for effectiveness, how do schools go about making their choice? This qualitative commentary contributes by examining international and national research on social emotional learning (SEL) and positive youth development (PYD), towards identifying how children's wellbeing might be promoted biculturally in schools in Aotearoa New Zealand.

Introduction

In this commentary, we respond to calls from Macfarlane et al. (2017), the New Zealand Education Review Office [ERO] (2015) and the New Zealand Council for Educational Research [NZCER] (Boyd2017), for the need to address child and youth social emotional wellbeing in school contexts in Aotearoa New Zealand, hereafter referred to as NZ. Social emotional wellbeing is a significant component of mental wellbeing (World Health Organisation [WHO], n.d.), and has recently been prioritised in the NZ Child and Youth Wellbeing Strategy for 2018-2022 (Department of the Prime Minister and Cabinet, 2019). The NZ Child and Youth Wellbeing strategy aims to improve the wellbeing of all NZ children, encompassing youth up to the age of 18 years, or 25 years if transitioning from state care, through a multi-agency approach, including the Ministry of Education (MoE). Children's mental wellbeing outcomes identified in the Child and Youth Wellbeing Strategy include a number of social emotional variables, such as their happiness, freedom from bullying, good decision-making, and awareness of the effects of their behaviour on others.

NZ Registered teachers have a primary professional obligation "to those they teach" (Education Council of NZ [ECNZ], 2018, p.26). They must "strive" (p.26) to nurture their students' capacities for thinking and developing independence, while also promoting their physical, emotional, social, intellectual and spiritual wellbeing, in line with the Māori concept of generosity and caring for others, known as Manaakitanga (ERO, 2016; Macfarlane et al., 2017). Other significant Māori values that must be reflected in teachers' nurturing of students are: pono, which requires teachers to show integrity through acting fairly, honestly, ethically and justly, and whanaungatanga which prioritises teachers' building "positive and collaborative relationships with [our] learners, their families and whānau, [our] colleagues, and the wider community" (ECNZ, 2017, p. 2). In Te Whāriki, the Early Childhood Curriculum, mana atua (wellbeing) is one strand of the woven mat (whāriki), as the metaphor that underpins the interweaving of wellbeing with the four remaining curriculum strands. In the NZ Primary and Secondary Curricula, wellbeing is conceptualized as hauora (Durie, 1984, in MoE, 2007), and forms the underlying philosophy of the Health and Physical Education curriculum. The concept of hauora encompasses the physical, mental, emotional, social, and spiritual dimensions of health, which are also recognised by the WHO (MoE, 2019). Professor Sir Mason Durie's Te Whare Tapa Whā model compares hauora to the four walls of a whare (house), each wall representing a different dimension: taha wairua (the spiritual side); taha hinengaro (thoughts and feelings); taha tinana (the physical side); and taha whānau (family). All four dimensions are necessary for personal strength and symmetry. However, while the inclusion of hauora in the curriculum acknowledges Māori perspectives, Heaton (2018) cautions against simplistic interpretations of this concept, that may overlook the complexities and what "Māori ways of knowing could offer the field" (p.466). This is an important consideration for this commentary, in which we focus on child and youth social emotional wellbeing in NZ school contexts, due to its positive relationship with physical health, school success, career and life success (Macfarlane et al., 2017; Taylor et al., 2017).

The purpose of this commentary is to bring together various conceptualisations and research related to social emotional wellbeing, in order to assist our understandings of this construct and to discuss the research evidence as to

effective ways of nurturing this in education contexts, in line with the goals of the NZ Child and Youth Wellbeing Strategy. We discuss international recommendations as to the key content, processes and timing for successful outcomes of interventions or programmes. We suggest possible ways forward to improve children's social emotional wellbeing in NZ schools, which will also require specific attention to the social emotional wellbeing of Māori students. As explained by Professor Russell Bishop, "What's good for Māori is good for everybody [but] what's good for everybody is not necessarily good for Māori." (Te Kotahitanga, 2020). Therefore, throughout this commentary, we are aware that social emotional wellbeing for NZ children and youth must be considered through the lens of Te Tiriti o Waitangi, which acknowledges the Tāngata Whenua (Indigenous people of NZ) status of Māori. This has research implications for how we might go about fostering students' wellbeing in NZ.

We start by looking at the wide variation of wellbeing terminologies to determine which constructs may be the most relevant and useful in relation to children's social emotional wellbeing in NZ education contexts.

What is social emotional wellbeing, and how does this relate to mental wellbeing?

Mental health is defined as "a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, n.d.). Wellbeing is therefore integral to mental health, and as assessed by the WHO-5 (a 5-item questionnaire), comprises positive mood, vitality and feeling interested in and satisfied with life (Fleming et al., 2014; Topp et al., 2015). The NZ Youth2000 Survey Series has identified a key role for youth emotional wellbeing as a significant component of youth health, characterizing emotional wellbeing as "being happy and able to cope with problems" (Youth12 Report, Clark et al., 2013, p. 16), generally having "greater capacity to do well at school [and able to] contribute to their families and communities" (p. 22). Other indicators of student wellbeing include predominantly positive feelings and attitudes, and resilience (ERO, 2015). The NZ Child and Youth Wellbeing Strategy outcomes should enable children and youth to "build self-esteem and resilience, have good mental wellbeing and recover from trauma" (NZ Government, 2019, p. 27). Mental wellbeing is also known as "positive mental health" and "flourishing", and means more than simply feeling happy: it includes "feeling good, functioning well, has satisfaction with life, is developing as a person, and has strong relationships" (NZ Mental Health Foundation, 2019, p. 1). Other Child and Youth Wellbeing Strategy outcomes, include children and youth having knowledge of their identity and heritage (whakapapa), feeling valued and connected, making age-appropriate decisions, coping with challenges, being creative and having fun (2019).

