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Mana Wāhine, Mauri Ora: Decolonising psychological practice in Aotearoa

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Abstract

Me aro koe ki te hā o Hine-ahu-one – "pay heed to the dignity and power of women"

Wāhine Māori (Māori women) reflect the intricate balance between life and death; the above whakataukī refers to the creation of the first Wahine Māori (Māori woman) in the flesh, and her transcendence from Te Ao Wairua (the spiritual world) to Te Ao Marama (the physical world). Wāhine Māori remain inherently tapu (sacred) within Te Ao Māori (a Māori world view) given our many roles, our kaha (strength) and our mana (prestige). Yet on our own whenua (land) we continue to be demarcated, diminished and disrespected by systems and frameworks within health and psychology that fail to reconcile our unique standing. This article explores the intersections of the field of psychology and its response to Wāhine Māori, centring the perspectives of two Wāhine Māori Kaimātai Hauora Hinengaro (Clinical Psychologists). We address the imminent need for redress to reposition psychology within Aotearoa New Zealand in a way that is responsive to the needs and aspirations of Wāhine Māori.

Keywords: Mana Wāhine, Wāhine Māori, decolonisation, Māori mental health, cultural safety, hauora, Mātauranga Māori, Indigenous

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Introduction

Within Te Ao Māori, Wāhine Māori hold a position of profound significance as Mana Wāhine (strong and prestigious women), embodying the balance of Mana Atua (spiritual power), Mana Whenua (connection to land) and Mana Whānau (familial strength and connection; Simmonds, 2011). Our roles and contributions are both vast and deeply valued in the sense we are life givers, nurturers, protectors, warriors and knowledge holders all of which underpins our inherent tapu (sacredness) and mana (prestige; Mikaere, 1994; Stanley, 2016; Maydell, 2018). This can be seen today in the way Wāhine Māori continue to be at the forefront of initiatives for the betterment of our people, such as language revitalisation, hauora (wellbeing) initiatives, parenting and whānau (family) support, storytelling, advocacy and leadership (Forster et al. 2016; Rameka, 2018). Embodied within such leadership is a focus on mana motuhake (autonomy), and tino rangatiratanga (self-determination).

For generations, Wāhine Māori have been central to the preservation and transmission of tikanga (customs), mātauranga (knowledge) and wellbeing practices (Ruwhiu, 2009). Our links to both the spiritual and physical worlds enable us to be pou (pillars) in supporting our whānau, hapū (sub-tribe) and iwi (tribe) to navigate the interconnectedness of life and death (Moeke-Pickering, 1996; Pihama & Panehira, 2005). Māreikura (esteemed women) feature heavily within our histories as Māori beginning with Atua such as Papatūānuku (the Earth Mother), the various iterations of Hine, Muriranga-whenua (Maui's grandmother) and Taranga (Maui's mother). From there we have our Tīpuna Tapairu (chieftainesses, esteemed tribal leaders) such as Whakaotirangi (Tainui), Rongomaiwahine, Muriwai (Te Whakatōhea), Wairaka (Ngāti Awa), Hinepoupou (Ngāti Kuia), Ruapūtahanga (Ngāti Ruanui) and Rohi (Kāi Tahu). In more recent times we have Rangatira (leaders) such as Princess Te Puea Hērangi, Te Arikinui Dame Te Atairangikaahu and 'mother of the nation' Whina Cooper; and Kairangahau (researchers) such as Professor Linda Tuhiwai Smith, Ngāhuia te Awekōtuku and Dr Tahu Kukutai. This pattern of effective, assertive and fierce Wāhine Māori leadership spans to present day Mana Wāhine with the likes of our youngest politician Hana-Rāwhiti Maipi-Clarke, the newly appointed leader of the Kingītanga Te Arikinui Kuini Ngā Wai Hono i te Pō Pootatau te Wherowhero viii, and the late founder of te Pāti Māori, Tariana Turia.

Wāhine Māori exist within a sex, gender and sexuality continuum which is inclusive of whānau who identify as Takatāpui (Māori of diverse gender, sexuality and sex characteristics). The colonial invention and problematic polarity of a male/female gender binary (Berryman-Kamp, 2024) does not serve Wāhine Māori or Takatāpui. The reconstruction of Māori gender identities is not without critique (Hamley, 2022) and it should be acknowledged that historical understandings of gender roles may differ in how gender plays out for Wāhine Māori today. Māori traditional rituals such as oriori (lullabies created before birth to outline a child's ancestral characteristics and place in community) and our 'gender neutral' term 'ia' (meaning he/she and they) suffice as evidence that one's 'ira' (essence, life principle, gene) was and is deemed of great significance perhaps over and above one's sex, gender of sexuality. The mana of Wāhine cannot be seen in isolation from Mana Tīpuna (ancestral power/prestige), Mana Tipua (supernatural creatures who could change form or gender), Mana Takatāpui (the inherent dignity of sex/gender/sexuality diverse Māori), and of course of Mana Tāne (strong and prestigious men). In their 2015 publication Takatāpui: Part of the Whānau, Dr Elizabeth Kerekere states that "issues of gender and sexuality cannot be fully resolved for takatāpui until the mana of Māori women is restored throughout Māori culture and society (p.18)."

