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Nga Whaiora Tikanga Roanga: Māori Views of Health in Utah

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NGA WHAIORA TIKANGA ROANGA: MĀORI VIEWS OF HEALTH IN UTAH

by

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ABSTRACT

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by

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This study looked at the health beliefs of Māori who live in Utah, U.S. and examined what ways those beliefs have evolved from traditional Māori health beliefs. It also looked at the conditions and indicators of those conditions that maintain those health beliefs. A New Zealand study found that Māori older than age 45 years were more likely to have traditional health beliefs, whereas Māori younger than age 45 were more likely to have western-based health beliefs. Using grounded theory, the narratives—from two groups, younger or older than 45 years, where each group was composed of eight randomly selected participants—were collected and analyzed. It was found that all participants held traditional Māori health beliefs. Those beliefs were compatible with the construct of the Māori health model as presented in *Te Whare Tapa Wha*. This Māori model, along with participants, presented health as holistic, comprising components of physical, mental, spiritual, and family. Participants perceived health as having all four elements interconnected, with spirituality being the key element that binds all the others.

Conditions that maintained this belief were time in country; acculturation, with racism possibly providing resistance to that condition; enculturation; and spirituality. Participants' spirituality was the key condition of maintaining their Māori health belief that is presented in this study. Enculturation, as a necessary but insufficient condition of Māori health beliefs, was based on indicators of opportunity, location, family, and social support and how these indicators play out over the life course of individuals. The most important indicator for enculturation was family or other social support for individuals to engage in Māori cultural activities.

(124 pages)

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To my father Gordon Ponga Kingi Davies 1906-1998. To my wife, children, and grandchildren. To all of whom I could not attend their tangi while away.

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CHAPTER I

INTRODUCTION

The U.S. is experiencing the largest wave of immigration in its history (Schmidley, 2001). Children of immigrants represent half of the children in California. In 10 other traditional gateway states, children of immigrants account for 20-30% of children (Hernandez, 2004). Other states that are not traditional gateway states have experienced between 100-200% increase in immigrant populations (Hernandez, 2004). Utah has experienced an increased population of ethnic minorities, resulting from both new births and immigration. The non-Hispanic White population in the U.S. is predicted to become the minority by 2050 (47%). Ethnic minority newborn births reached 42.5% of the total birth population in 2002, with births of Hispanic and Asian populations playing a role in the growth of minorities in the future (Fuentes-Afflick, 2005; Passel & Cohn, 2008). The greater number of minorities has resulted in challenges in delivery of culturally competent health services. Health care providers will require greater training in cultural and linguistic competency to serve a more diverse client population with divergent help-seeking practices, beliefs, and values involving health and health care (Cauce et al., 2002). Health as a construct has many definitions, which are explored later in this paper; however, for this definition, western health can be defined as the absence of illness within a sickness model of health understanding (Kingi, 2005). A Māori definition of health can be based on a holistic process, within a wellness model of health understanding (Durie, 1998).

The health and wellbeing of migrant people is a multilevel, dynamic, and value-

dependent phenomenon (Prilleltensky, 2008). A person's health beliefs and practices are based on their cultural health norms (Ayalon & Young, 2005). In like manner, the practice of providing health services is based on health care provider cultural norms (Spector, 2002). Conflict may arise when health care providers interact with ethnic groups that have a different understanding of health than that of the provider. When investigating the health and wellbeing of a population, one must clarify and understand the cultural definition of health and wellbeing within the target group as part of the process. In doing so, the meaning of the behaviors relating to seeking health care and providing equitable health service becomes apparent. Although research on health has a long history, the dynamic nature of the interplay between the developments of health over time and measurements to monitor population trends in health and wellbeing is still needed (McCormick, 2008). A good place to start this investigation is to understand the diverse meanings of health and wellbeing among ethnic groups.

The understanding of health and illness are culturally defined variables (Durie, 1998). It is not surprising that current structures and conceptualizations of health and illness are born of dominant cultural notions, beliefs, and values (Kingi, 2005). An excellent example of this is the dominant belief based on western models of health. Within western models of health discomforts of the body, purports to be a physical entity and discomforts of the mind as a cognitive entity and both constitute an illness.

The increasingly multicultural fabric of U.S. society, along with more sophisticated etiological models, will require a different way of looking at health constructs. Many health disparities between ethnic minorities and dominant society

populations in the U.S. make current conceptions of health/illness (and their accompanying structures and treatments) outdated and inadequate (Beller, 2005; Boyce & Cain, 2007; Kilbourne, Switzer, Hyman, Crowley-Matoka, & Fine, 2006). When pre-Christian western model of medicine is compared to that of Chinese traditional medicine some argued that they are based on two differing epistemological world views (Kaptchuk, 1983). Others argued that they have significant cognitive and epistemic similarities from a pre-Christian Europe (Kavoussi, 2007).

In contrast to dominant western post-Christian cultural notions of health based on an illness model, some ethnic minority groups may have diverse way of interpreting health. As an example, Spector (2002) developed a traditional model of health that incorporates the body, mind, and spirit on three levels (maintain, protect, and restore). To demonstrate the diverse understanding of health between differing ethnic groups, Māori, the indigenous peoples of Aotearoa/New Zealand (NZ) view health within eight domains (see Appendix D for glossary of terms used): spirituality, uniqueness of self, life principles, heritage from ancestors, the physical body, group dynamics of family, the emotions, and the mind (Pere, 1986).

Values expressed in health behavior of indigenous peoples exposed to colonizing factors can be seen as a circular continuum between the indigenous cultural values and western cultural values. For Māori, the expression of cultural values of health is not homogeneous with differences between tribal groups but can be seen within a holistic construct. A study by Scott and Sarfati (2000) concluded that Māori in NZ who were aged greater than 45 years were more likely to view health within Māori cultural values

as a holistic function where there is no separation of physical and mental health components. Those Māori in NZ who were less than 45 years were more likely to view physical and mental health as independent functions. There were, however, no findings to identify any causal factors that may determine what influences this age dichotomy.

For the purpose of this paper, health beliefs are defined as the constructs of health by the participants. The purpose of the research is to investigate and describe (a) the health beliefs of Māori (Ngatiwai tribe) who live in Utah, (b) how those beliefs have evolved contextually from a traditonal Māori health belief model, (c) the conditions that contribute to those beliefs, as well as (d) the indicators of those conditions. The questions in this study were as follows.

1. What are the health beliefs of Māori in Utah?

2. To what extent have Utah Māori health beliefs evolved from a traditional Māori health belief model?

3. Under what conditions are these beliefs maintained?

4. What are the indicators for those conditions? This will be investigated within an exploratory and descriptive methodology.

CHAPTER II

LITERATURE REVIEW

A population's health seeking behaviors were impacted by a number of factors such as their view of health. Kakai, Maskarinec, and Shumay (2003) looked at ethnic health behavior differences based on choices of health information providers. Participants were White, Japanese, and non-Japanese Asian Pacific Island cancer patients in Hawaii, and most patients were users of complementary and alternative medicine (CAM; N = 140). In the findings, White patients favored objective, scientific information via medical journals or research newsletters, telephone, and internet information services. Japanese patients favored media and commercial sources such as television, books, magazines, newspapers, and CAM providers. Non-Japanese Asian Pacific Island patients, as well as other cancer patients and physicians, favored information via face-to-face communication within social groups. Patients with higher education levels relied on objective scientific information, while those with lower education levels preferred interpersonal sources of information. When the authors examined ethnicity and education levels collectively as factors, the ethnic-specific patterns of health information-seeking behavior were stable within each of the three ethnic groups, implying that ethnicity overrides education level in health information choices. The authors concluded that culturally developed worldviews were important to understand health information-seeking behavior.

The interaction of ethnic minority people and health service providers is based on the cultural beliefs and practices around notions of health (Macfarlane & Alpers, 2009). The determinants that impact those beliefs and practices are based on socioeconomic and

contextual factors (Cauce et al., 2002). Associated with those factors are: time in country (Smokowski, Rose, & Bacallao, 2008), age (Scott & Sarfati, 2000), identity formation factors of enculturation and acculturation (Berry, 1997; Davies, Elkington, & Winslade, 1993; Oetting & Beauvais, 1990; Phinney, 2000), life course (Elder, Nguyen, & Caspi, 1985), spirituality and religion (Miller & Thoresen, 2003), and colonization (Kawharu, 2003; Smith, 1999). The authors will report information relevant to the above factors in this literature review. Also reported are Māori models of health based on cultural values and beliefs as well as western models of health.

Models of Health

The definition of health by the World Health Organization (WHO) stated that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] This alternative view of the western model of health is growing in popularity and usefulness (Durie, 2001). Although western views of health are not homogenous, they can be viewed as being based on germ theory involving a disease/sickness model of health, which is in contrast to the WHO definition that is more holistic and not just the absence of disease (Kingi, 2005).

Models of health are constructed from within society's meanings of health and ways of knowing. Models of health also form interrelatedness with the formation of health policy for the society that it serves. The selection of the type of treatment for

[1] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948. Retrieved from http://www.who.int/suggestions/faq/en/index.html

health conditions is based on belief systems of health. This point is highlighted in a study of the Nasioi people of Bougainville Papua New Guinea (PNG), which studied Nasioi treatment-seeking behavior (Macfarlane & Alpers, 2009). The objective of the study was to describe how health knowledge and belief systems influenced treatment-seeking behavior of indigenous peoples of PNG, along with a description of their use of traditional and western health care systems. The descriptions were developed using a cross-sectional ethnographic method ($N = 200$).

Knowledge that contributes to public policy on health originated predominantly from professional social and health scientists (Raphael & Bryant, 2002). Raphael and Bryant commented that "to develop relevant and effective public policy, it is necessary that contributions of lay actors; i.e., non-experts, be valued and solicited" (p. 196). In the study by McFarlane and Alpers (2009), both traditional and western medical models were used by the participants of the study. Although the Nasioi people had assimilated the western medical concepts, this had not displaced traditional understandings of illness. The participants displayed confidence in the efficacy of both western and traditional medicine treatments. The authors concluded that a health system incorporating the belief system of illness of the indigenous peoples of PNG would lead to more appropriate health service utilization and eventual health improvements to the population health status.

In a similar way as the indigenous peoples of PNG, Māori health is based on a holistic view of wellness that is centered on the attributes of social, spiritual, and environmental collectiveness of the group. The understanding of the Māori view of health is within the protocols and rituals of cultural values. Those Māori that identify with

Māori rituals and cultural values are more likely to be of older age (Durie et al., 1997). Culturally competent health services for Māori require understanding of both ritual practices and powerlessness within a colonized environment (Durie, 1998).

Māori Models of Health

Western health views, like Māori views of health, are not homogeneous. Asian views of health are also not homogenous, but there are similarities to those of Māori. Chang and Subramaniam (2008) reviewed the literature of health help-seeking behavior in Asian and Pacific Island American men. They used an ecological-contextual framework to understand the impact of cultural values and health beliefs as well as gender roles and racial stereotyping on health help-seeking behavior. Help-seeking behavior of the *Iwi* (tribe) and *hapu* (subtribe) of the participants of this study have been investigated in the past (Heperi, 1996). The participants of the help-seeking study were of the same approximate generation as the older group of participants in this study. The findings of the help-seeking study concluded that participants were more likely to seek help from family in the first instance rather than a medical professional for both physical and mental issues. They were also likely to seek out spiritual assistance in both instances.

Pacific Islanders, as with Asian populations, see health as a holistic process with a balance between elements. The Pacific Island populations view the elements of mind, body, family, and spirit as an interaction of the physical and metaphysical world. Asian ethnicities focus on a balance in the same fashion and have elements of water, fire, earth, wind, and ether (or wood and metal in place of wind and ether (Kavoussi, 2007). Both

rely on an interrelated balance based on physical and spiritual aspects that are combined to define a holistic view of health.

Models of Māori health (see Table 1) presented in this paper are not ancient texts or historical models handed down from past generations orally or in text, but rather are processes of continuation of Māori values and adaptation through the process of change over time (Davies, 2008). This adaptation reflects the modern rendition of health as seen in a contemporary Māori world. The more modern renditions of Māori values of health are a response to a trend of reversing the impact of colonization through western health practices (Durie, 2001).

Māori health was viewed as being within the values of physical (*tinana*), mental (*hinengaro*), spiritual (*wairua*), and family (*whanau*), and was understood within the context of land (*whenua*) as a sense of identity, Māori language (*te reo Māori*), environment (*te ao turoa*), and extended family (*whanaungatanga*; Durie, 1998). Cram, Smith, and Johnson (2003) interviewed 28 self-identified Māori to investigate how Māori talk about health. One of the topics discussed was *What is Māori health*? The researchers expressed Māori health as being holistic and containing interconnected physical, mental, and spiritual elements. The interconnectedness or balances of elements of health were reported in a number of healing systems such as Traditional Chinese Medicine as well as in Māori health (Saylor, 2004).