Social emotional wellbeing has been an elusive construct to define. The early Greek philosophers debated the contrasting purposes of a good life as being one of happiness or pleasure (hedonism), compared to one of virtue and meaning (eudomania) (Olsson et al., 2012). This debate underpins many present-day Western philosophical and psychological approaches, including Ryff's (1989) often-cited Personal Well-Being model (e.g. Fullchange et al., 2016), which defines wellbeing as encompassing "six domains of human growth: autonomy, personal growth, mastery and positive relatedness" (Olsson et al., 2012, p. 1070). The social connectedness dimension of wellbeing was explored longitudinally, through structural equation modelling (SEM) of a subset of data from the NZ Dunedin Multidisciplinary Health and Development Study (DMHDS, in Olsson et al.). They demonstrated that adolescent social connectedness is a strong predictor of adult wellbeing, as assessed though sense of coherence, positive coping, social participation and prosocial behaviour.

Over the past 30 years, a large number of interventional approaches to improving social emotional wellbeing across the lifespan have been undertaken and investigated from the psychological perspective. Four main groupings have been identified internationally by Tolan et al. (2016), based on their different theoretical origins: 1) Social Competence (SC; Waters & Sroufe, 1983); 2) Social Emotional Learning (SEL; Elias et al., 1997); 3) Positive Youth Development (PYD; Lerner et al., 2005), and 4) Positive Psychology (PPsy; Seligman & Csikszentmihalyi, 2000). Two approaches that are considered as being more currently "influential" (Ross & Tolan, 2018, p. 1171), are PYD and SEL, which have substantial theoretical overlap, with some differences. We therefore focus mainly on PYD and SEL approaches in this commentary, due to this relevance and their common use in interventions to date for children and youth in NZ (e.g., ERO, 2015, Farruggia & Bullen, 2010; Macfarlane et al., 2017). These approaches may be regarded as complementary: SEL focuses on the intra-individual processes with emphasis on individual skill development such as self-management, towards social and academic outcomes (Ross & Tolan, 2018), while PYD includes the dynamics of person-environment interactions, as a "person-environment transactional view" (Tolan et al., 2016, p. 229), towards "societal contribution and engagement outcomes" (Ross & Tolan, p. 1173).

Positive Youth Development (PYD)

PYD is a strengths-based approach drawing on Bronfenbrenner's (2005) bioecological model, and acknowledges the role of context in children's development (Farruggia & Bullen, 2010). PYD assumes that every child has potential or strengths or "assets" (Taylor et al., 2017, p. 1157) that can be developed, provided that their learning and development can proceed in nurturing and supportive developmentally-appropriate contexts. Children and youth are regarded as "resources to be developed, rather than problems to be managed" (Roth & Brooks Gunn, 2003 cited in Farruggia & Bullen 2010, p. 145). According to Tolan et al. (2016), the most frequently addressed PYD constructs include: 1) the validated Five C's Model which was developed from existing SC and social functioning measures by Lerner and Thompson (2002): Competence, Confidence, Connection, Character, Caring or Compassion, and 2) the

Assets Model (Benson et al., 2011), which derives from a developmental systems approach, focusing on ways that individuals can access and be supported by their environment towards their effective functioning and personal goals. Benson et al. identify 40 assets comprising 20 individual resources or strengths and 20 environmental systems. Resilience for example, may be seen in the individual's ability to bounce back from stress (individual resource), and knowing how to access environmental assets such as family, social or organisational support (environmental systems).

PYD approaches have been incorporated in a number of NZ services for at-risk youth as clients of multiple service systems such as child welfare, juvenile justice, education and mental health (Sanders et al., 2015). Service level PYD approaches appear to have a small direct influence on the wellbeing outcomes of at-risk youth, including pro-social behaviour, life satisfaction and self-esteem; these outcomes being mediated by their improved resilience (Sanders et al., 2015). Liebenberg et al. (2016) have identified three key service-related characteristics for effective promotion of the PYD Five C's (Bowers et al., 2010). These include enabling youth to: 1) experience positive and sustained relationships with competent, caring adults; 2) have opportunities for their engagement and empowerment; and 3) have opportunities to develop their personal life skills (Liebenberg et al., 2016). When youth had personal agency, empowerment, and were treated respectfully by service professionals, they made greater wellbeing outcome gains.

In NZ, PYD's equating of the inner individual strengths or assets with the strengths to be found in family and community contexts, resonates with Māori perspectives, whereby any wellbeing initiatives to support an individual child or youth should also involve whānau (family), hapū (clans or descent groups), iwi (tribe) and community. Sanders et al. (2015) found that although Māori males were at higher risk of engaging in harmful behaviours and/or educational disengagement than other groups, Māori and Pasifika youth across their sample reported significantly higher wellbeing and resilience than their Pākehā counterparts, which might be attributable to the protective value of Māori and Pasifika "cultural resources" (p. 50). PYD cultural resources include spiritual beliefs, feeling connected to culture, and relationships with whānau. Masten and Wright (2010, cited in Sanders & Munford, 2015) also noted a relationship between cultural group membership and resilience of Māori and Pasifika youth, and the "protective role that this has been noted to confer upon children and youth exposed to high levels of background adversity" (p. 81). Sanders et al. (2015) suggest that PYD approaches utilising intensive home, school and community-based interventions should be able to address both contextual and individual risks concurrently. This resonates with Simmonds et al.'s (2014) PYD model, Te Kete Whanaketanga—Rangatahi (The Developmental Kit—For Youth), which gives equal priority to "collective responsibility, navigating the world, cultural efficacy, health and individual strengths" (p. 220) for wellbeing for Māori youth.