Wāhine Māori exist in the context of colonial systems which seek to undermine and subjugate our mana and disrupt our traditional roles and narratives. 256 years post first contact and 185 years since the signing of Te Tiriti o Waitangi, the deliberate and violent imposition of colonisation on Māori continues in its failed attempts to diminish the power of Wāhine Māori. We continue to face deficit-focussed stereotypes that misrepresent our true essence and position (Gemmell, 2013). As Simmons (2011) highlights, colonisation has sought and continues to seek to fracture the balance between Mana Wāhine, Mana Whenua, Mana Whānau, and Mana Atua. These deliberate attacks on Wāhine Māori, are a mere replication of colonial efforts to subjugate Indigenous women worldwide. By disrupting these roles, colonial systems attempt to weaken Wāhine Māori as cultural anchors and in turn, effect the collective strength of our communities and our future generations.

Deficit misrepresentations persist today in narratives that label Wāhine Māori as aggressive, overly sexual, welfare dependent, poor parents, uneducated, unambitious, victims, substance dependent or

criminals (Lewis, 2021). For example, Māori mothers are often demonised as being 'unfit' or 'too young,' while little attention is given to how the disruption of traditional whānau structures, once central to supporting Māori mothers, has contributed to these challenges (McFayden, 2018). This in turn has silenced the realities, voices, worldviews, roles and needs of Wāhine Māori. Problematising this further, narratives of fetishisation and exotification (i.e. the 'dusky maiden') that affect Wāhine Māori, and our stories are otherwise defined as myths or a figment of the cultural imagination (Pihama 2001).

Gender-binary based re-imaginings of Wāhine Māori can be equally problematic—as described in the common misconception or kawa and tikanga related to marae protocol (i.e. karanga, waiata, seating and speaking positions) get re-constructed into Western ideology as oppressive or patriarchal. Additionally, even Wāhine Māori have contributed to the denigration of Wāhine Māori through early mana wāhine theory overemphasising te whare tāngata (the womb, house of humanity), thus excluding kōtiro (girls), kuia (elder women), infertile women, women who cannot menstruate and whakawāhine (those born with the wairua of a woman, transgender women). These limited narratives of our experience have contributed to the conceptualisation that Wāhine Māori are cast as second-class citizens on our own whenua (Murphy, 2011; Menzies, 2023). The inadequacy of these narratives must be challenged (Rautaki, 2008; Whānau, 2020). We categorically reject reductionist, sexist, racist and essentialist conceptualisations of what, and who, it is to be Wāhine Māori.

This article explores the intersections of psychology and its relationship with Wāhine Māori, posing the question; does the field of psychology honour or diminish the mana of Wāhine Māori? This article is written from the perspective of two Wāhine Māori Kaimātai Hauora Hinengaro currently practicing in mental health. Key Te Reo Māori terms are deliberately capitalised as a reflection of our perspective and in resistance of western and colonial linguistic convention. By grounding this article in resilience and aspirations of Wāhine Māori, we aim to envision a psychology that centres our voices, needs and strengths.

History of psychology in Aotearoa

Despite the altruistic foundations, and the genuine desire of many psychologists to help others, the field of psychology has not been immune to the oppressive systems that pervade society worldwide and within Aotearoa New Zealand (Harris et al. 2012; Houkamau et al. 2017; Waitoki et al. 2024). From its very inception and development, psychological theories, models and practices have been influenced by societal beliefs and power structures (Prilleltensky, 1997; Rudman & Glick, 2021). This has often resulted in approaches that, rather than liberating, have perpetuated harm – sometimes unintentionally and other times deliberately – towards Indigenous communities. Critically, psychologists operate with the New Zealand Mental Health system which recent studies demonstrate is currently operating disproportionate diagnostic overshadowing and inadequate treatment of Māori (Cunningham et al., 2023), inequitable access to Kaupapa Māori services (Te Hiringa Mahara Mental Health and Wellbeing Commission, 2023) and alarming use of medical and physical restraint and seclusion (Te Aka Whai Ora Māori Health Authority, 2024) for Māori Tāngata Whai i te Ora (people seeking wellbeing/patients).

It was not that long ago that psychology played a significant role in some of the most harmful and unethical practices in modern history. For instance, right here in Aotearoa New Zealand, psychologists contributed to the field of eugenics (Garton, 2010; Spencer, 2018), directly influencing policies that promoted the idea that certain populations (i.e., Māori, or disabled people) were inherently inferior. These policies aimed to control, assimilate and/or eliminate Māori for the betterment of society (Metcalfe, 2000; Paul et al. 2018). Psychologists played a role in labelling so-called 'mental defectives' which disproportionately targeted Māori. Ways in which this played out for Wāhine Māori also included control and disparities of access regarding reproductive rights and the traumatic uplifting and rehoming of Tamariki Māori (Māori children) from their Māori parent/s. The legacy of these structural and inbuilt inequities continues to affect Wāhine Māori in continued efforts to erode cultural practices, access to healthcare and mana.

While the field of psychology has made significant strides in ethics, inclusivity and respect for human dignity we cannot ignore our ties to the troubling past. These belief systems - rooted in power, control and a false sense of superiority - are not mere relics of the past; they persist within psychological practices today (Wairoa-Harrison et al. 2023). Many psychologists may think 'I do not cause harm', a sentiment we have heard many times as students and now as practicing psychologists. Psychologists are not bound to the Hippocratic Oath taken by medical Doctors but are bound by ethics and codes of conduct which echo the sentiment of 'do no harm'. Under

Section 3 of the Health Practitioners Competency and Assurance Act (HPCA, 2003), Psychologists must "protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions". This alludes to an individual and collective responsibility we have in both mitigating and acknowledging our contributions towards harm with regards to Wāhine Māori. Psychology is not exempt from harm, and we must embrace opportunities for nuanced reflection.