Other themes that emerged in the Cram and colleagues (2003) study included specific Māori ways of providing healthcare, being linked to ill health, the impact of social and economic wellbeing on health, and disparities between Māori and non-Māori

Table 1

Five Māori Health Models

Name	Te whare tapa wha	Te wheke	Nga Pou Mana	Te Pae Mahutonga	Te Roopu Awhina o Tokanui
Descriptor	(the four walls of the house)	(the octopus)	(supporting structures)	(the southern cross constellation)	(The Māori mental health support group of Tokanui)
Value-Māori	Taha wairua Taha Hinengaro Taha Tinana Taha Whanau	Wairuatanga Mana ake Mauri Taha Tinana Ha A Koro Ma A Kui Ma Whanaungatanga Whatumanawa Hinengaro Waiora Te whanau	Whanaungatanga Taonga tuku iho Te ao turoa Turangawaewae	Mauriora Waiora Te Oranga Toiora Nga Manukura Te Mana Whakaheere	Taha wairua Taha Whanau Taha Hinengaro Taha Tinana Taha Whenua Taha Tikanga Māoritanga Pakehatanga Taha tangata
Value-English	spiritual Mental physical extended family	spirituality uniqueness life principles, ethos, vitality physical the breath of life from forbearers, cultural heritage extended family emotional aspects the mind mental health total wellbeing— eye of the octopus family— the head of the octopus	family cultural heritage physical environment indisputable land base	Cultural identity Physical environment Participation in society Healthy life styles Community leadership Autonomy	Spirituality family well-being physiology environment compliance Old world New world self

health. The most widely discussed aspect of Māori health by participants was the spiritual (*wairua*) element. The spirit is the most important aspect of Māori health and binds all other aspects of health (personal communication with G.P.K. Davies and T. Te Hira 1974). Participants of the Cram and colleagues (2003) study understood this as being the key to understanding health and illness. For Māori health practitioners, this was also seen to be the fundamental element for treatment and non-Māori practitioners treated the symptoms as opposed to the cause of the problem or illness (Cram, Smith, & Johnson, 2003).

Lyons and Mark (2010) explored Māori health and wellbeing by interviewing Māori spiritual healers to obtain views on health and healing practices. The five elements presented by these healers were mind, body, spirit, family/genealogy, and land. They saw spirituality as a major component in health and healing practices. They also saw land as an element of health and healing as important and central to healing as it was seen as a potential cause of illness. The conceptual model of Māori health and illness put forward by Lyons and Mark as a result of this research was *te whetu* (the star) signifying the five elements presented (body, mind, spirit, family, and land) which corresponds to the five points of the star.

Five other models of Māori health have been presented in recent years (see Table 1 for expanded content) to include: (a) *Te Pae Mahutonga* (The Southern Cross; Durie, 1999), (b) *Nga Pou Mana* (supporting structures; Royal Commission on Social Policy, 1988), (c) *Te wheke* (the octopus; Pere, 1986), (d) *Te Roopu Awhina o Tokanui* (Ora, 1987), and (e) *Te whare tapa wha* (the four cornerstones of the house (Durie,

1998). *Te whare tapa wha* as a model of Māori health has been used on a number of occasions; used within a Māori nursing model (Barton & Wilson, 2008), *Te kapunga putohe* (the restless hands) a nursing practice model of health; The use of *Te whare tapa wha* as a method of analysis of smoking cessation (Glover, 2005); It was used in clinical psychological settings as a measurement tool (Pitama et al., 2007). The NZ Ministry of Health also uses this model (Bryder & Dow, 2001; Durie, 2004; Rochford, 2004). *Te whare tapa wha* will also be the model used in this study.

All the models of Māori health have similar themes (see Table 1 for themes). These include aspects of a wider, more encompassing understanding of culturally embedded health. This Māori world view of health is based on the maintenance of a balance between the body, mind, and spirit, with (a) the extended family,(b) wider social networks, and (c) the spiritual and physical environmental world (Durie, 1998).

An issue that has been asked by many in the health industry of NZ is, "how do you implement an intervention based on a Māori model of health, when the model is so wide and goes beyond the individual that it may be impractical to develop?" (Durie, 2001, p. 135) In order to be an effective intervention, treatment for obesity based on the Māori model for example requires interventions in historical trauma, land alienation, loss of culture, and language, along with mental thinking and spiritual aspects of not only the individual but the extended family. A solution has been put forward based on Māori self-determination. From the 1980s in NZ, health reform has involved Māori in policy and development of health strategies (Durie, 1998). In 1988, the NZ Ministry of Health started to develop a power distribution that facilitated Māori health care by Māori in

advocating five principles: (a) holism, (b) empowerment, (c) social and cultural determination, (d) equity of access and devolution, and (e) equitable and effective resources use. The Ministry adopted principles strongly aligned with the Māori and WHO definition of health. Thirty years later Māori are still implementing health initiatives and continuing to negotiate with the NZ government. A new Ministerial position to oversee the setting up of *Whanau Ora* (family wellbeing) is the result of a task force set up to look at developing a framework for a family-centered approach to family wellbeing and health development. A Task Force report was produced (Durie, Cooper, Grennell, Snively, & Tuaine, 2010), from which the implementation of this framework is being established at the time of the writing of this dissertation. Collectively, Māori and the NZ government support health initiatives that are not only in alignment with Māori views of health, but also in keeping with global health trends (Durie, 1998).

Scott and Sarfati (2000) found that there was an intergenerational difference in conceptions of health. The study of Māori in NZ (N = 7,862) was based on a principal component factor analysis of the cross-cultural validity of SF36[2] (Scott & Sarfati, 2000). The SF36 is a measure of a two-dimensional structure of mental and physical health. The questionnaire measures participant's identification with a dualistic construct of health. Māori younger than 45 years identified with a dualistic independent function of body and mind based on western models of health. Older Māori over the age of 45 identified with Māori models of health based on a dependent interaction of body and mind. The authors theorized that for younger Māori, determinants of identifying with a western model of health may be due to acculturation, urbanization, severed ties to their subtribe and tribe, a

[2] SF36 is a generic health survey questionnaire.

weakened cultural affinity, and lack of the Māori language. The authors theorized that older Māori identified with more traditional Māori models of health as a result of being more likely to follow traditional Māori lifestyles and have a strong Māori cultural identity. These two differences based on age are the basis of the present study.

Two other studies looked at similar constructs. Devlin, Hansen, and Herbison (2000) used the EQ-5D[3] (a health state classification system) to conclude that Māori and non-Māori views of health were not statistically significant ($N = 1,350$). The researchers did not examine age as a factor. There were a number of limitations in the study, including sample bias, Māori participants being under represented in the study (9%), missing values, and pair-wise logical inconsistencies.

The second study conducted by Perkins, Devlin, and Hansen (2004) concluded that most Māori do not identify with Māori models of health, based on the EQ-5D as a measure. The researchers did not examine age as a factor. The authors listed a number of limitations of the study: the instrument lacks construct validity, sample bias, high prevalence of missing values, known problems of participants answering the questionnaire, small sample size ($N = 66$), and the sample being unrepresentative of the Māori population.

Western Models of Health

While Māori models of health are based on a holistic and inclusive view of health centered on the family as the base unit of analysis, western models of health are based on

[3] EQ-5D is a standardized instrument for use as a measure of health outcome

the individual as the base unit of analysis. Western health models and definitions represent a dualistic Cartesian philosophical view. The western medical models' manifestations of this philosophical view are that health is divided into discrete components and the mind and body represent different functioning systems (Saylor, 2004). Westerners tend to be more analytical and easterners more holistic, with westerners' social orientation patterns being independent while easterners' are interdependent (Varnum, Grossmann, Kitayama, & Nisbett, 2010). Western models of health can be conceptualized within four models: (a) biomedical, (b) institutional, (c) professional, and (d) socialization (Kingi, 2005).

The biomedical model engaged in the early 1900s reflected health as the absence of illness or disease. The point of view expressed in this model was that all patients with the same disease have the same biological problem regardless of their religion, culture, or ethnicity (Kingi, 2005). The model emphasized that biomedical treatment should be the same for all, and that the treatment discussion should reside in the domain of health professionals where consumer input has very limited involvement (Kingi, 2005). Health was a biomedical construct and health gains would eventuate from technological advancements such as the invention of antibiotics and other "drugs" along with discoveries of knowledge at the cellular and genetic levels (Kingi, 2005).

The institutional model is based on the assumption that health is attended to by large purpose-built health care, delivery, and treatment centers with specialized environments. These health providers are to attend to the illness presented by patients and are the best way to attend to individual needs. In the original design of these institutions,

it incorporated systems of isolation and separation of family and support systems of the individual (Kingi, 2005).

The professional model is based on the presumption that the professional holds the expert knowledge and that the medical profession represented by the attending physician knows what is best for the patient in treatment, care, and health advice. This does not require the involvement of the patient or "lay health persons" for advice or comment (Kingi, 2005).

The socialization model is based on the concept that social factors contribute to the health of the individual. Issues of poverty, education, lack of availability based on social factors of clean water and good food, housing, and social support networks are some areas that affect the health of the individual (Kingi, 2005). This is augmented by lifestyle choices that are or are not reinforced by social media. It is this last model that has been the topic of discussion in the ethnicity health disparities literature (Kilbourne et al., 2006; Shi & Stevens, 2005; Stevens & Shi, 2003).

Time in Country

Time in country (see Table 2) is defined as the time that has been spent by immigrants in their new country and is usually recorded as a time measurement or recorded by generations (e.g., 1st generation, 2nd generation, etc.; Umana-Taylor, Alfaro, Bamaca, & Guimond, 2009). It is also referred to as nativity and measured as a variable of birth origin (i.e., an ethnic minority who is born in the U.S. or born out of the U.S.

Table 2

Models of Time in Country

Model	Measurement	Example
Generational	Time in new country	1st generation, 2nd , 3rd , etc
Nativity	Birth origin	Born in or out of new country
Age	Age at time of immigration	X yrs old before immigration
Transnationalism	Relationships with old country	Communication, social networks

(Rumbaut, 1994). Other measures of time in country can be age at time of immigration or length of time in country since immigration (Buchanan & Smokowski, 2009; Smokowski et al., 2008; Umana-Taylor et al., 2009).Transnationalism looks at the relationships of immigrants and their parent country, and is another way of looking at time in country.

Transnationalism

Transnationalism has been studied within the Tongan community (Lee, 2004). Transnationalism in regards to immigration is the ongoing development of immigration patterns to reflect the ongoing transnational ties to more than one home country (Lee, 2004). With modern technologies, it is easier to maintain contact with family and social networks globally than in the past. This enables immigrants to maintain a social presence in both countries. For over 100 years, Māori have maintained a presence in Utah and other areas of the U.S. Many Māori have kept in contact with family that lives in NZ in diverse ways. How they have maintained contact will be one of the issues investigated in

this study as a function of relationship between host and home countries.

Many of the attributes of Māori transnationalism may have similarities to the work that Lee (2004) put forward when looking at Tongan transnationalism. These may include; (a) economic remittance by family structures that imitate corporate structures; money and goods flow to family heads who transmit this to family heads in other countries who distribute down within family structures (Marcus, 1974); (b) communication where family members keep in touch with those in NZ by phone or mail and, in contemporary times, mobile phone or internet (Lee, 2004); (c) fostering of children by other family members, where children of differing ages are sent back to NZ to be raised or to "be kept out of trouble" (Morton, 1996); and (d) visiting "home," where family make trips to NZ to renew links, seen as a possible positive or negative action on the family making the visit. However, as noted by Lee (2004) with Tongan visits, they were generally a negative experience. Lee (2004) argued that besides economic ties, there are emotional and social ties to the homeland. However, with Tongans, the ties to the homeland are diminishing. Recent social and cultural gaps of traditional Tongan life for those not living on Tonga are also widening.

Enculturation

Enculturation is "the process by which a person learns the requirements of the culture by which he or she is surrounded, and acquires values and behaviors that are appropriate or necessary in that culture" (Grusec & Hastings, 2007, p. 547). For example, Māori parents may participate in ritualistic prayer at special occasions and include their

children in that experience. Culture exists within the context of a group. Conversely, no group exists without a culture; they are both mutually inclusive (Bonner, 1961). Enculturation within a group's socialization process requires that there be opportunities to both learn and practice the culture (Rangihau, 1992; Walker, 1989). For example, Māori engage in rituals when they return to traditional lands, and the opportunities to return to traditional lands needs to be part of process of opportunities. For indigenous peoples, enculturation processes have also been used to navigate around colonizing processes so as to negate or resist colonization (De Leeuw, 2007). Enculturation has been found to be a critical factor in identity formation for ethnic minorities and in particular when investigating processes of counseling intervention (Davies et al., 1993; M. Miller, 2007; Schoen, 2005). What has been found to be important in counseling settings are client identity formation and the relationship between enculturation and ethnic cultural worldview, as this impacts on clients other life's decisions (Davies et al., 1993; M. Miller, 2007; Schoen, 2005).