Social Emotional Learning (SEL)

SEL is a "conceptual umbrella" (Tolan et al., 2016, p. 218) for a variety of approaches for improving social and emotional wellbeing at an individual level. SEL draws on extensive international research findings as to specific personal and social capabilities that produce adequate functioning in school and interpersonally. SEL is sometimes known by various other terms such as, character education, grit, soft skills and 21st-century skills, as but a few examples (Jones & Doolittle, 2017). However, SEL appears to be the preferred terminology used by policy makers, practitioners and parents, because it provides a common language and framework (Weissberg & O'Brien, 2004) and also perhaps because it indicates (based on evidence) that these skills can be learned, and is therefore an optimistic term (Jones & Doolittle, 2017). The potential responsiveness in children's personal SEL skill acquisition is also likely to resonate with school teachers. For example, 95% of U.S. teachers surveyed believed that SEL was teachable, with 97% seeing it as beneficial for students from all socio-economic backgrounds (Greenberg et al., 2017), which is consistent with current SEL outcome research findings (Taylor et al., 2017). International findings show that better mental health and longer-term wellbeing outcomes can result from actively supporting children's SEL skill development in school-based interventions, through promoting the development of social emotional knowledge, skills and behaviours for coping with normal life stressors (Taylor et al, 2017; Weissberg & O'Brien, 2004). However, despite the general consensus on the importance of SEL skills, there is generally a "healthy scepticism" (Jones & Doolittle, 2017. p. 4) as to how these skills can actually be successfully taught in schools. Furthermore, many qualified and preservice teachers feel ill-equipped to facilitate SEL (Garner et al., 2018).

Much of the international SEL interventional research emanates from the Collaborative for Academic, Social and Emotional Learning (CASEL: https://casel.org/). CASEL is a North American organisation that promotes evidence-based SEL as an integral part of education from early childhood through to secondary school. CASEL shares their findings widely, with up to 180 different countries as at 2019 (Mahoney & Weissberg, 2019), and has been cited in NZ by ERO (2016, p.17) and NZCER (Boyd et al., 2017, p. 10). CASEL has identified and defined five core SEL skills or competencies: 1) self-awareness, which includes the ability to identify one's own emotions, accurate self-perception, recognition of strengths, self- confidence and self-efficacy; 2) social awareness, consisting of perspective-taking, empathy, appreciating diversity and respect for others; 3) self-management, of impulses, stress, self-discipline, self-motivation, goal setting and organizational skills; 4) relationship skills, including communication, social engagement, relationship building and teamwork, and finally, 5) responsible decision-making, for which the skills are listed as identifying problems, analysing situations, solving problems, evaluating, reflecting (reflectiveness) and ethical responsibility (CASEL, 2013). This list has synergies and overlaps with PYD and the outcome characteristics identified by the NZ Child and Youth Wellbeing Strategy. As discussed by Macfarlane et

al. (2017), these SEL competencies also resonate with Māori perspectives, particularly manaakitanga and the Hikairo Rationale (Macfarlane, 1997). Macfarlane et al. (2017) have related SEL to significant Māori models, including Te Whare Tapa Whā (Durie, 1997), Ka Hikitia: Managing for Success (MoE, 2008) and Ka Hikitia: Accelerating Success (MoE, 2013). Macfarlane et al. (2017) cited Tomlins-Jahnke and Graham's (2014) successful tribally-based curriculum that focuses on relationship and partnership, through utilising "Māori thought processes and intangible features, including the social dimension (whanaungatanga) and the emotional dimension (te whatumanawa) to nurture the learning process, and ultimately the well-being and quality of life that are bound to SEL" (p. 278).

Current Social Emotional Wellbeing of NZ Children and Youth

Mental health difficulties are common during the period of early adolescence (ages 11-14 years), when many children experience heightened anxiety or stress as they negotiate their changing social, familial and peer relationships (Fleming et al., 2014). In the broader context of NZ's shameful ranking of 34th out of 41 developed countries for child and adolescent wellbeing (UNICEF, 2017), ERO (2015) expressed concern that many Year 7 and 8 students (10 - 12 years of age), were not experiencing "the desired outcomes for student wellbeing" (2015, p. 25). This correlated with their higher rates of being suspended or stood down, and lower academic achievement. Year 9 to 13 students (13 – 17 years of age) are also of concern, with Māori boys in this age group "three times more likely to be stood down, suspended, excluded or expelled than their non- Māori peers, and four times more likely to be frequent truants" (Macfarlane et al. 2017, p. 276). In an extensive questionnaire survey administered nationally to 8,500 Year 9 – 13 NZ secondary school students, Clark et al. (2013) found that 38% of females and 22% of males reported having experienced at least one prolonged period of feeling down or depressed, and reports of deliberate self-harm were common. Moreover, Māori and Pasifika adolescents and youth from economically vulnerable families were at higher risk for mental health issues (Clark et al., 2013; Crengle et al., 2013). However, across the total sample including all ethnicities, 94% of male and 90% of female secondary students were generally satisfied with their life, with 76% reporting "good emotional wellbeing" (Clark et al., 2013, p. 22). Life-satisfaction was assessed on the students' self-reported responses to five wellbeing items in the 2012 questionnaire (Clark et al., 2012), which drew directly on the five positively-stated items on the WHO-5 Questionnaire for mental wellbeing (Topp et al., 2015). This questionnaire is used worldwide, and some researchers argue that it reliably screens for depression (Topp et al., 2015). The WHO-5 Questionnaire includes self-assessment of levels of positive feelings such as feeling cheerful, calm, rested, and finding daily life interesting. These self-assessable items align with ERO'S (2015) definition of student wellbeing discussed above, and with SEL (Weissberg & O'Brien, 2004). Overall, and of concern moving forward, Fleming et al. (2014) found that although secondary school students' self-reported mental health was generally positive, there had been a "slight decline" (p. 472) between 2007 and 2012.