There are legal frameworks enforced by the New Zealand Psychologist Board as a Regulatory Authority which should be responsive to the needs of Wāhine Māori. Psychologists practicing in Aotearoa New Zealand must abide by the Code of Ethics (2002) which explicitly mentions Māori with respect for the dignity of persons and peoples (Principle 1; section 1.3), emphasis on responsible caring (Principle 2) and integrity in relationships (Principle 3). In 2011, Cultural Competencies were further explored in a five-page guide issued by the New Zealand Psychologists Board. Unfortunately, these documents are woefully inadequate and the outdated focus on cultural competence rather than cultural safety has been widely criticised (Curtis et. al., 2019). Despite rapid innovation in Māori models of mental health and Māori contributions to Indigenous psychology broadly (often spearheaded by Wāhine Māori), it has taken the New Zealand Psychologist Board until last year (2024) to issue a proposed change through Te Tikanga Whanonga me te Matatika: The Code of Conduct and the Code of Ethics. It should be noted that progress within the field of psychology in Aotearoa, and specifically within Māori and Indigenous psychology has actualised due to significant contributions from Wāhine Māori academics and psychologists such as Professor Waikaremoana Waitoki, Professor Linda Waimarie Nikora, Dr Makarena Dudley, Professor Suzanne Pitama, Dr Leonie Pihama and Dr Michelle Levy to name a few.

Evidence shows that psychology continues to pathologise Māori, uphold western-centric models and perpetuate biases that cause harm (Wairoa-Harrison et al. 2023). Unless we actively decolonise and (re)indigenise our practice, dismantle power structures and address systemic racism, psychology risks complicity and active participation in ongoing harm. There is no room for neutrality, passivity or turning a blind eye to psychology's dark past, especially when its echoes linger in the present day. It was only in the last five years that a group of psychologists claimed that Mātauranga Māori (Māori knowledge) was 'not science'; perpetuating the very biases and western-centric perspectives that continue to harm Māori communities (Waitoki, 2022). We are now situated within recent governmental decisions, such as the disestablishment of Te Aka Whai Ora (the Māori Health Authority) in early 2024 and the majority opposed Treaty Principles Bill grounded in a colourblind agenda, which raises alarming concerns about the future direction of Māori health initiatives which will impact directly on Wāhine Māori and our wider hāpori (communities).

Implications for Wāhine Māori

There have been significant implications for Wāhine Māori in Aotearoa New Zealand who have interacted with the profession of psychology. These impacts are multifaceted and rooted in the intersection of colonialism, racism and sexism. Findings from the Waitangi Tribunal claims Wai 2700 and Wai 2725 provide insights into how these dynamics have shaped inequities and caused harm in health and psychology.

The Wai 2700 – Mana Wāhine Kaupapa Claim focusses on historical and ongoing grievances that have affected the rights, status and wellbeing of Wāhine Māori due to consecutive breaches of Te Tiriti by the Crown. It outlines systematic policies that undermined the role and status of Wāhine Māori, leading to social, economic and cultural marginalisation. The continued impact for Wāhine Māori has led to disparities in health, education, employment and justice. For example, the pay gap is so inequitable for Wāhine Māori we are essentially working for free from the start of November every year (Perese, 2024). The Crown has been directly responsible for perpetuating these disadvantages while simultaneously failing to protect the rights and status of Wāhine Māori guaranteed within Te Tiriti o Waitangi and the Treaty of Waitangi.

The Wai 2725 report spearheaded by Dr Michelle Levy is concerned with the failures to deliver culturally compliant and safe psychological services to Māori. This is inclusive of the failures of the Crown to ensure psychology as an academic discipline and profession is safe and accessible to undertake. This claim highlights that there is insufficient training, inadequate support in developing the Māori workforce and insufficient incorporation of Māori perspectives and needs in the provision of psychological services. This has meant Wāhine Māori have been disadvantaged not only as Tāngata Whaiora but also as professionals seeking to study and practice as psychologists. In our case, we

practice at the intersection of being both tāngata whaiora with lived experience and in being Wāhine Māori Kaimātai Hauora Hinengaro. This is a place where whakawhanaungatanga (i.e. peer supervision, forums for Wāhine Māori psychologists to gather) is critical to both our cultural safety and longevity in the profession.

Both claims are significant and must be understood together given our intersections to fully grasp the injustices faced by Wāhine Māori within psychology. It is our experience these barriers often overlap in ways that are difficult to untangle, demonstrating just how pervasive the issues and impacts are. The Wai 2700 claim focuses on the intersections of gender, culture, and identity, while the Wai 2725 claim highlights the impact of these injustices on health and education. Together we demonstrate the complex and ongoing barriers Wāhine Māori navigate when accessing psychological support, as we contend with the overall marginalization of our cultural identity and systemic inequities within health services.

Disruptions to land, language, and whānau structures have severed many Māori from our cultural foundations, leading to cycles of disadvantage that persist across generations (Gemmell, 2013). For Wāhine Māori, this trauma can manifest as so-called 'disconnection' from whakapapa, diminished access to traditional support systems, and struggles to reclaim cultural identity in a society that has historically marginalized our voices (Wirihana & Smith, 2019). These compounded challenges are not just individual experiences, they ripple through whānau and communities, perpetuating inequities in mental health, education, and wellbeing. This is most evident in the overrepresentation of Wāhine Māori in incarceration rates and our experiences within family and children social services – both historically and currently (McIntosh & Workman, 2017; Stanley et al. 2920; Aho, 2022).