Cultural Identity Formation

Cultural identity formation is a multilayered, complex interaction involving issues of changing culture, historical, and developmental factors (Phinney, 2000). These complex interactions are difficult to analyze even with statistical techniques such as structural equation modeling to understand multivariate processes. Longitudinal studies of individuals and groups are an effective method; however, they are difficult and costly and few have been conducted (Phinney, 2000). A better alternative is the narrative

approach to examine the socio historical context of how individuals and groups make sense of their lives (McAdams, 1988).

How an individual views his or her cultural identity has an impact on their world view and how they interact with society (Berry, Poortinga, Pandey, Segall, & Kâgtçbas, 1997). The two main models to describe these differences are a) the linear model based on an ancestral cultural view at one end of the continuum and a dominant cultural view at the other and b) a multidimensional orthogonal model (Berry, 1976, 2001a; Berry et al., 1997; Oetting & Beauvais, 1990). Davies and colleagues (1993) put forward an orthogonal model called *Putangitangi* (Paradise Duck) that provides an explanation of the diverse realities of Māori. On the horizontal axis, it provides for cultural identity being strong at one end and weak at the other. On the vertical axis, acculturation is strong at one end and weak at the other. This provides four different views of the world (see Figure 1): (a) those that reside in a bicultural world (strong acculturation and enculturation), (b) acculturated world (strong acculturation weak enculturation), (c) enculturation world (strong enculturation weak acculturation), and (d) a world that presents identity confusion as it reflects a combinational flux or complete rejection of all three previous world views (weak enculturation and acculturation). The impact of these diverse realities is that it can provide an explanation of a person's view on health depending on the strength of their view of acculturation and enculturation.

Acculturation

Acculturation is the process where societies, communities, families, and

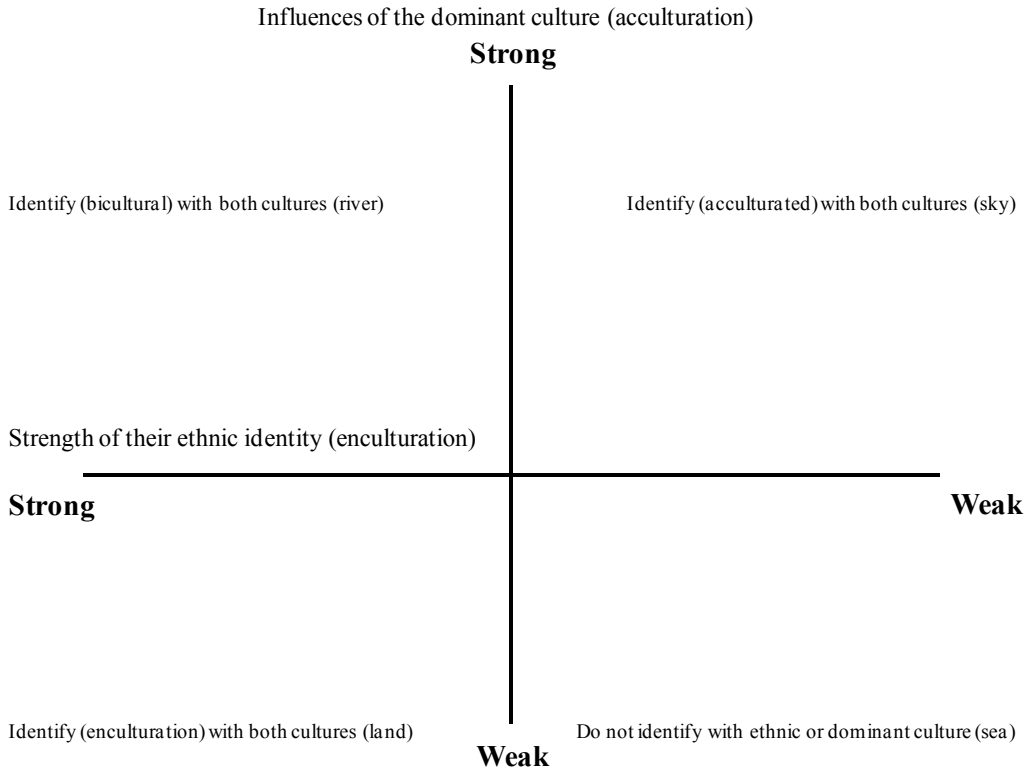

Figure 1. Putangitangi (Davies et al., 1993).

individuals react to intercultural contact (Rudmin, 2003). Discussions on concepts that represent acculturation have been found in works by Plato in 348 BC, while the use of the word "acculturation" was first used in 1880. Since 1918, there have been more than 100 differing taxonomies of acculturation proposed (Rudmin, 2003). Kroeber (1948) proposed that acculturation constitutes changes in one culture brought about by the contact with another culture, which results in increased similarities between the two cultures. Acculturation may be reciprocal, but very often it is an unbalanced process with a result of at least, in part, the absorption of one culture into the other. Kroeber (1948) articulated that acculturation is gradual as opposed to being sudden.

There are two main schools of thought about acculturation; one based on a linear process (Gordon, 1964; Park & Burgess, 1921), the other a non linear process (Berry, 2001b; Portes, 2003; Rumbaut, 1997a). In more recent times, acculturation has been seen as more of a blend of the two with aspects of language seen as linear (Weisskirch & Alva, 2002) and differences of generational aspects as non linear. When comparing different ethnicities on issues of acculturation, differing data support one or the other or both schools of thought (Alba & Nee, 1997; Herman-Stahl, Spencer, & Duncan, 2003; M. Miller, 2007; Portes, 2003; Rumbaut, 1997b).

Segmented Acculturation

The notion of a segmented acculturation has emerged where the second generation and beyond of immigrants have acculturated to different segments of American society. As reported by Portes, Fernandez-Kelly, and Haller (2005), as a result of segmented acculturation, second generation and beyond immigrants acculturated to ether the mainstream middle class or marginalized and racialized populations of society. In a study by Gibson (1997), it was found that Mexican high school students did better in school if they identified strongly to their own culture, and this identity was supported by their family, community, and peers. In contrast, students who were disenfranchised from their culture (i.e., substituted their historical culture with contemporary gang culture) were at greater risk of failure at school.

Acculturation as a Variable

Acculturation has been seen as a variable in a number of research issues, such as

drugs, alcohol, cigarettes, health service and psychological needs, family dynamics, and cultural orientation (Akins, Mosher, Smith, & Gauthier, 2008; Buchanan & Smokowski, 2009; Corona, Gonzalez, Cohen, Edwards, & Edmonds, 2009; Gil, Wagner, & Vega, 2000; Kim, 2007; Smokowski et al., 2008; Umana-Taylor et al., 2009; Warheit, Vega, Khoury, Gil, & Elfenbein, 1996). The vast majority of these investigations involved studies based on Latino/a and Hispanic populations.

Cultural attitudes, values, beliefs, and other contextual factors affect mental health (Cauce et al., 2002). Ho, May, McCabe, and Hough (2007) found that the level of parental acculturation was a partial mediator in the relationship between ethnicity and mental health service use of Asian/Pacific Island and Latino youth. The parental acculturation level was used as a measure of adherence to culturally specific values, beliefs, attitudes, and behavior.

Globalization Acculturation

Acculturation as a process of two different cultures interacting so as to produce an integration of those cultures is only one possible outcome as presented by Berry (2008). He proposed that globalization as a process of intercultural exchange, when combined with acculturation, can produce outcomes of separation or marginalization as well as integration or assimilation. Globalization was defined by Berry as:

> The multiplicity of linkages and interconnections that transcend the nation-states which make up modern world systems. It defines a process through which events, decisions, and activities in one part of the world can come to have significant consequences for individuals and communities in quite distant parts of the globe. (p. 329)

Globalization, then, centers on the complex process of cultural interaction rather

than any outcome as a result of global interaction at a cultural level. The processes can be in the form of trade of goods, media, crime, knowledge, fashion, pollutants, or beliefs. Globalization as a process of combining multiple global attributes with acculturation can, therefore, produce multiple outcomes. Berry theorized that there are four possible outcomes for ethnocultural groups as a result of globalization of acculturation: (a) integration, (b) assimilation, (c) separation, and (d) marginalization. All four outcomes are based on interactions with dominant societies, with the ethnocultural societal position as the outcome.

Integration is where there is a mutual exchange of culture and each culture shares common qualities while maintaining their distinct features. Assimilation occurs when the nondominant cultural societies converge and a homogeneous cultural society based on the dominant society emerges. Separation is where the nondominant cultural society rejects the influence of the dominant society's culture at the beginning of the social interaction or at some time after social interaction has started. Marginalization is where the dominant culture totally destroys the nondominant cultural. This leaves the non-dominate culture with no cultural connection that they can use to guide their lives and become marginalized within the dominant society.

Acculturation as a Predictor

Acculturation effects on health behavior when viewed on an orthogonal model that entails behavior changes on two axes describes four cultural orientation categories in which an ethnic minority can place themselves. Although this model has been able to describe acculturation effects, it has been unable to predict health behaviors when used as

a predictor (Landrine & Klonoff, 2004).

Acculturation can be a predictor by the following variables: similarity between minority and host cultures (the greater the similarity, the faster the adaption by minority to host culture), hostility of dominant group to minority group (the higher the hostility, the slower the adaption by minority group to dominant culture), and strength of intra- versus interethnic relationships (the closer the intraethnic relationships, the slower the adaption by minority group to dominant culture; for a faster adaptation there needs to be both a weaker intraethnic relationship and stronger interethnic relationship; Florack, Bless, & Piontkowski, 2003; Kosic, 2002; Kosic, Kruglanski, Pierro, & Mannetti, 2004).

Acculturation and Colonization

Acculturation is seen within the context of colonization for Māori assimilation policies and institutionalized racism (Rangihau, 1992; Smith, 1999; Walker, 1990). Acculturation for Māori also includes the choices made so that change comes about as an adaptation rather than a change of original values to which they have subscribed (Davies, 2008). For example, by choice the Māori used European style ships for sea transport instead of dugout canoes. Another example is the value of education within Māori society and the adaption of integrating the English school system in Māori learning systems. For *Ngati Wai* (Māori tribe) and the *hapu* (subtribe) from which the participants of this study came, education has been a priority of the elders both past and present. The pursuit of education as a tribal priority for extended families has been evident over many generations, as discussed by Davies (2008) in his research on *kaumatua* (elders) roles over time.

Adaption to another culture as a process of acculturation within colonization usually implies a power imbalance within that process. Acculturation is a process that is contained within an environmental context. The same acculturation process within two differing contexts may provide differing results. For Māori who have immigrated to the U.S., the change of context may or may not stimulate patterns of acculturation that exist in NZ, but may follow other patterns of acculturation that have been found in the U.S. For at least the second generation of Māori immigrants, segmented acculturation as discussed previously, utilizing works by Portes and colleagues (2005), Perlmann and Waldinger (1996) and others may be found.

Life Course

Life course is defined as a sequence of socially defined events and roles that the individual enacts over time (Giele & Elder, 1998, p. 22). The life course manifests historical and social factors intersecting with personal biography and development, in which the study of family life and social change can develop (Elder et al., 1985). The life course approach to investigation directs awareness to the strong connection between individual lives and the historical and socioeconomic context in which these lives unfold. There are four areas that are investigated when looking at life course: (a) location which deals with time and place such as historical, social structure and culture; (b) linked lives which look at institutions, groups, and families; (c) human agency which involves individual goals and sense of self; and (d) timing, which encompasses the integration of historical, social, and individual activities. For understanding health and health

development, the life course approach has been used in developing policy and research (Halfon & Hochstein, 2002; Wise, 2003), investigating racial disparities (Lu & Halfon, 2003), maternal health (Grason & Misra, 2006), and maternal child health (Pies, Parthasarathy, Kotelchuck, & Lu, 2009).

Browne, Mokuau, and Braun (2009) used a combination of life course and resilience theory to analyze and understand health and social disparities of native Hawaiian elders. He found that life course showed that a cumulative adversity for some and cumulative advantage for others provided divergent directions and increased health inequities for Hawaiian elders. Historical factors impacted life course while resilience mitigated for this impact. Resilience theory, which focused on underlying protective and recovery factors in Browne's study, demonstrated health promotion. Browne found that the contribution of Hawaiian cosmology provided understandings of human behavior. He found wellbeing within health, which was grounded in the interconnections of biological, psychological, social, and spiritual aspects of the individual and the world. This world was comprised of individual, family, community, land, and the spiritual domain.