Fleming, et al. (2013) analysed a subset of their data to investigate the mental wellbeing of Christchurch students, due to their questionnaire (Clark et al., 2012) having been administered after the 2010 and 2011 Christchurch earthquakes. The 558 Christchurch students were demographically "younger, less ethnically diverse and from wealthier (less socioeconomically deprived) neighbourhoods than non- Christchurch students" (p. 11), and included 77 Māori and 18 Pasifika students. Overall, Fleming et al. found a similar average rate of good emotional wellbeing at 76.5%, but lower rates of satisfaction with life and higher rates of worrying a lot, compared to students from elsewhere in NZ. Students who were directly affected by any of the earthquakes showed significantly higher rates of negative psychological symptoms compared to other students, including experiencing nightmares, avoiding situations and thoughts, hypervigilance, and feeling "numb or detached from others" (p. 17). Taking into account the decline in student wellbeing nationally since 2007 noted above (Fleming et al., 2014), these post-earthquake findings should be of concern, especially because, as cautioned by Fleming et al., this was a small voluntary sample. Other researchers have expressed similar concerns and have called for more research on the health and wellbeing of Christchurch children and adolescents, post-earthquake (Thomson et al., 2016). Also noteworthy, is the Malatest International (2016) report specifically including Christchurch as one of the four larger urban areas with the largest number of at-risk youth, the other centres being Manukau, Waitakere and Hamilton. Malatest International recommends that for these four urban centres diverting "even a small proportion from negative outcomes with significant financial cost can result in long-term financial returns" (2016, p. 109).

School is a significant social context for children who spend thousands of hours of their childhoods and youth in school classrooms (Greenspan, 1997). Therefore, it is not surprising that schools have been identified as important contexts for fostering and supporting the social emotional wellbeing of children and youth (Chodkiewicz & Boyle, 2017; ERO, 2015). In support of the previous Prime Minister's Youth Mental Health Project (2012), and drawing on a range of NZ and international research as at that time, ERO (2013) obtained national feedback on their draft evaluation of wellbeing indicators, towards developing wellbeing resources for students' success at primary and secondary schools (ERO, 2015; 2016). These publications provide conceptual and theoretical information to assist teachers' understandings of key wellbeing outcomes, and links to a range of teaching resources through their website (ERO, 2020). These resources include some Māori specific content and are provided to support the achievement of ERO's (2015) comprehensive definition for wellbeing for NZ students, as encompassing their satisfaction with life at school, their engagement in learning and social emotional wellbeing.

NZ schools are accountable to ERO for the provision of wellbeing support for students, while retaining autonomy in their decisions as to how this is to be

implemented. ERO has recommended that the MoE should support primary schools in particular, to focus more on the wellbeing outcomes for primary school children, prior to years 7 and 8 when the "cumulative effects" of earlier wellbeing outcomes become evident (ERO, 2015, p.iii). A similar concern for the mental wellbeing of this younger age group was expressed in Malatest International's (2016) report on the 2012 Prime Minister's project. Their evaluation of 26 mental health initiatives, revealed some "gaps" (p. 9), in these services for the under-12–year-olds. Their report recommended "funding for innovation" (p. 11), particularly for supporting Māori and Pasifika children and youth, and for more cross-sector collaboration between health, education and justice.

According to Boyd et al.'s (2017) report on the NZCER nationwide survey on wellbeing in New Zealand schools, 85% of responding teachers reported that their schools had strategic plans to support wellbeing and belonging, and 86% reported "deliberately teaching emotional skills in class" (p. 1). Strategic approaches included clearly-stated goals relating to mental and physical wellbeing outcomes as priorities in schools' strategic plans, with the majority (47%) of schools having "some well-embedded approaches" (p. 17), 27% having one or none, and 26% having many. Although a high proportion of schools used Positive Behaviour for Learning (PB4L) as a positive intervention, other wellbeing needs which had yet to be adequately addressed, included reducing bullying behaviours, helping children recognise and manage their feelings in general, and more specifically helping them manage strong emotions such as grief and anxiety (Boyd et al., 2017).

The MoE (2013) has acknowledged that more needs to be done for Māori students, too many of whom have been left behind and have become disengaged (Bishop et al., 2009), in particular Māori boys in years 9 – 10 (12 – 14 years of age) (Macfarlane et al., 2017). National data indicate that when compared to their Pākehā peers, Māori youth "are less likely to report being treated fairly by teachers and to have teachers who have high academic expectations for them" (Crengle, et al., 2013, p 5). Māori students' oranga (wellbeing) is enhanced when schools acknowledge and work with "Māori ways of knowing" (Macfarlane et al., 2007, p. 68). As teachers develop their knowledge of, and empathy for, Māori students' identities, languages and worldviews, they are more likely to support the SEL and motivation of Māori students. (Macfarlane et al., 2017). One successful example cited, and described qualitatively in Malatest International's (2016) evaluation, was the Kauri Restoration Project focusing on the "four quarters of life: spiritual, emotional, mental and physical" (p. 80), consistent with the four cornerstones of Māori health espoused in Te Whare Tapa Whā (Durie, 1997), and with the metaphor of the rākau (tree) expressed in the Hikairo Rationale (MoE, 2007). The Kauri Project's focus appears to address the definition of hauora about which Heaton (2019) has cautioned (cited above), and challenged the NZ curriculum to address. Hauora is explained as:

"the supernatural hau (breath) of ora (life) given to Hine-ahu-mai-i te-one (the first feminine form).

Hau (wind or vital essence of life), ha (breath), ora (to be alive, healthy, to survive) and wairua (spirit) were infused into the first feminine form, the progenitor of humanity to animate life. If hauora can indeed be described as the animation of life, then it delivers a formidable edict to a curriculum or learning area, which may not have the metaphysical tools to meet it" (Heaton, 2018, p. 461).