Barriers to Hauora and Psychological Care

The intersection of gender, culture, and identity creates significant barriers for Wāhine Māori within the mental health system. Many of our Māori models of hauora have become normalised in the health sector (i.e. Te Whare Tapa Whā - Durie, 1994; Meihana Model; Pitama et al., 2007). Māori understandings of hauora (wellbeing) are that it is an interconnected collective experience between atua (deities, higher powers and/or ancestors), tāngata (people) and whenua (land), emphasizing the strength, resilience and the wellbeing of the collective relationships (Mark & Lyons, 2010). In contrast, western psychological approaches often frame mental health issues as sourced within the individual and within a deficit lens (Chakkarath, 2010), leading to a profoundly different conceptualisation of wellbeing as both a concept and a lived experience. Wāhine Māori live within this contradictory and colonised reality (Mikaere, 1994) whereby the misalignment of worldviews fosters mistrust and reluctance to seek help. For Wāhine Māori there is valid fear and apprehension as we are exposed to stigma, racism, and are aware of the potential cultural labour required during our own care (Jeffery, 2005, Dew et al. 2007). We have witnessed countless times the oversight of cultural nuances within practice, which result in an added layering of marginalising and in some cases trauma for whaiora as well as kaimahi Wāhine Māori.

When Wāhine Māori do engage in psychological services (not always consensually) our experiences often differ starkly from our non-Māori counterparts. For instance, cultural experiences like Matakite (foresight) or Matekite (insight) are at risk of pathologisation (Niania, Bush & Epston, 2016) as opposed to acceptance or understanding from a cultural lens (Kopua et al., 2020, Lindsay et al., 2022). This shows a broader inability within mental health frameworks to hold space for cultural experiences. Instead of allowing both clinical and cultural perspectives to exist together, clinical perspectives are favoured and treated as more valid than the other. This results in misdiagnosis, inappropriate treatment, reinforcement of negative stereotypes, deprivation from cultural understanding and the prevention of cultural safety; each of these factors contributes to delays in accessing care and intensifies experiences of being misunderstood, isolated, and unsupported. (Bishop, 2005; Kopua et al. 2020). Research shows that Wāhine Māori are twice as likely to have a diagnosable mental disorder compared to our non-Māori counterparts and exhibit a greater severity of symptoms at presentation partly due to these systemic failures (Ease, 2007; Tricklebank, 2017). We often think about the number of Wāhine Māori dealing with misdiagnosis within a system in which we don't feel safe or heard. The enormity of responsibility to our people in this regard is taumaha (heavy), but it is a privilege for us to navigate and advocate on behalf of fellow Wāhine Māori.

Inaccessibility of traditional Māori healing practices further exacerbates issues of adequate and culturally safe mental health care for Wāhine Māori. Policies like the Tohunga Suppression Act of 1907 rendered Tohunga as illegal creating consecutive generations

dislocated from Mātauranga Māori, hauora practices and resources (i.e. land, economic and people) (Woodward, 2014, Wirihana & Smith, 2019). Although repealed in 1962, its legacy persists, with healing practices like Mirimiri (traditional healing massage), Romiromi (deep tissue bodywork), Taonga Puoro (traditional musical instruments), and other forms of Rongoā (Māori healing) often inaccessible, whether that be a loss of access within whānau, hapu and iwi, and often not offered with mainstream services (Durie, 2009) despite finding recent 'legitimacy' through Rongoa Māori ACC funding and MoH contracts. In addition, understandings of Wāhine Māori as tohunga are poor despite many historical examples including the late legendary Rangimārie Te Turuki Arikirangi Rose Pere. Even when Māori healing practices are incorporated into care, they are often viewed as secondary to western approaches, and remain under-resourced and under-threat in terms of funding, time, kaimahi (workers) and support. Wāhine Māori psychologists, such as ourselves often come to form dual roles in both the practice of psychology and of hauora Māori healing practices. We hold hope for the day interventions such as Taonga Puoro, mirimiri or rituals such as pure and whakawetewete are offered before medication is considered (Ahuriri-Driscoll et al. 2008) or in support of the reduction and/or cessation of ineffective, metabolically burdensome and spiritually destructive psychiatric medications.

Wāhine Māori psychologists are a minority within a minority. Māori psychologists comprise 6% of the psychological workforce, despite recent emphasis on the critical need to train more tauira Māori (Levy, 2002; Waitoki et al. 2023). This leaves huge gaps between the services Wāhine Māori need and the people equipped to deliver them. As outlined in Wai 2725, psychology programs prioritise western models over Māori models, leaving many practitioners ill-equipped to provide culturally safe care (Morunga, 2009; Waitoki et al. 2023). The plan moving forward for the profession of psychology to bridge this gap between practice and whaiora needs remains unclear. These gaps leave Wāhine Māori underserved, while those entering the profession face systemic barriers, the combined forces of sexism and racism as well as the impacts of cultural erasure, lateral violence and tokenism within our training and practice.

Distinctive needs of Wāhine Māori

Wāhine Māori present with distinctive needs and therefore require tailored approaches and considerations within psychology. This means the future involves avoiding a one size fits all mentality that assumes best practice for one group is best for everyone.