Spirituality

Gallup and Lindsay (1999) reported that 95% of Americans have a belief in God or a higher power, and that 90% of Americans give an account that they pray, with 67-75% praying on a daily basis. Spirituality and religion has rarely been a subject of research due to two assumptions: that it cannot be studied scientifically and that it should not be studied scientifically (W. Miller & Thoresen, 2003). Within the field of social,

behavioral, and health science, however, a body of research has been created in this area since the 1990s (see *Journal for Scientific Study of Religion, American Psychological Association Division 36, Society of Behavioral Medicine*).

The definitions of spirituality are varied and usually are understood to include transcending physical limits of time, matter, energy, and space (Thoresen & Harris, 2002). The concept of spirituality is best defined from the believer's perspective (W. Miller & Thoresen, 2003). To study spirituality based on these parameters makes it complex; however, there are features that are observable, such as spiritual practices, spiritually motivated behavior, or other physical manifestations of spirituality (W. Miller & Thoresen, 2003).

Religion

Religion is a socially based institution and is differentiated by specific beliefs and practices. Religion as a social phenomenon differs from spirituality, which is understood at both an individual level and within a context (Thoresen, 1999). Religiosity can be seen at the individual level in a similar way that spirituality is: through observations or self-declaration of beliefs or practices. Religiosity is defined in relation to a religion; whereas, spirituality is defined in relation to the individual and their spiritual beliefs, which may not include religious beliefs. For some people religion and spirituality may have overlapping constructs; for others there may be very little overlap (W. Miller & Thoresen, 2003).

Colonization

For the purpose of this research paper, colonization is the process where one country invades another country and imposes (usually by force) the culture of the colonizing population onto the indigenous peoples of the invaded country (Brave Heart & DeBruyn, 1998; Brave Heart & Deschenie, 2006). Colonization plays out in various forms, including racism, subjugation, physical, spiritual and cultural genocide, confiscation of land and natural resources, implementation of policies, laws and legislation that support institutionalized racism, and dominance of the colonizing peoples over the indigenous peoples (Kawharu, 2003; Rangihau, 1992; Smith, 1999; Walker, 1990). Effects of colonization are not homogenous as issues of resilience come into play and are complex. They will not be the subject of this paper.

Racism as a process of colonization is the belief that race is the primary determinant of human traits and capacities and that racial difference produces an inherent superiority of a particular race (Berman & Paradies, 2010). Racism encompasses beliefs, attitudes, behaviors, and practices. It involves a generalized lack of knowledge or experience as it applies to negative beliefs and attitudes (Shook & Fazio, 2008). It is based on the assumption that group differences are biologically determined and, therefore, inherently unchangeable. Racism does not exist in a vacuum, but is born and reinforced through social, cultural, and institutional practices that endorse the hierarchical power of one racial group over another. Racism is usually understood within aspects of power and prejudice (Paradies, 2006). For this study racism is defined as “that which maintains or exacerbates inequality of opportunity among ethnoracial groups” (Berman &

Paradies, 2010, p. 217).

Micro aggression is subtle insults—verbal, nonverbal, or visual—directed towards ethnic minority people automatically or unconsciously. There are three forms of micro aggression: (a) micro insults, which are behavioral/verbal comments that convey rudeness, insensitivity, and demean a person's ethnical heritage or identity; (b) micro invalidation, which is verbal comments or behavior that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of an ethnic minority; and, (c) micro assault, which is explicit racial derogations that are characterized primarily by a violent verbal or nonverbal attack that is meant to hurt the intended victim (Sue et al., 2007, p. 278). Micro aggression is often referred to as the modern racism due to the fact that more open overt displays of racism have become far less socially acceptable (Sue, 2003).

Colonized to Colonizer

The move of Māori from NZ to the U.S. has brought about a process of change: that of coming from a colonized environment to becoming part of a process of a system of colonizing. Putting this into context, Māori have been subjugated to colonizing practices of western, and in particular, British immigrants as a colonizing force in NZ Māori, as a part of their world in NZ, have experienced an environment of marginalization, land loss, cultural, spiritual and physical genocide, racism, and other factors that contribute to historical and continued colonizing trauma (Durie, 1998; Kawharu, 2003; Pool, 1991; Rangihau, 1992; Walker, 1990). Since the 1970s, Māori have undergone a cultural renaissance within NZ; a wider social understanding of a

bicultural world has come about through a greater understanding of the importance of the role that "The Treaty of Waitangi" (a treaty between the English Crown and NZ Māori in 1840) has played in NZ.

With the combined histories of colonization, historical trauma, and the renaissance of cultural awakening, those first generation immigrant Māori have arrived in the U.S. to become a part of a multicultural society after leaving a bicultural society. The main difference between the multicultural and bicultural world is the power differential. An association with a new society constitutes a colonizing society in relationship to the indigenous peoples of the U.S. For Māori in the U.S., there may or may not be a conscious awareness of being part of a colonizer society that are colonizers where they were part of a society that was being colonized. There may or may not be a conscious affinity of Māori in the U.S. with the struggles of colonization of the indigenous peoples when the opportunity for encounter arises.

Māori Renaissance

As a resistance to colonization, Māori participated in affirmative action to facilitate a period of cultural awakening. One can view Māori renaissance within two domains: the arts and culture. The arts renaissance started in the 1950s with a rise in prominence of Māori artists that incorporated Māori materials, imagery, and techniques with European art materials and techniques. One of those artists was Paratane Matchitt whose art translated into *whare tupuna* (ancestral house) and *marae* (central area of village and meeting house). The renaissance of Māori culture also has roots in the 1950s when, during and after WWII, there was a migration of Māori from rural to urban areas

(Pool, 1991). In the 1960s, there was an ongoing awareness by Māori as to the impact of colonization. In the 1970s protests and affirmative action was being instigated by Māori to rectify grievances of inequality and the loss of land and culture (Rangihau, 1992). The Land March by Dame Whina Cooper was a powerful process of activism that resulted in an increase of protests and political activism culminating in the establishment of "The Waitangi Tribunal" in 1975 (a tribunal to facilitate restorative justice for Māori over colonizing practices). The political pressure has continued to present times with apologies from both "the Crown" (The Queen of England) and NZ Government with repatriation of land along with monetary allotments and resources as part of settlements to historical grievances.

Methodological Practices

Health care is a medical science-based institution, but at the practice level, it is a social science-based institution. As an example, the process of determining that an appendix needs to be removed is based on medical science, but the interaction with the patient to facilitate the removal is based on a social science practice. Understanding at the social level requires knowledge of the social constructs of health for the various ethnic/social groups. The base of this knowledge stems from exploratory and descriptive research, which leads to other more specific investigations based on diverse scientific methodology.

The first steps to understanding the social constructs of health requires direct dialog with those who are seeking health help (Lincoln & McGorry, 1995). This is even

more necessary when there is little literature on the subject within the context of socially constructed health beliefs. The use of grounded theory to explore and describe socially constructed beliefs of health is one method one can use

Within grounded theory, there are three approaches: inductive, deductive, and abductive. Grounded theory (as an inductive approach to scientific research) is where the categories and names for categories emerge from the data rather than starting with categories a priori. These categories allow for new insights to emerge. This comes about through data analysis where the researcher reads the data repeatedly to achieve immersion and an understanding of the whole (Tesch, 1990). The researcher then makes notes on impressions and thoughts of the narratives, which then becomes the first part of analysis. Labels for codes then start to emerge that reflect a group of related thoughts; these codes often come from the data and become the coding scheme. The codes then are grouped into meaningful categories based on links and relationships of the codes (Patton, 2002). As an example, a number of codes from the data have to do with activities of elderly grandparents with grandchildren; these could be grouped to create a category of role model as grandparents for grandchildren. The categories are then organized into smaller categories (i.e., based on the last example, a smaller category could be, grandparent roles in society) with relationships to subcategories along with definitions developed. Exemplars of the categories and codes are then located for the researcher to use in reporting.

This approach provides relevant knowledge based on direct information from participants without the imposition of categories or theoretical perspectives a priori. This

approach is difficult because of inferring theoretical relationships from findings (often used for development building). The difficulty with inference of theoretical relationships is a result of failing to develop a complete understanding of the contextual environment of the area of investigation, and thus failing to capture all key categories which leads to reliability issues. Ways to combat the lack of understanding of the contextual environment is the utilization of triangulation of data sources; the utilization of a contextual framework such as an ecocultural framework; or having a researcher on the team who is part of the social cultural group on which the research is being conducted. This allows for a deeper contextual understanding so as to provide contextual links between categories as well as contextually deeper understandings of categories that emerge.

Another school of thought on grounded theory places an emphasis on a systematic deductive process. Through the use of existing literature, a priori topics are used to assist in developing the emerging theory (Kelle, 2005). This allows for the comparison of what information is in the data to what the researcher finds in the literature. These a priori categories then become the basis of coding data and provide definitions of categories that when combined, provide the framework for analysis of the data. Any data that do not conform to the a priori coding are given a new code. The researcher combines the categories and coding in the same way as in the inductive approach. The findings based on these categorizations and coding either supports previous information or does not support a priori theory. As in the inductive approach, the researcher uses exemplars of the data to describe the evidence presented while the theory or prior research from the

literature is the guide to the discussion.

The advantage of a deductive approach is that the researcher can support, extend, or not support existing theory. This approach also supports research that has already had preliminary investigation of the issues being investigated. Deductive approach also makes explicit that the research is not a naïve approach, which is a mark of a more naturalistic design such as an inductive approach. The challenges to a deductive approach is that the researcher bias of having categories a priori can flow onto participants, who may get cues to answer in a particular way to please the researcher. The research based on bias may find evidence to support the theory rather than evidence to not support the theory by binding the contextual view of the data on theory. A way to limit this bias is to provide an audit trail of analysis that is then examined by an auditor (Hsieh & Shannon, 2005). A deductive approach allows for theory investigation.

When the two approaches (inductive and deductive) are combined, it then becomes an abductive approach to grounded theory (Haig, 2006). The abductive approach is the accumulation of both schools of thought from the grounded theory of Glaser and Strauss (1967) and Strauss and Corbin (1990). An abductive theoretical approach allows for the inclusion of possible categories to be explored in research based on investigation from the literature as well as allowing for the data to formulate new or adaptive categories to provide for a more comprehensive investigation and description of the issue being investigated.

The application of an abductive approach involves an iterative process of both deductive and inductive analysis of the data, allowing categories to emerge from the data.

Analysis is conducted using three forms of codes: open, theoretical, and constant comparative (Glaser, 1992). Open coding is the initial step through which thematic codes are identified in the data along with their properties and dimensions. Theoretical codes are "conceptual connectors" that develop relationships between the thematic codes forming categories (Glaser, 1992, p. 38). As an example of theoretical codes, the analysis of narratives based on open coding finds that there are four differing thematic codes of grandparents looking after grandchildren. The connection between these differing thematic codes is the theoretical code. This describes the overall connection of key roles of grandparents as a category within the research population. Constant comparative is coding that describes the method of constantly comparing of the narrative to provide saturation between both open (thematic codes) and theoretical coding (categorical codes). Based on the last example, the narrative would be revisited in an iterative process to look for further examples of child minding (thematic codes) that did not fit the role of grandparents (categorical codes) as defined by the coding within the narrative. Strauss and Corbin (1994) had similar coding phases: open coding, axial coding, and selective coding. The accumulations of categories within the findings are presented with exemplars from the data to support the arguments presented.

Abductive approach can be used to build models or theory investigation or to provide a comprehensive process of description so that the findings can become the basis of more comprehensive but specific exploration of singular parts of the findings. An abductive approach to grounded theory is proposed in this research as there has been very little investigation that is both exploratory and descriptive of Māori health beliefs

providing a base to allowing for further more specific investigation at a later date.

Deliverables of Study

Through undertaking an exploratory and descriptive research of Māori health beliefs and indicators of those beliefs, this research will contribute to the conversation for Māori on further understanding health beliefs. The findings in this process also allow for concept development and model building that provide the basis for further, more specific investigations that may lead to findings that have more generalizability. Although the specific findings will not have generalizability to other indigenous peoples, it will provide both a starting point for further investigation and a model of methodological investigation.

CHAPTER IIII

METHOD

Research Questions

1. What are the health beliefs of Māori in Utah?

2. To what extent have Utah Māori health beliefs evolved or not, from a traditional Māori health belief model?

3. Under what conditions are these beliefs maintained.

4. What are the indicators for those conditions?

Research Theory

The research was a mixed methods approach using both qualitative and quantitative methods and utilizing Grounded theory. Mixed methods is explained by Creswell, Clark, Gutmann, and Hanson (2003, p. 212) as "the collection or analysis of data that is quantitative and/or qualitative within a single study, where the data are collected concurrently or sequentially and the data are integrated at one or more stages of the process of the research." In this study, the data were collected both concurrently and data was returned to participants for confirmation of content and revision at a later date, and were also collected sequentially. Less data were obtained from quantitative methods that were centered on closed questions and short answer structured questions that dealt more with demographics. The larger data set was collected through qualitative methods utilizing semi-structured open-ended questions and collection through the narrative of

participants. The grounded theory utilized was based on an abductive approach in which the data underwent an iterative deductive and inductive analysis as explained and defined previously (Haig, 2006).