Hauora knowledge, therefore, is much more complex and heterogeneous than may be presently inferred from the NZ curriculum. As one example, hinengaro (Te Whare Tapa Whā) is the Māori term for the spleen, the bodily organ "where the physical manifests in the emotional and the emotional manifests in the spiritual" (Metge, 2010 cited in Heaton, 2018, p. 464). This is "privileged" (p. 465) knowledge within Māori tradition, highlighting the need to understand and value the enrichment possible, should Māori ways of "knowing, being and doing" (Macfarlane et al., 2017, p. 278), be woven together with the core emotional competencies of SEL (CASEL, 2013; Macfarlane et al., 2017).

Evaluations of SEL Intervention Effectiveness: Key meta-analytic findings

SEL conceptualisations, theories or models and SEL interventions, programme effectiveness or best practice are different and require separate research considerations (Brzycki & Brzycki, 2019). SEL models are the ways we define and interpret SEL. Best practice is a working method (or set of working methods) that has been evaluated as being effective in producing the attributes, skills and competencies in the SEL model. In this section, we discuss the most recent evaluation research.

In 2011, Durlak et al. reported their "first large-scale meta-analysis" (p. 407) of 213 school-based, SEL programmes that had involved 270,034 students from kindergarten to secondary school level. This meta-analysis captured studies as far back as 1959 up to 2007, with the rate of evaluation research of these programmes (interventions) rapidly increasing across those decades. Criteria for inclusion included: 1) targeting one or more SEL skills; 2) targeting children and youth aged 5 to 18 without any identified behavioural or learning problems; 3) including a control group; 4) sufficient data for calculating effect sizes, and 5) if available, post-intervention at least 6 months later. For this first meta-analysis, the outcome variables focused on SEL skills, attitudes to the self and others, pro-social behaviours, emotional distress and academic performance. One of the key independent variables was the intervention format, which they had stipulated should follow four recommended practices for SEL skill development, as captured in the acronym SAFE: Sequenced (logical progression of skill development); Active (children need to be participating and practising), Focused (take the time to learn and practise) and Explicit (in terms of SEL learning goals). Findings confirmed that school-based SEL programmes "significantly improve students' SEL skills, attitudes and behaviours" (p. 412), and these programmes can be delivered successfully by classroom teachers. Both SAFE practices and implementation problems were significant in moderating SEL outcomes,

alongside an 11 percent gain in academic outcomes as assessed through achievement tests scores in standardised reading and maths and grades in those topics.

Taylor et al.'s (2017) meta-analysis extended the outcome focus of Durlak et al.'s (2011) meta-analysis, to include PYD outcomes that were in alignment with SEL constructs. SEL skills align with a number of PYD individual assets, such as social competence, positive values, positive identity, and the promotion of social, emotional, behavioural and cognitive competencies identified by Catalano et al. (2002, cited in Taylor et al, 2017). Furthermore, both SEL and PYD have similar goals, with PYD research having already demonstrated longer-term effects. Thus, Taylor et al.'s (2017) main aims of their second meta-analysis were to: 1) extend the previous one (Durlak et al., 2011); 2) determine the longer-term follow-up effects of SEL interventions; 3) explore the synergies between the two frameworks (SEL & PYD) as noted by Tolan et al. (2016), and 4) identify ways that these approaches may be integrated. This meta-analysis also sought to test one theory of PYD that is "articulated in the SEL framework namely that: fostering social and emotional skills and positive attitudes provides students with assets that will promote wellbeing and protect against negative outcomes" (p. 1158).

Taylor et al.'s (2017) meta-analysis included 82 school-based universal (meaning school-wide, discussed in the next section) SEL interventions, 38 of which were outside of the USA, comprising 97,406 students ranging from kindergarten to high school, whose mean age was 11.09 years. Inclusion criteria were similar to the 2011 study, but SEL programmes needed to cover kindergarten through to high school. In this (2017) meta-analysis, the constructs of PYD (Bowers et al., 2010) and SEL were considered alongside each other due to the shared wellbeing goals of both. The dependent variables assessed for the meta-analysis were focused on individual change in the students only, and as for 2011, included their attitudes towards the self, others and school, positive social behaviour, academic performance, conduct problems, emotional distress, substance use and other longer term outcomes (Taylor et al., 2017). Findings showed that children and students who participated in the SEL programmes reviewed, improved in both their social and emotional assets (PYD constructs) and SEL skills, attitudes and wellbeing indicators. Specific SEL skills taught in these effective programmes included identifying emotions, perspective taking, self-control, interpersonal problem solving, conflict resolution, coping strategies, and decision-making, depending upon the developmental level of the child. Follow-up studies, ranging from 6 months to 18 years later, showed remarkable persistence in these improved outcomes. Key outcomes also included "the dual benefits of SEL interventions in terms of affecting both positive and negative indicators on wellbeing" (p. 1166). As well as the development and improvement of social emotional skills, pro-social behaviours, positive attitudes and academic performance, these also provided a protective factor reducing the later development of problems such as conduct disorder and emotional distress. These higher outcome effects were more significant in the 5 – 10 year olds, compared to the 11 - 13 year olds and 14 - 18 year olds (Taylor et al.,

2017). At follow-up, ranging from shorter to longer terms, which included measures up to 18 years' post intervention, such as high school graduation, positive wellbeing and positive life trajectories, the persistence of the effects indicated the high value for investment. The authors encourage other investigators to include these sorts of longitudinal outcomes in their follow-up studies.