For Wāhine Māori, our Māoritanga (expression of cultural identity) is deeply rooted in whakapapa (genealogy), connection to whenua (land), and Te Ao Māori (the Māori worldview; Waitoki et al. 2018; Ngawhare, 2019). These elements provide a foundation of belonging and continuity that is central to our wellbeing. Whakapapa connects Wāhine Māori to our tūpuna (ancestors), our whānau (family), and our descendants, creating an intergenerational framework of support and responsibility (Jahnke, 2002). This relational identity transcends the individual. embedding Wāhine Māori within a collective network of people, whenua, and atua (spiritual beings).

Relationships within Te Ao Māori are not limited to the physical world; we exist beyond time, carrying significance on a spiritual level. These connections are not always tangible in the present or physical sense, but we are never null or void, even for those who may not feel deeply entrenched in us (Mark & Lyons, 2010; Nikora et al. 2013). We avoid using the word disconnected to describe everyone's links to our whakapapa, as it implies a severing or break. These connections are not broken, nor are the people experiencing the mamae (emotional pain) and pāmamae (trauma) of not yet knowing who they are. Instead of disconnected we are dislocated, waiting to be reset and for our potential to be revealed. Whakapapa can never truly be unlinked, no matter how distant it might feel or how little someone knows or expresses. Clinicians can be directly responsible for the use and misuse of the term 'disconnection'. The term may be reserved for specific experiences – such as closed adoptions – where whakapapa connections have been legally severed or erased and cannot always be found or re-created. This nuanced distinction is important for clinicians to be aware of when working with Māori, while reserving space and care for those who may describe their lived experience as a sense of 'disconnection'. The term is often used to express feelings of ambivalence or distance, yet is not always the reality of the situation or something that needs to be pathologised.

Due to colonisation, the disruption of whakapapa, knowledge systems, and relationships with people and whenua (land) has created a spectrum of what it is to be a Wāhine Māori—how it feels, looks, and is expressed (August, 2004; Tahere, 2023). Any

feelings of dislocation or isolation within this spectrum should be approached with curiosity and exploration, not condemnation or pathologisation within an individual framework. We have witnessed colleagues scapegoat Wāhine Māori (and Māori in general) in their rejections of cultural identity as absolution for providing any cultural support or care. In extreme instances, we have witnessed colleagues go as far as incorrectly coding whaiora ethnicity data as non-Māori due to poor understanding of identity politics, inequity and the impacts of colonisation. Māori whaiora belittling or minimising their own cultural identity is not a free-pass to exempt clinicians from culturally safe care. Every therapeutic interaction with whaiora Māori is an opportunity to challenge the internalised deficit narratives that burden our people. Wāhine Māori deserve clinical relationships, empathy and care that respect our identities and wellbeing.

To effectively support Wāhine Māori, psychology must move beyond western frameworks that fail to account for cultural, spiritual, and historical contexts. Wāhine Māori wellbeing is shaped by our cultural identity, our role as Mana Wāhine and our connection to tikanga Māori (Māori customs and values; Ruru, 2016). This requires approaches that honor and integrate our cultural values, uphold our mana, and address the systemic injustices that have limited our ability to thrive. Understanding and addressing the concept of Mana Wāhine is particularly vital within psychological practice. Mana Wāhine reflects resilience, leadership, and intergenerational strength (Ruru, 2016). This is seen in upholding of tikanga and kawa practices across generations, for example the taking off shoes at the front door, removal of a hat during karakia or use of water to cleanse. It is also seen in the intuitive and instinctual aspects of Mana Wāhine where knowledge and practices are drawn from the spiritual realm, through experiences such as matekitetanga (spiritual giftedness). This can be evident through instinctive habits or when someone may not be able to describe the term wairua but can describe the felt and embodied sense of being Wāhine Māori in connection with our whenua, our tangata and atua.

Western psychology, as it is currently taught and applied, often emphasizes rigid therapeutic modalities that are not always aligned with the holistic needs of Wāhine Māori (Mika, 2019). For instance, the preoccupation with compartmentalised approaches to health frequently overlooks the interconnectedness central to Te Ao Māori. While it is essential to attend to immediate risks and safety within therapy, there is often a failure to zoom out and address the broader picture of wellbeing (Waitoki et al. 2018). This includes recognising the centrality of relationships in the lives of Wāhine Māori. For psychological frameworks to be effective, we must integrate Māori values and practices, centering the cultural and spiritual dimensions that are intrinsic to Wāhine Māori wellbeing. This requires shifting away from deficit-focused models to strengths-based approaches that reflect the aspirations and lived realities of Wāhine Māori. By prioritising holistic and culturally grounded methods, psychological services can begin to uphold the mana of Wāhine Māori, honouring our unique identities and supporting our journeys toward hauora (wellbeing).

Altering the therapeutic space

Creating a therapeutic space that truly supports Wāhine Māori requires intentionality, cultural humility, and a willingness to challenge existing practices or norms even within one's own practice. To dismantle systemic barriers and honour the distinctive needs of Wāhine Māori, practitioners must actively reshape the therapeutic environment to centre cultural identity, values, and wellbeing.

Whakawhanaungatanga is the process of establishing and nurturing meaningful and reciprocal relationships. In therapy, this involves creating trust and connection not just at an individual level but by recognising and respecting the client's broader connections to our whānau, whakapapa, and whenua. Whakawhanaungatanga is not a once-off event, it's a practice that evolves throughout the therapeutic relationship to reflect the natural changes, ebbs and flows and trust within a relationship. It is by virtue reciprocal in nature ensuring that wāhine feel valued and supported as whole individuals, deeply connected to our cultural identity.