Culturally Competent Process for Working with Indigenous People

Approval for this research was first conducted in a manner that is consistent with Māori protocols and will be described next. The researcher first held a meeting with elders from his own tribe; and, obtained consent for the research. The researcher then presented himself to elders of the Māori community to obtain consent from them to conduct the research. The researcher also made a presentation to the Māori community at a family gathering about the research to answer any questions about the research. Under the direction of elders, a community advisory committee was formed that was made up of elders and members of the tribal community providing a "voice" for the tribal community and constituting part of a model of a culturally competent research process. This community advisory committee provided assistance in liaison with the Māori tribal community in Utah and provided introductions to participants. This process provided for a community-based research approach as well as opportunities for data validation. This community committee differed from my dissertation advisory committee that advised the researcher on the competencies required to complete this research in fulfillment of my Ph.D. requirements. After the research proposal was granted from the researcher's dissertation committee, a formal approval was obtained from the Institute Review Board

(IRB) of Utah State University.

Inclusion and Exclusion Criteria of Participants

The participants of this research were NZ Māori from the Ngati wai tribe residing in the State of Utah, United States of America, aged 19 years old and over. The definition of a NZ Māori that is Ngati wai is any person that can make a genealogical link to an ancestor that is an indigenous person of the Ngati wai tribe, NZ All of the participants were from the same tribe as the researcher. The researcher's relatedness and knowledge of the target group provided the opportunity to conduct research that was useful for both the researcher and participants for possible social change. Of the target group, the estimated total population was about 40-50 persons that met the inclusion criteria. There were 16 people interviewed utilizing a "maximum variety sampling" method based on age as a variable (Morse, 1994). The participants were randomly selected from a list of possible participants that was compiled with the help of the elders of the Ngati wai tribe in Utah. Two lists were made based on age. One list held names of possible participants aged 19-45yrs; the other list was aged 46+. Eight persons from each list were randomly selected to be possible participants and were approached to take part in the research. The random sample was obtained by assigning a unique number to each person in the two groups. Those two groups of numbers were then applied to a random number generator using a program from www.random.org/sequences . Those possible participants that were randomly assigned numbers 1-8 from both groups were then approached to participate. All who were approached participated in the research. The age of 18 was selected as this

is the age of majority in accordance with Utah State law and would exclude minors from the research.

Recruitment

The most effective recruitment method in this geographical and ethnic was word of mouth (Domenech-Rodriguez, Rodriguez, & Davis, 2006). The networks were already in place (e.g., community organizations, community centers, key community members) to which the researcher was able to reach out. It was unlikely for potential participants of this study to agree to participate if the researcher was a non-Māori. Recruitment was via contact with the elder members of the tribal community already known to the researcher as well as tribal members already known to the researcher. From the contacts known and others who were introduced by elders of the tribal community, a "snowballing" technique was used via referrals from possible participants to locate further potential participants (Weiss, 1994). From these contacts a list of possible participants were made and from which a random sample was selected.

With the endorsement of community elders, the researcher made personal contact with members of the random sample list with a request for participation in the study. Contact was made by telephone, e-mail, and personal visits. An information sheet (Appendix C) was sent or hand delivered to potential participants. The information sheet provided information about: (a) the goals of the research, (b) what was to be asked of participants; and, (c) how the information they provided will be used. The participants' rights were explained, a verbal consent was obtained and they were advised that they had

the right to withdraw from the study at any time with no penalties along with an explanation on how their identity would be kept anonymous. Data was organized with new identification numbers and all documents with participant names were secured separately from the research data. Participants were given an opportunity to have any questions answered about the research before the interview is started. When a verbal expression of willingness to participate was given, the researcher negotiated a time, date, and place for the interview to be conducted. In most cases, participants were happy to conduct the interview immediately.

Data Collection Procedures

The interview was conducted at a place convenient to the participant usually at their home (6% in a public area, 25% in elders home, and 69% in their own home). Where appropriate, permission was requested for interviews to be voice recorded via the use of a digital voice recorder brand name: Sandisk MP4, model: Sansa, which has voice recording capabilities. In all cases, where permission was sought, permission from participants was given, field notes were also taken during the interview (permission was not requested from 6% of participants).

The interviews were approximately 1.5 hrs long with the total time of visit with provisions to obtain rapport being approximately 2-8 hrs depending on cultural protocols of ritual engagement that were required (e.g., rituals of welcome and protocols of connection). The participants were invited to have other persons of their choosing with them as support, which allows for a cultural normative setting. As an example, some

participants requested to meet together in a group. All participants of the group setting agreed to be participants and were classified as participants for the purpose of individual data collection. Group settings provided group conclusions on some topic, and were compared to other participant's individual statements on the same topics. In any case, data obtained from group settings (n = 4) were analyzed separately from data from individual settings (n = 12) before comparisons were made of the two data gathering settings.

Personal History and Demographics Schedule

The interview schedule consisted of two parts. The first was a structured demographic questionnaire (see Appendix A) with both closed and open questions. The second was a semi- structured open-ended set of questions (see Appendix B) organized around expanding participants' understandings to answers provided in the demographic questionnaire and participants' thoughts on their construct of health. This provided a beginning that allowed for the participant's narrative to flow. The personal history and demographics questions were structured to facilitate a dual purpose: first, to establish rapport and to enable the participant to feel at ease with the interview process; and second, to provide a context for the narrative and to allow the researcher to establish the participant's view of their Māori world (enculturation) and of their own acculturation to Utah and U.S. culture. This last point is important, as the researcher needed to employ the participant's world view in a way that the interview questions were structured. This ensured that the participants' feelings and wellbeing (a cultural norm) were not violated.

Some of the questions of this research are embedded in a more conservative Māori worldview and the researcher needed to first ascertain if the participant felt alienated from that view. That alienation, if any, would be recognizable through an understanding of the participant's worldview via the rapport session; that is, if the participant demonstrated unfamiliarity of Māori cultural terminology, the researcher then adapted prompting questions to minimize any possible offense. It was imperative that the researcher displayed a cultural, competent question style and did not challenge the participants' worldview in a way that disrespected their feelings and wellbeing while obtaining information on personal history and demographic data.

The rationale for the questions asked in the demographic questionnaire (Appendix B) is as follows: (a) The gender of the participant has relevance to questions about possible gender health roles, as some roles are traditionally gender specific; (b) The age of the participant has significance so as to ascertain if age is relevant as found in the NZ study (Scott & Sarfati, 2000); (c) The birthplace of the participant is of interest so as to make comparisons between those that were born in NZ and those that were not. Birthplace may also be a factor in cultural alienation as discussed by Durie (2003) and Maaka (1993); (d) Where the participant has lived and for how long, allows for an examination of emigration patterns along with issues around both enculturation and acculturation; (e) Marital status of the participant is a useful data point when making comparisons with other data; (f) The Household make up and relationship of persons in the household of participant provides an idea of the significant others present in the lives of the participant and opportunities of enculturation; (g) Information about the

participants' main daytime activity, educational attainment and income range has a relationship to possible financial preparedness for health issues; (h) The income ranges also allow for comparisons of participants' income to health insurance coverage; (i) Participant's engagement and opportunity to engage in cultural activities provide information on enculturation activities of the participant; (j) Information on health insurance provides knowledge on the adequacy of health insurance coverage of the participants.

The Interview Schedule

The researcher conducted face-to-face interviews with participants that consisted of a non self-administered demographic questionnaire (Appendix B) with structured questions to obtain information that was incorporated with data from the semi-structured interview. The semi-structured interview guide (Appendix A) allowed for flexibility in conversation and centralized personal narratives, whilst covering important issues (Creswell, 1994). Open-ended questions that simply explore notions of health beliefs and practices were used to stimulate personal narrative. The first three open-ended questions of the interview schedule (see Appendix A) clarified and provided the context to the answers provided in the corresponding demographic questionnaire (see Appendix B) and were the bases of the open ended question (i.e., In your answer to the question _____ you stated _____. Can you tell me more about that?). The balance of the questions in the interview schedule prompted the participant's thoughts of how they engage the construct of health.

Data Analysis

The analysis was based on standard grounded theory practices comprised of coding and categorization of themes with the use of the data coding system spoken of in the introduction, utilizing an abductive approach (Glaser, 1992; Haig, 2006; Hsieh & Shannon, 2005; Strauss & Corbin, 1994).

First, data were organized, via recordings of narrative of participants and were augmented by field reports. Second, a summary of the narrative was returned to the participant for checking and further clarification by the participant if needed. Each participant, whether as an individual or in a group, received their own summary report with the opportunity to edit the summary. The third, involved a report and discussion of preliminary findings with key informants of the community (elders).

The summary report of each narrative was compiled from field reports and voice recordings of each interview. A summary report (a report that summarizes the discussion between researcher and participant that provides a report of points made by participant as understood by the researcher) was constructed rather than a verbatim report (a report that is an exact word for word of the discussion between the researcher and participant) of the narrative as the researcher was seeking feedback from the participant as to the accuracy of the researchers understanding of the interview as opposed to the accuracy of the narrative.

Summary reports returned from participants were coded (open coding); codes from individual participants were compared to those from group participants. The open coding was processed through themes from the narrative of each question asked by the

researcher. These themes then became the codes (the actual key words of themes, e.g., relaxed, bicultural, comfortable, and spirituality as used by the participant in answering question about behavior change became the codes used).

The codes were then grouped into thematic categories (theoretical codes, e.g., the following theoretical codes were found; bicultural, relaxed, cultural practices, and spiritual connections for the question about behavior change). Theoretical codes were processed by grouping all participants' narratives along with open codes by the questions asked of the researcher. These codes and categories were reassessed in an iterative process of coding utilizing inductive (where thematic coding is derived from the data) and deductive (where thematic coding is set a priori from literature) analyses of data continues until categorization of all thematic codes emerged from the data (constant comparative). The categories that emerged from the data were then compared to literature on the same categorical subjects to ascertain similarities and/or differences.

The preliminary report of findings was presented to the Māori community advisory committee for discussion with the researcher. For example, the researcher reported that participants felt more relaxed and comfortable when around other Māori than non-Māori. The committee provided feedback to the researcher as to the perceived accuracy of knowledge obtained from the study along with any contextual clarification of knowledge obtained. For example, the committee confirmed to the researcher that the report on Māori being more relaxed and comfortable around other Māori than non-Māori was accurate. This knowledge and clarification was then incorporated into the overall analysis. The final report of findings was then compiled for inclusion in the findings of

the researcher's dissertation.

Data Validity

To provide for the opportunity of triangulation of data as a method to increase researchers' confidence in the veracity of the findings (Patton, 1990) three data sources were used: (a) data came from the participants based on discussions and narrative arising from open- ended and closed questions; (b) data via a report written to summarize the discussion was sent to each of the participants for participant-checking with a request that the report be verified as being an accurate reporting of the discussion and understanding of the researcher (validation at the individual level); and (c) data from the preliminary findings were discussed with the community advisory committee (validation at the community level). The combination of these three data collection processes were the basis of analysis of the research.

Participant Benefits and Research Dissemination

The dissemination of the research was via a report, which was created independent of the dissertation and after the dissertation defense, to be given to the elders of the community as well as a copy to each participant that requested one. The researcher has presented this report, which was written in a language that is appropriate to the intended audience in both content and style; in, both paper form and orally, at a gathering of elders and other members of the Utah Māori community including participants.

Through undertaking an exploratory and descriptive research of Māori health

beliefs and indicators of those beliefs will contribute to the conversation for Māori on further understanding these health beliefs. The findings provide the bases for further more specific investigations that may lead to findings that have more generalizability.

CHAPTER IV

FINDINGS

Structure of Findings

The findings section is formatted to provide the result of the various investigations so as to answer the research questions presented, which were as follows.

1. What are the health beliefs of Māori in Utah?

2. To what extent have Utah Māori health beliefs evolved from a traditional Māori health belief model?

3. Under what conditions are these beliefs maintained?

4. What are the indicators for those conditions?

To be able to answer these four research questions, the conditions and indicators of those conditions first need to be explored so as to provide a background to the first two questions dealing with health views of Māori in Utah.

The presentations of findings will commence with main categorical headings that equate to categories found in the literature. These categories constitute the conditions that maintain the health beliefs of participants. Under these main categorical/condition headings, each theme is presented that has manifested as a result of the "constant comparative" (codes) process of the "theoretical codes." Exemplars of themes to support both "theoretical and open codes" are presented. Each theme is then compared to what is found in the literature in order to either support the literature or express differences to the literature. These themes constitute the indicators of the conditions that maintain the

health beliefs of participants. The author will present the indicators based on the information provided by the participants in answer to the questions posed in this research. To maintain anonymity, participant's names have been changed.