A more recent review and meta-analysis conducted by Corcoran et al. (2018), focused on the effectiveness of universal school-based SEL interventions on the specific academic domains of reading, mathematics and science in classrooms from Pre-Kindergarten (pre-K) to Grade 12 (equivalent to New Zealand Year 13). Forty studies were included according to nine criteria, including dependent measures of reading, math and science, duration of at least 12 weeks, and programme intensity (number of sessions). Amongst their findings, SEL interventions had more positive effects on academic domains of reading and mathematics, compared to science. Effect sizes in turn, were higher or lower, according to whether the research designs were randomized control trials (RCT's) or quasi-experimental, respectively. Corcoran et al. made note of the Positive Action Programme (Flay & Allred, 2003), as "having substantial promise as an effective SEL program on academic outcomes" (p. 22). The Positive Action Program focuses on social emotional character development and has shown improvements in positive affect and self-esteem, with a corresponding reduction in psychological distress such as anxiety and depression, in youth in low-income urban environments (Lewis et al., 2013). Corcoran et al. (2018) also observed that "more SEL does not necessarily result in better outcomes" (p. 21). They suggest the need for more large-scale, RCT's focusing on academic outcomes, perhaps focusing on programmes with similar designs to facilitate "better comparisons" (p. 69). They also recommend that there is a place for more qualitative research, through which more could be revealed on both the content and processes of SEL interventions.

Structure and content of effective SEL interventions

The term "universal" as applied to school-based SEL interventions refers to those that are designed to meet the needs of the majority of the participants, such as a whole-school and sometimes home approach (Greenberg & Abenavoli, 2017). Universal intervention design structure may be represented by a three-tiered "Intervention Triangle" (Boyd et al., 2017, p.10). Typically, a Tier 1 Intervention is a school-wide, protective, preventative "universal proactive approach" (p. 11), to promote positive outcomes, foster a sense of belonging and reduce risk factors for students overall, and is likely to be successful for approximately 85% - 90% of the students. Tiers 2 and 3 focus on the 5-10% or 1-5% of students who may be respectively more vulnerable, or at more severe risk. The three-tier approach therefore provides a model that enables schools to be clear in their targeted groups for programmes (Boyd et al., 2017, p.10; ERO, 2016, p. 17). This three-tiered model has been used successfully in NZ in the implementation of PB4L (Boyd et al., 2017). Boyd et al.'s (2017) NZCER report has also identified classroom SEL experiences as reviewed in Durlak et al.'s

(2011) meta-analysis of SEL programmes, as important Tier 1 contributors to student wellbeing and achievement. Other contributing factors include feeling connected and a sense of belonging, caring relationships with teachers, perceived fairness and justice regarding behavioural concerns, and access to comprehensive health support.

Greenberg et al. (2017) have found that the most effective school-based interventions are those that begin as Tier 1 interventions and then target Tiers 2 and 3, as, if and when required, which they describe as "vertical integration" (p. 22). Horizontal integration refers to the ways that the SEL interventions are integrated within and across the school curriculum. If teachers themselves are specifically trained in SEL skills, they can then model and teach these skills, while also embedding such skill development into topics across the curriculum (Greenberg et al., 2017). This point has been highlighted by Schonert-Reichl et al. (2017), who have identified the need for more explicit SEL training for teachers in preservice training and inservice professional development, so that they can effectively deliver SEL programmes. They state strongly that "to reach the students, teach the teachers" (p. 6), and that professional development for teachers is crucial. Chodkiewicz and Boyle (2017) also recommend teachers as the ideal facilitators, because they are with their students more than any visiting facilitator could be, and can therefore foster their wellbeing goals in an integrated and persistent way, with professional support. Macfarlane et al., (2017) note that SEL is "not a new phenomenon for Māori" (p. 275) whose oral traditions and values are permeated with SEL "imperatives" (p. 275). Therefore, imbuing SEL approaches with te ao Māori perspectives, inclusive of mātauranga Māori (Māori knowledges), experiences and spirituality, should enhance the authenticity of any SEL intervention programme for both teachers and children/students and their whānau, hapū, iwi, and community.

For teachers trying to make sense of the wealth of data that has accumulated on SEL and wellbeing programmes in general, CASEL (2015) provides a summary of specific outcome measures of individual programmes that they have evaluated. Criteria for effectiveness (evaluation outcomes) include evidence of improved academic performance (up to 11% higher than non-SEL counterparts), improved positive social behaviour "such as greater motivation to learn [and] increased time devoted to schoolwork" (p. 9), reduced conduct problems, and reduced emotional distress, such as less depression and anxiety. However, SEL programmes reviewed by CASEL may not directly superimpose onto or fit into NZ's Te Tiriti context. One aspect not included the CASEL criteria, that is highly relevant for Māori students, is the importance of language and culture as integral to identity, wellbeing and success (Macfarlane et al., 2017). As noted by Macfarlane et al., the national strategy of Ka Hikitia (MoE, 2013) has laid down the challenge to the NZ education sector to provide more empathetic and appropriate educational experiences for Māori, such approaches aligning well with these SEL goals of improved academic and social emotional outcomes. As argued by Macfarlane et al., the time is right to map out and compare the various components of the various models of SEL and related interventions towards assisting

practitioners and researchers together to find effective developmentally and culturally appropriate interventions that can be applied at a practical level and critiqued as to their fit for the NZ context.

To ensure the success of school-based SEL approaches, the SEL programme content must be based on "a sound theoretical framework based on reliable research [and on] sound theories of child development" (Weissberg & O'Brien, 2004, p. 94). The most effective programme content includes teaching the five core SEL skills of self-awareness, social awareness, self-management, relationship skills and responsible decision making, at a developmentally appropriate level (Taylor et al., 2017; Weissberg & O'Brien, 2004). Based on their findings, specific content should include teaching about and facilitating skill development in emotional awareness, self-control, interpersonal problem-solving skills and peer relationships. Where these skills are taught didactically as knowledge transfer they have minimal impact, compared to interactive approaches which have greater effect, with weighted effect sizes (ES) of 0.05 and 0.15 respectively. Successful interactive methods include modelling the behaviours or skills, allowing time for children to rehearse and obtain feedback, and helping children with "behavioural goal-setting and cues to prompt competent behaviour in a variety of settings" (Weissberg & O'Brien, 2004, p. 93). Extending this beyond school to the home and community, enhances the effectiveness. Overall, the beneficial effects extend to all aspects of daily life and as their team's later meta-analysis has shown, these effects can persist through to adulthood and beyond (Taylor et al., 2017). Also, key to the success of such programmes, is the need for a coordinated approach and for professional development and ongoing support for teachers implementing these. In applying these findings to wellbeing programme development that is applicable with a Te Tiriti approach, it is important to acknowledge that culture is a determinant in identifying the key assumptions, understandings and theoretical perspectives of emotion, wellbeing and related constructs. As Keltner, Oatley and Jenkins (2014) argue, different cultures will have "different stances" (p. 58) on the authenticity of emotions as constructs and experiences. Therefore, any intervention in NZ should extend the Western construction of emotion and related competency development to include Indigenous understandings of "emotional healing and wellness" (Heaton, 2018, p.461).