Recognising and demystifying colonial narratives that perpetuate the marginalisation of Wāhine Māori. In our experience, reframing the narrative and lens can shift unconscious bias. For example, replacing deficit and medical model focussed assumptions with strengths-based perspectives, this can not only alter the way therapists view Wāhine Māori but also empower whaiora to reconnect with their resilience and mana. Strengths -based practice must be applied with intention and must not be misinterpreted as simply being positive. 'Toxic positivity' refers to a practice in which negative and oppressive realities are minimised in favour of acknowledging strengths in a manner that is disproportionate to the lived experience a whaiora is going through.

We suggest a focus on the haerenga ki te hauora (journey to wellbeing). As well as this, a reversal or 'flip the script' so that rather than labelling someone as disconnected from their whakapapa, you might frame it within the context of whaiora living off their papakāinga (homelands) or tūrangawaewae (place of belonging) or not yet having the opportunity to learn more about themselves. Acknowledging that whaiora may have limited knowledge of their whakapapa due to colonial influences such as land loss, migration, urbanisation, whāngai, adoption, uplift/removal are all contextual markers that give a more complete narrative. When we seek to find out what exactly took place across the last several generations, we offer both a reframing of the lens and a powerful therapeutic intervention.

Intersectionality. Practitioners need to consider our own intersectional identities and how these influence our practice. This includes understanding how our own power, privilege, and cultural background intersect with the experiences of Wāhine Māori. For instance, a Pākehā (non-Māori of British or European decent) or tauiwi (non-Māori) psychologist may reflect on when our Te Tiriti journey began in this country and contextualise it amongst events at the time or reflect on how our western training shaped our assumptions about mental health – and how these may inadvertently cause harm. Wāhine Māori practitioners are not exempt to considerations of intersectionality also. For us, considerations of colourism and so-called 'white passing' privileges are critical in understanding our positionality and its effects on whaiora in our therapeutic relationship. By recognising these dynamics, therapists can better understand how societal systems of oppression, such as racism, sexism, and colonisation, affect our whaiora and the therapeutic relationship. Regular supervision of a clinical cultural nature is essential in developing a more empathic and equitable therapeutic space.

Cultural labour can be burdensome to both whaiora and therapists. Therapists must create a space where Wāhine Māori feel safe and valued without the added burden of educating our therapist on basic cultural concepts or practices. This requires practitioners to acknowledge our own limitations and actively learn about Te Ao Māori, tikanga, and Māori models of health before sessions. By embedding culturally informed practices—such as opening with karakia or integrating Te Whare Tapa Whā—therapists demonstrate cultural humility, reducing the need for whaiora to explain or advocate for culturally safe care. Understanding the historical impacts and ongoing process of colonisation in Aotearoa is also critical in avoiding the harm of cultural labour for whaiora, and can also be transformative as a psychoeducational tool in supporting whaiora to engage in understanding themselves. When practitioners take responsibility for cultural competency and cultural safety, the therapeutic space becomes a place of shared respect rather than a source of additional labour.

The concept of mana and being mana enhancing should be in the forefront of all work with Wāhine Māori. Models such as Dynamics of Whanaungatanga emphasise the need to restore tapu (wellbeing, sacredness, that which needs protecting) and enhance mana. Drawing from a Kaupapa Māori framework Wāhine Māori voices, experiences, and strengths should take centre stage. By virtue, this acknowledges our spiritual, cultural, and social power while challenging colonial and patriarchal structures that have sought to diminish our roles. Psychologists would benefit from taking a strengths-based approach in considering if our practice is enhancing the mana of the wāhine we work with. A good rule of thumb is to write as though your whaiora will read what you've written and that in doing so you do not want to whakaiti tōna mana (diminish their mana). This means ensuring that the therapeutic voice generalises into all aspects of work.

Prioritising Te Ao Māori. Rather than attempting to "add" cultural elements to existing western models, therapy should start from a foundationally Māori cultural lens and overlay psychology where appropriate. This means prioritising Māori worldviews, values, and models of wellbeing as the default of therapeutic work with Wāhine Māori. For example, using Whakapapa Kōrero (genealogical storytelling) and Karakia (incantation, intention setting, prayer) as integral parts of the therapeutic process before introducing other modalities ensures that care aligns with the client's identity and values. For non-Māori therapists, this may be a confronting challenge to clinical practice. For Māori therapists, cultural and clinical practice can be considered one in the same and the lack of kaimahi Māori throughout mental health can place immense pressure on us to uphold kaupapa Māori in all spaces (Te Aka Whai Ora Māori Health Authority, 2024). Another way of looking at this is that working with Māori whaiora we are all presented with a direct opportunity to show our whaiora that their identity, culture and worldview are valued, important and critical to their healthcare and healing.

Prioritising Clinical and Cultural Supervision. To genuinely support Wāhine Māori, practitioners—especially non-Māori therapists—must engage in regular clinical and cultural supervision. Therapists should use this opportunity to discuss how our positionality may interfere with culturally safe care and to seek guidance on integrating culturally responsive approaches. Racism within health and psychological systems remains a significant barrier for Wāhine Māori (Espiner et al. 2021; Wikaire et al. 2023; Haitana et al. 2023). Therapists have a responsibility to recognise and address racism wherever it arises, whether within our organizations, professional networks, or therapeutic practice. Calling out racism is not a one-time act but an ongoing commitment to dismantling systemic inequities and advocating for equitable care. This also includes standing as allies for Wāhine Māori and amplifying our voices within professional and public spaces.