The conditions that have emerged from the narrative of the participants and that do or do not support the health beliefs of Māori in Utah are: time in country, transnationalism, acculturation, enculturation, spirituality and religion, and health models. The author presents these conditions along with the indicators of these conditions.

Time in Country

The reasons that first generation participants came to the U.S. were: to go to school, to work, or to join family already here. A few that came for work opportunities brought their spouses with them, while others married in the U.S.

> We came over the years for various reasons; our brother came first to go to school, he married then stayed. Then we all came over time. (Elizabeth)

Of the second generation participants, some have spent time in NZ for a number of years as children or teenagers, others have had extended visits, and all have visited NZ at some stage of their lives.

> I was born in the U.S. but lived in NZ when I was very young. I was very excited to come back to the U.S. (Peter)
>
> I went to NZ and was there for 5 yrs. (Cora)
>
> I have lived here (U.S.) all my life, apart from when I visited NZ. (Ida)

Even though the first generation participants' reasons for immigrating were

varied, the opportunities as a result of immigrating to the U.S. appeared to be a motivating factor. The connection with family or other social supports in the U.S. also appears to be a motivating factor in both immigration and remaining in U.S.

> I found it unfriendly and I hated it…. I started to make friends and made connections too (social supports). With the (social supports) from these connections I could enjoy school and I had to keep my grades up to stay in the social groups. (Len)

> Our parents come over (to U.S.) because (family member) asked them to come. (Betty)

To investigate the conditions that maintain the participants' view of health, the amount of time participants have spent in the U.S. was explored. The participants represented first and second generation immigrants. In NZ, Māori have been, and still are, exposed to colonization policies and practices. The first generation immigrant Māori (the older age group) who came to the U.S. were exposed to this colonization process. Second generation Māori (the younger age group) had not been exposed to direct colonization as indigenous peoples, except for visits made to NZ

All participants that were first generation immigrants came from both urban and rural environments in NZ. The majority of these first generation immigrants came to the U.S. at the beginning of the Māori cultural renaissance period. Participants were exposed to a variety of cultural participation before immigrating, from very little to quite a lot. Participants also had been exposed to a wide range of experiences with colonization along with varying exposure to Māori cultural renaissance, as spoken of by Royal (2009).

The time in country for participants was a result of immigration motivated by opportunities of higher education, work, and family. They had been living in the U.S.

from 22-47 years, with the bulk leaving NZ between 1963 and 1975. This time period was before or at the beginning of the Māori Cultural Renaissance period (1970s). For this tribal family group, Davies (2008) spoke of education as being a highly regarded attribute, and motivation to pursue higher education may be expected. Being part of a culture where family ties are a dominant factor of social existence (Durie, 2001), social supports would also have been expected to be a motivating element. Supports by social networks of family and other friends were factored as elements for remaining in the U.S. For the second generation participants, social networks within the U.S. were augmented by the inclusion of social networks of family and links within NZ.

Time in country as a condition—with indicators of that condition being generations as immigrants, reasons of immigrating, motivations for remaining in country, urban/rural environments of first generation, along with limited exposure to Māori cultural renaissance—may be seen as a necessary condition but insufficient to maintain Māori health beliefs. In comparison with "time in country," "urbanization" may be an equivalent condition to investigate when looking at maintaining health beliefs of Māori health for a future research topic within NZ

Transnationalism

Transnationalism is defined as the way that a group of people who are immigrants maintain links in both the host and home countries so as to maintain a presence or affiliation within both countries (Lee, 2004). For the participants, all kept contact with family in NZ, some on a weekly basis, others less frequently.

> I made sporadic contact via the phone with parents and family and now in the last 10 years (I am) still sporadic with some people. (Aaron)

> We do a visit about every 5-10 years some more others less but we keep in contact… (Freda)

> I have weekly contact using the internet (Len)

With the more recent availability of the internet (Facebook, Skype, chat, family web sites, etc.), participants maintained contacts at a greater frequency. These contacts were primarily maintained by the second generation (younger age group) of the participants.

> I talk to my cousins on the internet via e-mail, chat and phone. (Ida)

> The internet has changed from (the use of) letters in keeping in contact with family in NZ. (Cora)

The second generation also relied on their parents to keep them up-to-date with information from family and what was happening in NZ This suggested that for some second generation participants, they did not have direct contact with family in NZ.

> My mom keeps in contact with the family in NZ. (Betty)

All of the participants have visited NZ at least once. The older participants visited on a regular basis as well as those that have jobs that provide opportunities to make more visits. The visits were seen as an enjoyable experience, unlike what was found by Lee (2004) in the study with Tongan people.

> I get to go home frequently through assignments (in my job) and would go to (NZ City) every 2 years or so and I have had continued contact with family. (Kenneth)

> In the last 4 years I have gone every year to NZ My job provides opportunities to go. (Norman)

> I went to NZ for about 2 weeks while in high school. (Betty)

> There is an overwhelming sense of love in the contacts with family in N.Z.… (Freda)

Participants maintained the continued contact with family and friends from NZ by reciprocal processes, with the participants visiting NZ and family and friends visiting the U.S. on an ongoing basis.

> We go back or family comes over here over time. (Debbie)

> I stay close to family, they visit and we keep in contact. (Len)

All participants maintained a continuous contact with family in NZ through physical visits both to and from NZ All of the second generation had established physical links to NZ by visiting, even if it was only one time. Older participants of the second generation visited more often than the youngest, suggesting that over time the frequency may increase. Some participants' jobs presented opportunities to visit more frequently. This was also the case with first generation participants, who may have had more opportunities due to less time constraints from employment obligations.

The internet and developing technology over time has seen an increase in frequency of contact with the use of applications such as Facebook, chat, family web sites, VOIP (voice over internet providers), phone systems, and Skype. The newer technologies were more popular with the younger age group of participants. Once again, the frequency of contact using these new technological methods ranged from daily/weekly to sporadic. Some maintained contact via a proxy process of keeping in contact with their family network here in the U.S., usually the mother, who then keeps in direct contact with family in NZ.

"Corporation systems" (i.e., the involvement of economic and commodity

remittance to another country) as spoken of by Marcus (1974) as an example of Tongan transnationalism was not found with participants in this study. However, participants did maintain links to uphold a presence in both countries; this can be seen as maintaining transnationalism, as spoken of by Lee (2004). Lee also spoke of second generation Tongans going home to visit and saw this as being a possible negative experience. All Māori second generation participants saw visits home as a positive and enjoyable time.

The range of participant connectedness to family in NZ is varied, although most have regular contact. Transnationalism as a condition—with indicators of that condition being physical contact via travel, the use of technology for contact with family networks or proxy contacts, so as to maintain a presence in both U.S. and NZ—may be seen as a necessary but insufficient condition to maintain participant's health beliefs.

Acculturation

Acculturation was investigated using three separate questions from the participants. The first dealt with how they communicate with other Māori compared to non-Māori. The second considers the behaviors of participants when they socially engage with other Māori compared to non-Māori. The third area that explored participants' exposure to racism. These three areas were selected to investigate behaviors that could easily demonstrate changes in behavior that may be due to acculturation (i.e. changes in use of language, changes in social behavior and exposure to racism)

Communication

Participants perceived communication to be different between Māori and non-

Māori. These differences included words used with differing meanings by each group and words in which one of the groups did not know the meaning.

> Our expressions get misinterpreted by non-Māori and they don't understand, they don't get our jokes and we use different words that have different meaning or they don't know the meaning of the words. (Gina)

> When I communicate with Māori, there is a difference in meaning (with the use of Māori words) of words that Māori use... (Ida)

> Māori slow the language down whether you are joking, laughing or serious. There is no common shared meaning between the two (Māori and non-Māori) (Len)

> Lots of things we use are different like names that we don't use here… (Peter)

Other areas of communication differences expressed by participants were based on cultural differences. They also expressed that to communicate effectively, they needed to learn new communication skills based on the customs of the new country. In learning these new skills, participants became bicultural in communication protocols.

> To communicate you need to understand the *kawa* (protocols) of the two cultures. You need to learn from the *pakeha* (non- Māori) of the different way of conducting *pakeha* formal processes. (Aaron)

> The language needs to be changed based on terminology of the culture spoken. (Jack)

Participants articulated that they were more relaxed in how they communicate with Māori when compared with non-Māori. Humor was also a component of communication that contributes to the relaxed environment for participants when interacting with Māori.

> I feel more at ease with Māori, I feel comfortable as they understand me…humor is a big thing with Māori. (Mark)

> They (non-Māori) don't understand, they don't get our jokes…. (Freda)

> With *whanau* (extended family) a word or gesture is all that is required to portray the same message. (Aaron)

> I am very comfortable (with Māori) and can be casual in my interactions. (Cora)

Connections made through the process of communication were established and maintained at a spiritual level when communicating with Māori compared to non-Māori.

> For Māori I connect in an overall manner, you can feel that spirit and you are more relaxed and it is a natural way of being. (Quail)

> With Māori I feel a more of a kinship, there is a difference and it is more comfortable because of the connections with them. (Owen)

> I am more at ease talking to Māori they have similar spirituality to me. Māori understand where I come from. (Kenneth)

The ways participants communicated with Māori and non-Māori highlight areas that facilitate acculturation as well as resistance to acculturation. As a result of misunderstanding in language use and meaning, participants adapted to a new communication environment. This environment includes the adaptation to include new cultural ways of communication, with participants learning new communication skills as well as protocols associated with the use of these skills. Through the acculturation of communication, participants were able to communicate in a bicultural environment, communicating with both Māori and non-Māori as the environment dictated. There were, however, aspects of communication with Māori that did not translate to a non-Māori environment and provided resistance to total acculturation in the way that participants communicated. One such aspect was the connection Māori maintain through communication processes such as spiritual and kinship connections, making for a more relaxed environment with other Māori.

There were differences between perceived communications with other Māori compared to communications with non-Māori by the two age groups of participants. More of the younger group than older found that they were more relaxed around other Māori when communicating. The next biggest difference for this younger age group and, correspondingly, the biggest difference for the older group were in the use and meaning of words, along with misunderstanding as a result of these differences. An explanation for this could be that the older group composed of first generation immigrants would be expected to have had a higher need of acculturation than the second generation that were born in U.S. What is interesting is that the younger group as second-generation immigrants still underwent an acculturation process for understanding words and meanings from both cultures. This would be due to the need to have an understanding of the language used at home by family members, which is different than the language of the dominant society. This could be compared to the home language being non-English, as experienced by non-English speaking first generation immigrants, as spoken of by Weisskirch and Alva (2002). The changes in language were a linear process with aspects of the language being blended over time, which was also spoken of by Weisskirch and Alva. This would account for the reported differences in language use by both first and second generations of participants.

For the younger group, cultural differences were not of high importance in communication differences. For the older group, they found cultural differences needed to be considered when communicating with non-Māori. Being able to make connections at a spiritual level with other Māori was the second greatest difference for the older age

group. This connection at the spiritual and kinship level was also important for the younger group, but not as important as the older group. It was not found that the younger group as second generation immigrants did not acculturate into different segments of American society as spoken of by Portes and colleagues (2005). Portes and colleagues found that second generation immigrants acculturated into different societal groups such as middle class or into marginalized and racialized groups.

Behavior

The behavior of participants when they socially interacted with other Māori compared to non-Māori provides insights into possible indications of acculturation. Differences in how participants communicated with non-Māori were found to be similar to how participants reported their behaviors with Māori compared to non-Māori. Participants reported that they were more relaxed in their behaviors when around other Māori than non-Māori.

> I am more relaxed around Māori even if I have just met them…. (Owen)
>
> I can see the person when I am with Māori as well as other Polynesians. The mannerisms are comfortable for me. (Mark)
>
> When I get together with Māori it is looser, more relaxed. (Len)
>
> I feel more relaxed and natural with Māori than *pakeha* (non-Māori). (Norman)

The participants reported that when they engaged in certain behavior, the cultural practice of that behavior provided a sharp distinction between Māori and non-Māori practices, such as:

> Like at the *tangi* (funerals), we joke and laugh and it is a very relaxed time but at *pakeha* (non-Māori) funerals it isn't. (Len)

> Our culture allows us to go and see anyone unannounced. You can't do that here in the U.S. you need to arrange the visit. (Jack)

Participants reported that there were spiritual connections when engaging in interactions with Māori that were not necessarily present when interacting with non-Māori.

> It doesn't take long to relate, there is a spirit there. It takes much longer to get to know other people but not with Māori. (Owen)

> I am more relaxed around Māori than *pakeha* (non-Māori) it goes back to spirituality, they can follow you. (Kenneth)

Participants expressed that they were able to interact with non-Māori equally as well with Māori, although they felt more relaxed and connected when with Māori. Participants expressed that they could function within a bicultural environment.