Macfarlane et al. (2017) have described an optimal structure for SEL programme delivery, drawing on the recommendation of Catalano et al. (2004) for "structure and consistency in programme delivery" (p. 114), through the acronym SAFE (Durlak et al., 2011) defined above. This SAFE structure may be applied to include ways of showing the respect, kindness and caring of manaakitanga, also including specific suggestions as to how to achieve caring for students' physical, mental and spiritual wellbeing. When manaakitanga is enacted to its full potential, students should experience a sense of belonging, a sense of security in their own identities, and engaged in school (Macfarlane et al.) These interpretations of manaakitanga should be included in any SEL programme development in NZ in order to ensure cultural responsiveness. Furthermore, social emotional

wellbeing needs to include the home language of the child and in NZ, the official language of NZ, te reo Māori (O'Toole & Martin, 2019).

Wellbeing, SEL and PYD research in NZ

In 2009, Swain-Campbell and Quinlan responded early to the growing expectations of NZ schools to address children's social and emotional needs. They investigated the school-related wellbeing of 461 children from nine Dunedin schools situated in a range of mid to lower socio-economic neighbourhoods. Almost half of these children were New Zealand European, 2.8% were Māori, 6.2% both Māori and New Zealand European, 1.5% Samoan, 1.2% Samoan/European and the remainder hade a wide range of ethnic backgrounds. Using a self-devised questionnaire, they obtained self-reports from children and parents on four school-related wellbeing components; namely, school variables, classroom factors, emotional wellbeing and health behaviours. The majority of the children reported liking school, 14% reported having been teased more than five times in the previous week, and 5% reported never feeling safe at school. School environment appeared to be a more significant variable for students liking school, which included having fun, finding the work interesting and having the sense that their teacher liked them. Although the authors found that social and emotional factors were less correlated with liking school, they acknowledged that this might reflect their questionnaire items. For example, shortly after their data collection they noted that a new happiness measure had become available. Also since that time, ERO (2015), and NZCER (Boyd et al., 2017) have extended the definitions and criteria for children's wellbeing at school. Current measures are more likely to include the SEL competencies as recommended by CASEL (2015) or as assessed in the Youth2000 Survey Series (Fleming et al., 2014). Six years on from their 2009 study, Quinlan et al. (2015) took a PPsy and PYD approach to investigate the effects of implementing a classroom-based, character strengths building, six-session intervention with 193 Dunedin 9-12-year-old students, on a number of school variables, including their affective wellbeing. Amongst their findings was a positive relationship between students' subjective wellbeing as assessed through the positive affect scores in the brief Positive and Negative Affect Scale (PANAS; Watson, Clark & Teilegen, 1988), and their improved awareness and use of their personal strengths. However, there was no associated decrease in negative affect, which the authors found to be consistent with previous research. It was found that the interactive nature of the students' engagement with the programme made a significant positive difference to the outcome, consistent with SEL recommendations above (e.g., Weissberg & O'Brien, 2004). This type of study may have scope in the future to include strengths from a te ao Māori perspective, such as identifying the strengths that are valued by whānau, hapū, iwi and community.

In another study associated with the overall student wellbeing research from Auckland University, Canning et al. (2017) investigated the relationship between neighbourhood opportunities for PYD and adolescent depressive symptoms, wellbeing and suicide risk. This was a large study comprising 5191 adolescents from 266 different neighbourhoods. They found that where there were more opportunities for youth to be actively involved in helping people, and participating in church groups or sports teams, youth in these neighbourhoods reported higher levels of wellbeing as self-reported through the WHO-5 wellbeing index (Topp et al., 2015). However, these neighbourhood opportunities did not reduce their depression or suicide risk as assessed through further measures, which was similar to the findings of Quinlan et al. (2015) above. As the authors explained, while PYD research has confirmed the positive influence of the neighbourhood external assets on the internal assets of being happy, healthy and making a contribution to society, perhaps neighbourhood assets are generally less relevant to these internal states (assets) than more immediate contextual assets such as family. Together with the findings of Quinlan at al. (2015), these findings, which are counter to the dual benefits found by Taylor et al. (2017), suggest a complementary role for SEL approaches to building intra-individual SEL skills to promote and/or enhance the PYD internal assets.

A wellbeing study that did focus on more internal SEL skills was conducted by Devcich et al. (2017). They compared the effectiveness of a mindfulness programme developed in NZ, that included Māori perspectives, and which had been researched previously, to the effectiveness of a commercially available resource designed to build emotional literacy, on wellbeing outcomes of 91 Auckland children aged 9 to 11 years. They found that both programmes increased the wellbeing outcomes measured, with the mindfulness programme having a significantly greater effect. Differences between these two programmes included the incorporation of Māori perspectives in the mindfulness programme, and the teachers' prior experience in coaching mindfulness.