Central to altering the therapeutic space is recognising and honouring the mana of Wāhine Māori. This is also inclusive of us, Wāhine Māori psychologists who are often approached for cultural expertise and labour above and beyond our assigned roles. Acknowledging the mana of Wāhine Māori means acknowledging our inherent strength, resilience, and sacred roles within our families and communities. If these are not present or easily accessible during therapy, then this is a good indicator where supports may need to be brought in. As with any matter in psychological care, being reflexive and willing to step aside if needed, or even acknowledging when you may not be the right person to help are all responsibilities of clinicians in delivering better therapeutic care for Wāhine Māori.

To create a culturally safe and empowering therapeutic environment for Wāhine Māori, therapists can take the following actions:

Use Te Reo Māori. Incorporate Te Reo Māori in therapy to acknowledge and honour cultural identity. Simple practices such as greeting whaiora with kia ora or closing sessions with ka kite. The next step would be incorporating Te Reo Māori in written form when communicating to and about your client. Our words have power and as psychologists the kupu (words) we choose influence and shape the narrative people have of someone and how we will respond to us. Te Reo Hāpai (2020) is a recently developed resource with transliterations and understandings of mental health using kupu Māori. This rauemi (resource) can be a powerful therapeutic intervention in ascertaining an alternative or more culturally congruent understanding of someone's experience of mental distress.

Incorporate Karakia. Offer to open or close sessions with karakia, allowing space for spirituality as part of the therapeutic process. This practice can create a sense of safety and connection, grounding the session in cultural practice. This should always be an offer and the responsibility of the therapist, and regardless of the answer given, a conversation should follow to explore the person's relationship with karakia, our experience of karakia and how we find it within the session, particularly if you are non- Māori using karakia. Non-Māori practitioners should be aware that karakia are not all prayer or Christian. Kara comes from the kupu karanga to call, ki towards, a something else, therefore karakia is about setting intentions and providing a holding space that can be formally opened and closed. There are a multitude of reasons why someone may or may not want karakia performed. If the reason provided is that they do not know any or are unfamiliar, this presents an important opportunity to safely and supportively introduce whaiora to a powerful therapeutic intervention with generalisability into other areas of life. Again, this is an ongoing kōrero, from experience people may decline in an initial session and change their mind once more comfortable within the therapeutic space.

Formulate from a Cultural Model. Using Māori models of health such as Te Whare Tapa Whā, the Meihana Model or Dynamics of Whanaungatanga provides a framework for understanding wellbeing that prioritises relational and spiritual dimensions. These models not only align care with Wāhine Māori lived realities but also influence the lens through which a client is viewed, reframing challenges within a culturally grounded context.

By integrating these models, therapists can more effectively balance clinical and cultural needs while maintaining the integrity of both approaches. We allow space to address concepts like mana (prestige, authority, and inherent power) and wairua (spiritual health) alongside clinical considerations, such as risk and safety. For example, a therapist working within the Meihana Model can explore what has happened to affect a whaiora's journey (Ngā Hau e whā - the four winds) as well as what keeps them going (Ngā Roma Moana, the waves that push you forward) as well as analysing the role of services (Iwi Katoa/Ratonga Hauora) with regards to exploring past experiences and current perceptions of the healthcare system. If formulating from Dynamics of Whanaungatanga, therapists may be able to pinpoint

the various whakanoa (transgressions, removal of tapu i.e. abuse) that have affected whaiora tapu-i (internal wellbeing) and tapu-ō (external/relational wellbeing).

Centre Mauri and Wairua. Therapists can integrate mauri (life force) and wairua (spiritual wellbeing) into sessions by creating space for whaiora to explore our connections to people, whenua and wairua, this might include practical steps like asking about daily practices that nurture our mauri or discussing how significant relationships impact our mauri. For example, you might ask, "What strengthens your sense of balance and vitality?" or "How do you feel connected to your whenua or tūpuna?" or "How would you like to be connected to your whakapapa?"

When mauri or wairua feels disrupted, the focus can shift to supporting finding balance. This could involve guiding whaiora to reflect on times when we felt a stronger sense of spiritual alignment, facilitating karakia (as its more than just a tikanga practice) during sessions if appropriate, or incorporating whakataukī that resonate with our experiences.

Explore Connections. Begin therapy by exploring the client's relationships with mana whenua, mana atua and mana whānau. These connections often hold key insights into our sense of identity and wellbeing. Practical questions such as "What role does your connection to whenua play in your life?" or "Are there spiritual practices or beliefs that feel important to your hauora?" can help ground the conversation in what is meaningful to the client. Sometimes tikanga and kawa are upheld in the whānau in practical ways that may not seem 'cultural' to Māori whaiora, for example 'did you grow up in a household where you take your shoes off at the door? Or do you separate your bathroom towels from your tea towels?' (these delineate tapu/sacred from noa/neutral and ordinary). Another example is 'who makes decisions in your whānau? How many generations live at home?' (these questions relate to collectivism and intergenerational living).

This approach avoids pathologising disconnection and instead situates challenges within a broader cultural and historical context. For example, if a client expresses feeling distant from our whenua, this can be understood as a reflection of external disruptions rather than a personal shortcoming. Acknowledging these relationships early on creates a culturally safe starting point for therapy and ensures that care aligns with the client's lived reality.

Focus on Mana. Therapy with Wāhine Māori should focus on enhancing, fostering and upholding mana—our inherent strength, authority, and dignity. Understanding mana involves exploring how it is expressed in our lives, the factors that enhance or diminish it, and what wellbeing looks like when standing fully in our mana. This shifts the therapeutic focus beyond symptom reduction, which often aligns with a medical model, and toward a holistic understanding of what it means to thrive.