> I am very relaxed around most Māori and as I know who I am, I have a comfort level around non-Māori and I feel I fit in both worlds. (Cora)

> When you are around Māori there are protocols, those things you just do. For *pakeha* (non-Māori) it is different there are other protocols you do, I can see both worlds—you engage in both and use what is appropriate. (Quail)

> We need to learn to accept each other in our own differences as we become friends. (Aaron)

For participants the differences in behaviors between Māori and non-Māori were similar to that of communication. The adaptations of behavior so that participants were comfortable in behaving within both Māori and non-Māori environments were evident in their responses. This adaptation of behavior enabled participants to participate in a bicultural world as presented in orthogonal methods of cultural identity by Berry and colleagues (1997) and others.

There were differences between the two age groups of participants, but both groups felt more relaxed and comfortable interacting around other Māori than non-Māori. The younger group articulated that there were lots of differences in behaviors based on cultural practices and also expressed the view that they were able to reside in a bicultural world and were able to fit in with both Māori and non-Māori worlds. The older group also expressed that there were cultural differences; however, they also indicated there was a spiritual connection when interacting with other Māori that was not present with non-Māori.

Racism

Racism is "that which maintains or exacerbates inequality of opportunity among ethnoracial groups" (Berman & Paradies, 2010, p. 217). Racism experienced by participants may have impacted their decisions on both how they engage the acculturation process as well as participation in enculturation practices. Participants had a range of racist experiences, from none at all to an extensive amount. Participants reported that often people did not know that they were Māori and mistakenly thought that they were Polynesian or from some other group of people.

> There have been some who have been "standoffish" because they thought I was an Islander, then Hispanic, then they didn't know who I was and then the prejudices disappear because they didn't know how to treat Māori. (Aaron)

> I get chunked into Polynesian (non-Māori pacific Island peoples) and they put me with them. (Quail)

Other participants did not experience racism at all but had seen it in their presence. Most participants attributed not having experienced personal racism to the physical characteristics of them not looking like a Māori.

> No, I have not experienced this; people don't believe I am Māori even when I tell them. (Ida)

> I have not experienced it so much with me. I have seen prejudices a lot against other people. (Kenneth)

> I haven't because I don't look Māori, but people have been racist in my presence because they don't know my ethnicity. (Owen)

Racism was a common experience for some participants. These experiences occurred at all ages and over both generations of participants. Some participants were victims of racism quite often and it had been continuous throughout their time in the U.S. For some first generation participants, it was more prevalent in the past than in the present. Second generation participants most often experienced it when they were younger in school. They also witnessed racism—including microagression, as discussed by Sue and colleagues (2007)—against others. Some participants reported that as adults, they had not experienced racism in the U.S., but had been victims of racism when in NZ.

> When I was younger because I look more like a Māori. Kids were very cruel…. I have not experienced racism in my U.S. adult life like that; I experienced it while I was in (NZ City). (Cora)

> There was a lot more back when we were first here than there is no… (Gina)

> My children were at school. They were criticized and made fun of and excluded. (Jack)

> Every day there is still tons of it. For *pakeha* (non-Māori), Māori are a very palatable minority, there is a mystique associated with being Māori but not about other cultures… (Len)

When participants articulated their views and experiences in relation to racism with the researcher, many that had experienced racism provided reasons that racism exists in their geographical location at the time.

> The Utah culture here is based on ignorance of other cultures. (Elizabeth)
>
> *Pakeha* (non-Māori) can be so arrogant sometimes (here in the U.S.)… American Indian (in the U.S.) is formally taught that there are different classes of people (and they belong at the lowest class). (Len)
>
> I have seen it in a verbal and informal ways and it is based on ignorance of not knowing about differences. (Mark)

Racism may not have been experienced by all participants, and those who did not experience racism either did not look like a Māori or lived in an area where Polynesians were the dominant ethnicity. Those who did experience racism looked Māori (darker skin predominantly). Participants experienced racism to a greater degree in the past than the present. They expressed that they now experience more microagression, which are more subtle but still racist behavior (Sue et al., 2007). Most participants had witnessed racism and/or microagression in their environment and offered reasons as to why racism is present. For Māori, racism as a process of hostility from the dominant culture to minority groups may be an indication of resistance to acculturation by the minority group. As discussed previously by Landrine and Klonoff (2004) the Māori experience with racism may be a function of resisting acculturation.

Acculturation Summary

Acculturation as a condition of maintaining participants' health beliefs is reflected in: (a) indicators of communication behavior change; (b) behavior changes in personal interaction; (c) experiences of racism. Participants had engaged in a wide range of acculturation processes, which included adaptation to existing cultural practices. Berry (2008) discussed the differences between acculturation and adaptation. For the

participants, the adaptation was a purposeful choice. This was evident in the way participants adapted communication styles by learning protocols of engagement of the dominant society in which they lived. Communication behavior changes were also based on a need to change language to facilitate differences in understandings along with language use that was based on cultural differences and was a more linear process (Weisskirch & Alva, 2002). The older group experienced the most need for the above changes, whereas the younger group experienced the need to change language based on understanding less than the older group. They also expressed that they were most relaxed around others who were Māori when communicating and also felt more connected with Māori including at the spiritual level.

The participants felt that they needed to change their behavior when around non-Māori in particular in regard to Māori cultural rituals. Changes due to cultural differences were more prevalent for the younger group of participants along with being able to adjust behaviors to maintain a bicultural environment. As with communication as an indicator, changes in behaviors relating to social interactions, both groups of participants felt more relaxed around Māori than non-Māori. The older group also felt a spiritual connection when interacting with other Māori. Adaption of behavior was also evident in the way participants adapted to interpersonal interaction (Berry, 2008). For example, participants articulated that skills needed for communication and interpersonal behavior between Māori and non-Māori were attained. Through these new skills of communication and personal interaction behavior, participants adapted existing skills and were able to engage in a bicultural environment. This allowed them to move between both Māori and non-

Māori worlds as the environment required. This demonstrates an integration of cultures rather than acculturation, as presented by Berry (2008).

Racism as an indicator of acculturation has elements of racism due to mistaken identity as well as a dependency on facial or other characteristics (i.e., skin color). Participants experienced racism within a wide range, from no racism at all directed at them to an extensive environment of racism. All participants observed racism in their presence and also within a wide range of experiences. Some participants experienced racism to a larger extent when in NZ than when in U.S.

Acculturation as a condition of maintaining participants health beliefs can be seen within three elements: (a) communication adaptation; (b) interpersonal behavior adaptation; (c) exposure of racism. The first two elements can be seen as necessary but insufficient to maintain participants' health beliefs. Racism, however, can be seen as a possible resistance to acculturation and as such could be viewed as an unnecessary and insufficient element of acculturation. Acculturation can be viewed as a necessary but insufficient condition to maintain participants' beliefs, with racism as a possible resistance to this condition.

Enculturation

Enculturation was investigated by discussing two questions with participants: the opportunities participants had to participate in cultural activates over their lifetime and the type and frequency of activities participants engaged in during their lifetime. These questions will be discussed based on the responses from participants.

Opportunities

Participants spoke about the opportunities to engage in Māori cultural activities. These opportunities varied considerably and some only engaged in them as time permitted or avoided them as opportunities coincided with other activities relating to family and work. Other participants sought out activities and even created their own opportunities to engage in their culture.

> With time issues and working full time with children, married life I can't take advantage of the limited amount of opportunities to participate in cultural activities. (Betty)

> There have not been many opportunities apart from what is at school…. (Ida)

> I engage in the cultural activities when there is time and they connect with the opportunities. (Len)

> I engage in cultural activities with the cultural group that does performances from time to time. (Aaron)

> I have been very involved in the culture over my life. (Quail)

> We made an effort to learn as we knew we would be asked to share our culture… (Debbie)

Family involvement in cultural practices was a key factor for some participants. For other participants it was the extended family or other social networks that provided opportunities to practice their culture. Having family or other social networks to support cultural engagement was a motivating force to practice their culture.

> We had a family group and performed at functions. (Cora)

> We continue to pass on what knowledge we have about our culture…. (Debbie)

> We have been involved in family activities…at the time the experience was ordinary but now it was extraordinary. (Jack)

> At family reunions we did cultural activities but there are fewer opportunities as there have been less family get-togethers. Now with children there is less time along with fewer opportunities. (Mark)

The location that participants found themselves in was a contributing factor to the opportunities to engage in cultural activities. For some, this opportunity was found at school or by living near cultural groups that performed and had practices on a regular basis. For other participants, living close to extended family so that they could engage in cultural activities when the families got together was a key factor.

> When I was at (college), I was part of the performance group (Māori and other cultural group). When at college people looked up to me because I was Māori and part of the (cultural group). (Cora)

> It depends on the location as to the opportunities that are available. (Kenneth)

Over the course of participants' lives, opportunities to participate in cultural activities increased or decreased over time. Factors that contributed to the life course of participants' engagement in cultural activities included family and job commitments, proximity to opportunities, family involvement, and participants' desire to participate in cultural activities.

> Over time, we have had more and less opportunities to engage in cultural activities (Debbie)

> When we were young, we did a lot of dance…in my teens we moved further away from the extended family…(later) I got heavily involved with Māori culture…not much lately but now that my kids are getting older I am getting involved in it again. It is very dependent on time availability and opportunities. Engagement in cultural activities has reflected on life's development over time. (Owen)

> There have not been many opportunities…. I don't know much but I would like to know more. (Ida)

> Enculturation is about participation in cultural activities and the opportunities to

practice your culture (Rangihau, 1992). To facilitate the process of enculturation there needs to be not only the opportunity to practice culture, but support systems to maintain the engagement in practicing your culture. These supports along with opportunities to practice culture are intertwined with the location of the participant and environmental circumstances at any given time over participants' lifetime. The cultural activities and degree of involvement are affected by the four areas discussed previously: (a) opportunities to practice culture, (b) family or other support systems to motivate engagement of cultural practice, (c) being in a location that provides opportunities to engage in cultural practice, and (d) how all these elements occurs over the course of a person's life. Enculturation was more prevalent with those participants that had involvement in all four areas as well as family influence and social network support.

Type and Frequency of Cultural Activities

All of the participants had been involved in cultural practices at some time in their lives. Although cultural practices can be engaged in in many ways, for this study, only public expressions of culture based on rituals and entertainment were investigated. Rituals would include activities such as *hui mate* and *tangi* (funeral processes), *powhiri* (formal welcome), and *poroporoaki* (closing ceremony). Entertainment would include activities such as, *kapa haka* (Māori performing arts), *haka* (Māori dance) and *poi* (female dance using balls on suspended flexible material). The extent of participation in cultural activities was varied; some had heavy involvement, while others were less involved. Age was not a determinant of involvement in cultural activities as both age groups had varied activities.

> *Kapahaka, Hui mate*, almost all activities that go on (Aaron)
>
> Most of the usual activities over time more or less we did some with our kids while they were growing up, *poi* with the girls, singing action songs going to family reunions (Elizabeth)
>
> The whole range, we have been involved in it all, *tangi, kapa haka* (Kenneth)
>
> I have been in *kapa haka*, involved in doing *hangi*. (Mark)
>
> All of it, performance—*kapahaka, tangi*, whatever is going on. (Quail)

Depending on the time of life of participants, they were heavily or less involved in cultural practices. With changes in life's activities and commitment, involvement for some participants in cultural activities changed; for others, activity involvement remained the same.

> I love to be with the family and cultural activities they are involved with. I was involved in more activities when I was younger with my family and liked the cultural performances with the family, now it is not so consistent. (Betty)
>
> I was involved with the (cultural group) but now as I get older and work… combined with limited opportunities I am not as involved as I was… (Len)
>
> Lots of activities depending on the stage of my life. (Owen)
>
> I have been in *kapa haka* and all cultural activities…. I have a close bond with the culture…. I like to be in key cultural events. (Mark)

Some participants felt they have had limited cultural activity involvement. This involvement was more a part of attending performances by others and activities supported by sports teams or school. For these participants there was little involvement in cultural activities with immediate or extended family.

> The cultural activities were involved with school and sport not so much with family. (Peter)
>
> I haven't been to many, mostly performances at school or at rugby games. (Ida)

Depending on the time of life of participants, involvement of both younger and older groups in cultural activities was of a greater or lesser extent. For some, involvement depended on opportunities and family or job commitments. For others, involvements in cultural activities were more constant. The older group created opportunities to expose their children to cultural activities. Some of the younger ones extended the experience of cultural activities as opportunities became available. Some of the younger ones excelled in cultural expertise so as to advance past the experience and capacity of the older ones. Some younger participants had very limited experience with cultural activities, which may be related to their parents' lack of exposure to cultural experiences. Over all, participants have experienced many types of cultural activities.