A cultural comparative perspective on adolescent wellbeing led a team of NZ researchers to explore the links between narrative identity, personality traits and wellbeing for 263 adolescents aged between 12 and 21 years, from three New Zealand cultures: Māori, Chinese, and European (Reese et al., 2017). Narrative identity was conceptualised as "the unique aspect of self that is tapped by one's life story" (p. 612), such as talking about one's traits, goals, motivations and coping strategies. Amongst their findings, was that narrative identity was positively linked to wellbeing in later adolescence, but not in early adolescence. Based on their view of the importance of narrative identity as a source of resilience in adolescence, especially for young Māori, they recommend that future in-depth research is needed with younger adolescents to find out cause for this disparity, towards suitable interventions to "foster wellbeing" (p. 625). These recommendations may be considered for inclusion in future SEL research in NZ and align with the recommendations on the importance of identity by Macfarlane et al. (2017). For example, manaakitanga, the perspective for viewing and implementing SEL through an "indigenous lens" (p. 273), encourages teachers to recognize the importance of and support the cultural identity or "mana" (p. 283) of Māori students as a priority. This should foster an environment of "aroha" (p.283), the Māori concept of love and care, which in turn should foster the wellbeing of both Māori and non-Māori students

in such classroom contexts. Positive impacts on the self-efficacy and improved Māori identity perception of six Māori youth over the age of 16 years resulted from an earlier PYD Project K study conducted in a context of cultural care and support synonymous with manaakitanga (Hollis et al., 2011). These youth reported experiencing "ethnic equality [without it being experienced as] "race specific" (p. 56).

More recently, Dyson et al. (2019) reported their case study investigating NZ primary school teachers' perspectives of SEL. Amongst themes found were positive interdependence, which incorporated social awareness, social interactions and problem solving, respect for the self and others, care, empathy, and two key competencies of the NZ curriculum, namely self-management and relating to others. They also identified the SEL competency of self-awareness. In the category of care, they identified two Māori concepts of mana and aroha (p. 74), which is consistent with Macfarlane et al.'s (2017) perspective on manaakitanga. The case study teachers had different individual perspectives on how these SEL characteristics were conceptualised and developed. Dyson et al. noted that with respect to Te Whare Tapa Whā, the teachers focused on taha hinengaro (mental and emotional wellbeing) and taha whānau (social wellbeing). They observed that the teachers saw SEL more as a means for developing positive behavioural competencies and social and emotional skills. Dyson et al. recommend further qualitative research in NZ school-based settings related to their communities. They argue that understanding and delivering SEL requires a "careful entwining of practices and skills on the part of teachers, that naturally differs from school to school and class to class" (p.79). It must be observed in real world settings, and also obtain students' perspectives. While it is agreed that SEL approaches are "imperative, we still have a long way to go" (p.79).

Implications for Research, Conclusions and future directions

The field of SEL school-based research is vast, with comparably few robust research-informed analyses of "what works" (Malatest International, 2016, p. 8). Meta-analyses such as those of Durlak et al. (2011), Taylor et al. (2017) and Corcoran et al. (2018), confirm the effectiveness of well-designed and developmentally-appropriate interventions, which ERO (2015, 2016) and NZCER (Boyd et al., 2017) also find trustworthy. However, despite the size of this work internationally, these reviews have recommended further research. Further experimental research is needed to show more clearly the effect sizes of various interventions, and whether effects on academic performance are direct, or indirectly mediated through SEL outcomes (Corcoran et al., 2018; Tolan et al., 2016). However, RCT's require large sample sizes, and many SEL programmes are unique and delivered in responsive ways within specific contexts. This issue could be addressed by limiting the research to specific SEL programmes that are showing indicators of success (Corcoran et al., 2018). Comparative measurement studies mapping constructs across various

PYD and SEL models, intervention designs that focus on individual agency, and lifespan developmental research could be "valuable in moving the field towards a shared model" (Tolan et al., 2016, p. 232). However, equally applicable, given the meta-analyses and reviews, schools might consider interventions that focus in "promoting or enhancing individual capabilities" (p. 232). This recommendation aligns with a further point made by Corcoran et al. (2018), that qualitative research could also be useful to reveal the content and processes of SEL interventions. Taylor et al. (2017) recommend that "for school-based SEL to be an effective approach to fostering PYD, educators need support to implement and appropriately adapt interventions such as those in their current meta-analysis. Without quality implementation, the potential positive impact of SEL programming is reduced" (p. 1168). This perspective is echoed by Malatest International (2016), ERO (2015, 2016) and NZCER (Boyd et al., 2017), for consideration here in NZ.

The recent NZ research findings on student wellbeing nationally as discussed in this commentary, are of serious concern and need our urgent attention. If we can incorporate a Te Tiriti approach by including whānau, hapū, iwi, and community as part of the Tier 1 intervention model, we may be able to encompass the "cultural strengths" (Sanders et al., 2015, p. 50) that have been noted in NZ PYD research. By incorporating more qualitative, locally-based research as recommended by Dyson et al., (2019) and Corcoran et al, (2018), we may gain more insights into how teachers can be supported to deliver SEL in their immediate school contexts. We may also be able to assess the impact of any intervention on not only students' wellbeing, but also on specific academic outcomes such as found for reading and mathematics (Corcoran et al., 2018). Furthermore, the goal for older adolescents is that staff working with them, need to be trained and competent (Malatest International, 2016). This is also an important variable that is crucial for the success of SEL school-based interventions (Schonert-Reichl et al. 2017).

In conclusion, this commentary set out to explore social emotional wellbeing, to discuss the synergies and conceptual overlaps of SEL and PYD constructs underpinning school-based wellbeing approaches, and to show the mutual value of these perspectives to each other. Recent national and international research has been discussed, and ways in which the various SEL research findings might apply in designing a research-informed, developmentally-appropriate, and culturally- and linguistically-relevant intervention for trial implementation in NZ, have been highlighted. Relating the various international recommendations to those noted by Macfarlane et al. (2017), it seems that the time is right and appropriate to consider combining SEL and Māori cultural approaches in a pilot intervention study, that might weave the strengths of SEL and Te Tiriti approaches together, in a unique and relevant wellbeing programme for children and youth here in NZ.

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