For Wāhine Māori, standing in our mana might involve reconnecting with whakapapa, embracing cultural practices, or feeling empowered in our roles within whānau and community. This approach moves beyond merely treating symptoms to supporting a state of flourishing that is deeply rooted in identity and resilience.

Contextualise the haerenga (journey). Spend time exploring the whaiora's haerenga to your service, considering the cultural, systemic, and personal barriers we may have faced to get there. This approach avoids pathologising and situates our experiences within a broader social and historical context. Far too often the questions begin at "What has your journey been like in finding support?" or "What has worked for you in the past?", which are great questions but again focus on the individual. Instead, you might also ask, "What were some of the biggest changes your whānau has experienced in recent generations?" or "What role has your whānau or community played in shaping where you are today?". This approach situates the client's experiences within a broader social and historical context while creating space for us to reflect on the impacts of systemic disruptions, such as colonisation, in a way that feels natural and non-confrontational.

Acknowledge intergenerational trauma. Validate the impact of intergenerational trauma caused by colonisation, such as disruptions to land, language, and whānau structures. Frame this as a systemic issue rather than an individual failing, while supporting the client's journey toward healing. Normalising these kōrero is crucial, as it helps whaiora understand that our experiences are not a reflection of inherent shortcomings or personal failures. Instead, we are the result of historical and systemic breaches of Te Tiriti o Waitangi, which have caused significant hurt and trauma for many whānau.

Shifting the focus away from self-blame allows whaiora to see ourselves in the context of a much larger story. Sharing knowledge about these

historical and systemic influences empowers whaiora by helping us contextualise our struggles. It is important to recognise the years of misinformation around Aotearoa New Zealand history. This understanding can reduce feelings of shame and open mental space to focus on what is within our control.

Acknowledge intergenerational strengths. A narrative will remain incomplete and one-sided without the acknowledgement of the gifts that get passed down through whānau. The context of intergenerational trauma and its severity can overshadow and overwhelm tāngata whaiora and diminish their sense of hope. Therefore a balanced approach to understanding the historical impacts of trauma and the factors that contribute towards an ability to survive and thrive is necessary.

Many of our whaiora Wāhine Māori are unaware of their taonga tuku iho (ancestral gifts) and may require therapists to gently and repetitively draw out and reinforce these. For some Wāhine Māori, taonga tuku iho may manifest in particularly strong domains in Te Whare Tapa Whā i.e,a whaiora may be very strong and active in the domain of wairua but diminished in the domain of whānau. Ensuring the opportunity of drawing on strengths is taken up is critical for healing to be facilitated and for tino rangatiratanga to be enacted.

Reduce Cultural Labour. Therapists can reduce cultural labour for Wāhine Māori by cultivating the insight to recognise what we know and don't while demonstrating a genuine willingness to learn. This requires openness, humility, and clear communication with whaiora. It is essential to acknowledge that therapists are not experts in every area, and to welcome feedback if something culturally significant is missing. At the same time, it is crucial to make it clear that the responsibility to seek out cultural knowledge rests with the therapist, not the client. This can be communicated with care by saying something like, "I'm committed to learning about how to support you in a culturally meaningful way. If there's ever something you'd like to share, I'm open to listening, but I also know it's my role to educate myself." Approaching these conversations with humility fosters trust and ensures the therapeutic space is one where Wāhine Māori feel seen, respected, and empowered.

Collaboration with kaumātua, kuia and/or cultural advisors is key to upholding cultural safety. The provision of cultural expertise ensures that the work being done is tika (correct) and appropriate for both clinicians and whaiora, safeguarding mana and integrity. As a clinician, it is always your responsibility to learn and understand why these practices are important, and it is important to recognise it will not always be the role of the psychologist to deliver the intervention, if that intervention is to be led by culture.

Conclusion

It is disheartening that a field like psychology, which is dedicated to understanding human behaviour and improving wellbeing, has often failed to meet the needs of Wāhine Māori. While psychology fundamentally serves to understand people, it is also a direct reflection of the society in which it was developed. Psychology is embedded in dominant political. cultural and social norms that have and may continue to undermine Wāhine Māori. Psychology is not neutral. nor is it an 'objective science' - it is a direct product of multiple cultural viewpoints and discourses which can be used for both the enhancement and the diminishment of the people it is designed to serve.

Wāhine Māori have not had a choice in the necessary mahi of addressing and restoring the mana of our people and we have an extensive history of fearless leadership that exemplifies our collective strength, survivability and potential. As Wāhine Māori Clinical Psychologists we encourage those like us and all psychologists to be unafraid to address racism and to stand on a commitment to better meeting the needs of Wāhine Māori. This involves continually critiquing what is considered best practice and questioning whose agendas our research, assessments, and treatment models ultimately serve—both the helpful and harmful. We welcome opportunities to have difficult conversations, to go against the grain and to advocate genuinely for the hauora of all Māori.

It is factual that colonisation remains an ongoing process in Aotearoa, New Zealand and it would be naive to assume psychology is unaffected. Recognising this is essential to understanding the ways our profession might inadvertently perpetuate harm and that we have both the opportunity and responsibility to dismantle the harmful practices. This may require some trust and courage in re-assessing the validity and legitimacy of Western psychological theory, models and practices. It also necessitates a power analysis that is inclusive and supportive of enhancing the mana, promoting leadership, supporting self-determination and ultimately, facilitating healing for Wāhine Māori.

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