Summary of Enculturation

Enculturation is comprised of four indicators: opportunity to engage in cultural activities, the support of family and or social networks, the location in which you reside, and one's life course. The opportunities to be able to engage in cultural activities ranged from very little to a great deal, varying by participants. The opportunities were also linked to geographical locations; for example, some participants had almost daily opportunities to engage in cultural activities while at college, which varied by participant. The support of family and other social networks was a key indicator of enculturation for those participants that engaged in frequent opportunities to engage in cultural practices. Those participants that did not have support of family or social networks did not engage as frequently in cultural practices. The encompassing element that encased the previous three indicators was participant's life course, as spoken of by Elder and Gielel (2009) and

Browne and colleagues (2009). Within the participant's life course, the time and place, linked lives, and individual goals with sense of self and timing provides a historical view of the environment that opportunities, support of family or social networks, and location change over time. These elements provide a comprehensive overview of enculturation of participants. Enculturation as a condition, and based on the indicators spoken of, is a necessary but insufficient condition to maintain the health belief of participants.

Spirituality and Religion

Spirituality versus Religion

Participants saw spirituality as being about self, whereas religion was seen as more of a social environment involving an institution, as spoken of by Thoresen (1999). Participants had a variety of views on the differences and similarities of spirituality and religion. For some, they viewed spirituality and religion as two very different things. Some participants expressed that the two are not mutually inclusive and spirituality was not a prerequisite to incorporate religion (W. Miller & Thoresen, 2003).

> They are different, I am a spiritual person and religion (has) is to do with church and you don't have to go to church to be spiritual. Spiritual is to do with self. (Betty)

> Going to church does not make you religious any more than standing in a parking lot makes you a car. Religion is about what you do or engage in. Spirituality is your connection with Divinity; it is who you are and who you are becoming. (Jack)

Other participants commented that spirituality and religion have connections. They reported that those connections are based on religion having an element of spirituality. They also reported that culture is combined with spirituality.

> Spirituality is learnt from ancestral past and I marry that to what my religion teaches me. (Aaron)

> Religion has spirituality within it but you can be spiritual without being religious. Spiritual can be a cultural thing where culture and spirituality are combined. If you are religious then it has the element of spirituality. (Cora)

> Having religion helps me to grow spiritually, it is all connected but it is not the exact same thing. (Quail)

Participants saw spirituality and religion as being the same and indicated that it cannot be separated.

> Spirituality and religion is the same thing. They can't be separated. (Kenneth)

> Spirituality is part of religion it provides for mastery of self and right and wrong. It is a matter of where your spirituality is, within your religion. (Mark)

Participants of both age groups had equally differing views of the differences and similarities of religion and spirituality. For some, religion is not needed for spirituality to be present, and others see spirituality and culture as combined. Religion was spoken of as being an institution or church and spirituality was about self, similar to what has been presented by W. Miller and Thorensen (2003). Some saw it as connected; religion and spirituality coexist and religion helps build spirituality, while others saw it as the same thing, and it cannot be separated.

Views on Spirituality

Spirituality was seen as an important aspect to all participants. There are two areas of spiritual connections that were expressed by participants: the spiritual connections spoken of with self and connections of spirituality with family or others.

Those who expressed connections of spirituality with self spoke of spirituality

with the physical body and the mind. Participants articulated it as being a very important characteristic of self.

> Spirit is the inner being and provides life to the physical body. Spirituality is very important to who I am. (Kenneth)
>
> It is a part of being religious…. It is the self-recognition of body, mind and spirit, which is in every aspect of my life. The spirit is a barometer of where I'm at, where I have been, and where I need to be. (Mark)
>
> It is the most important thing in my life. I focus on me and my family's spiritual health and well being. (Owen)

Participants also spoke of connections with family and others. Family was most spoken of as a connection with spirituality but it was also spoken of as an element of healing.

> Spirituality plays a part in who you are…. Children need a spiritual part of them in their life. (Betty)
>
> Spirituality is a huge component in my life…we use a holistic approach to health and sometimes spirituality is needed to heal. (Cora)
>
> The most essential aspects of your life and your approach to healthy living are based on spirituality. This enables you to contribute to society and render service to people. (Jack)

All participants saw spirituality as a very important aspect within their individual or family lives. Participants spoke of the connections of spirituality with body and/or mind along with healing. They also spoke of the need for spirituality within the family and for this knowledge to be passed on to children.

Views on Religion

The behaviors of participants in relationship to religion were going to church, prayer, studying scriptures, and both learning moral values and teaching them to their

children.

> I believe in a Heavenly Father…and I like to follow his gospel and to serve my fellow man. Prayer can be a very healthy process… (Betty)

> Children see the examples of practicing religion and through these observations they learn both the values and morals of life and spirituality. (Debbie)

> I consider myself to be religious; I go to church, say prayers and study the scriptures. (Ida)

> I have religious beliefs, it is a big part of my life, and it provides a base for my life. Within the culture of being Māori, the things in the (participants) church go hand in hand with being Māori. (Quail)

Religion was seen as being connected, or not, to spirituality by participants. Some saw religion as keeping in harmony with that which is both spiritual and physical. Others saw religion as a conduit for spirituality.

> I think I am religious, I was taught morals and values of…religion but you do not need to go to church to be spiritual. (Betty)

> Religion helps me to focus on both the physical and spiritual and to keep them in harmony. (Kenneth)

> Religion is a part of my life from birth but spirituality does not come necessarily from religion but it provides a cable to conduct spirituality and it focuses your spirituality. (Owen)

Some saw a disconnect between religion and spirituality; they believed that you do not need religion to be spiritual. The vast majority saw a link between religion and spirituality when talking about religion. Those that saw this link between spirituality and religion spoke about behaviors that they saw as part on their religion (i.e., prayer, scripture study, going to church, and acting out their beliefs in everyday life).

Summary on Religion and Spirituality

Some participants reflected that religion was not needed to be spiritual. Those that spoke about religion were able to articulate behaviors that they engaged in that reflected their religion. Participants expressed the connections between religion and spirituality very clearly. Equally clear was the articulation of participants between connections of culture and spirituality. Of all the indicators that arose from the narratives of the participants, spirituality was the only indicator that had both a strong and unanimous voice. Spirituality was universally voiced as the most important element in participants' lives, whereas religion was not viewed in the same way. Religion was expressed in a wide range, from not important at all to very important in participants' lives. Religion and spirituality combined as a condition of maintaining health beliefs of participants could be seen as a necessary but an insufficient condition. However, spirituality as an element could be seen as the key indicator when combined with other conditions as both necessary and sufficient to maintain health beliefs of participants.

Health Model

Physically Unwell

The participants were asked to whom they would speak, first and then second, if they felt that they were physically unwell. The first group of persons that the participants said they would talk to, in highest then descending order, would be (a) other family members such as spouse, parents, or siblings; (b) medical personnel such as doctors; and (c) talking to themselves about any physical problems they may have. The second group

of persons that participants said they would talk to, in highest then descending order, was (a) medical personnel, (b) family, and (c) spiritual personal.

When looking at responses by participants to the above question, an age group difference was found. The older group was more likely to engage with medical personnel as either the first or second person to talk to, whereas the younger group was more inclined to seek a spiritual interaction to talk to in both the first and second person, compared to the older group. Both groups would equally engage with family and self talk. The differences may be explained by the older group having had more experience with engaging with medical personnel than the younger group. The reported behaviors of seeking medical, family, and spiritual help for a physical health issue are congruent with reported health beliefs of including the body, family, and the spiritual aspects in health (as discussed below).

Mentally Unwell

The participants were asked to whom they would speak, first and then second, if they felt that they were mentally unwell (the term "mentally unwell" was not defined by the researcher but was left up to the participant to make meaning of the term). The first group of persons that the participants would talk to, in highest then descending order, would be (a) self and other family members such as spouse, parents, or siblings and (b) spiritual persons. The second group of persons that participants would talk to, in highest order, is (a) medical personnel and (b) spiritual or family persons. The difference between the first and second group of persons approach is that the first group included a medical person with any mental condition they thought may be an issue.

When looking at responses by participants to the above question, there was found to be no difference between the age groups. Both age groups would have included some type of spiritual involvement in a mental aspect of wellness. The older group may have included spiritual intervention sooner than the younger group, who would see this as a first option, but may have engaged self or family first. The reported behaviors of seeking medical, family, and spiritual help for a mental health issue are congruent with reported physical health beliefs of including the mind, family, and spiritual aspects in health (as discussed below).

Physical Versus Mental Health

All participants from both age groups saw health as a holistic process, which included physical, mental, spiritual, and, for most, family as elements of being healthy, with all elements being connected.

> When you look at spiritual, physical health, and mental health they are very connected. (Betty)

> Very holistic and mental, physical and spirituality is all combined and they all need to be equally addressed in a holistic way. Family and close friends are all part of this. (Cora)

The connection was seen in different ways. Some expressed that the connection could be seen as a physical separation, where one can have a physical problem without a mental problem and vice versa (i.e., chemical imbalance that affects mental functioning but not physical functioning, but are still connected at the biological level).

> I see both, mental wellbeing can affect you physically but there are mental health issues that are due to chemical imbalance in the body or as a result of trauma. This is where there is a need for mental health healing that is separate to physical health. (Cora)

> I have seen people that are physically well but have problems with depression but also people can "think" themselves into having physical problems. (Quail)

The other view seen by all was the element of spirituality. This element was included with both physical and mental and, participants expressed that a balance needs to be present to be healthy. The younger group saw the two worldviews of connectedness. This connectedness view changed depending of the way you looked at it from a medical illness model or within a holistic health model. Physical wellbeing and wellbeing of the mind can be seen as sometimes connected and other times not. The younger group expressed the dualistic view more than the older age group. The younger group also expressed the need for inclusion of the spiritual element as a binding component of health more than the older group. They expressed that a balance needs to be maintained between the four elements of health: physical, mental, spiritual and family.

> Absolutely they are all connected, spiritual as well, all three make up who we are and to be healthy there needs to be a balance between the three as well as family wellness. (Mark)

> I see them as being the same thing…. If one is out of synch, then it affects the others, the whole individual. (Aaron)

> They are all connected physical, mental, spiritual and family health. Sometimes it gets out of whack between these things; a balance needs to be maintained. (Elizabeth)

The older group pointed out that when they were younger, issues around mental illness were not spoken about, but were hidden from society. However, they now see that this is the wrong way of looking at mental illness.

> We didn't talk about this when we were younger, society kept all this type of thing quiet. We know that is not the right thing to do now. (Gina)

Although some of the participants saw a separation of the mental and physical as

a function of health, this was within specific settings (i.e., dealing with chemical imbalance or traumatic events, with connections of functionality at a biological level). Both the younger and older groups of participants saw health as a holistic process that included elements of health at physical, mental, and spiritual levels. For most participants this holistic view of health also extended to include a family level as well. This holistic view is in harmony with Durie's (1998) view of health, which was articulated in his *Te Whare Tapa Wha* model of Māori health. The connections between the four elements were seen as requiring a balance between them. The spiritual element was seen as the most important element and it also facilitated the balance between the other elements. This spiritual connectedness was expressed by Pere (1986) in her "*Te Wheke*" model of Māori health and was also reflected in the participants' view of health. The spiritual element is a component of all Māori models of health as presented in Table 1.

Health Beliefs of Māori in Utah

Scott and Sarfati (2000), in their investigation of the crosscultural validity of the SF-36 health survey, found that there was a dichotomy based on age between health beliefs of Māori in NZ Those Māori that were aged greater than 45 years were more likely to have a health belief that connected to a traditional health view that was holistic. This holistic view was presented as being the functionality of both physical and mental health being connected and interdependent. They also found that those Māori aged less than 45 years were more likely to view health within western models of health with the functionality of physical and mental health as being not connected and independent.

This view put forward by Scott and Sarfati (2000) as described above was not supported in this study. Participants unanimously endorsed a traditionally Māori holistic view, as put forward by Durie (1998). The elements of health, physical, mental, spiritual, and family, were found in this study. There were, however differences found between the age groupings of participants. These differences were not in the overall view of health as they were overwhelmingly of one view; they were in the subtle differences found in the conditions and indicators that maintain this health view. These differences have been discussed above.

Along with the study by Scott and Sarfati (2000) the Perkins and colleagues (2004) and Devlin and colleagues (2000) study's findings, were not supported by this study. Both Perkins and Devlin studies reported that Māori views of health were not different than those of non-Māori; and, were based on a western view of health. This study found that all participants held a health view that was aligned to a traditional Māori view and not a western view of health.

Evolution of Utah Māori Beliefs

The health beliefs of Utah Māori have not evolved from the traditional Māori view, which includes elements of physical, mental, spiritual, and family health as outlined in the *Te Whare Tapa Wha* model of health by Durie (1998). All participants in this study viewed health as a holistic process with no separation of physical and mental components as a function of health. The findings of Scott and Sarfati (2000) theorized that acculturation, urbanization, severed ties to *hapu* (sub tribe) and *Iwi* (tribe), weakened

cultural affinity, and lack of language could weaken a holistic traditional Māori view of health. They also theorized that a Māori traditional life style and strong Māori cultural identity could contribute to a holistic traditional Māori view of health. These conditions put forward by Scott and Sarfati (2000), along with any indicators for these conditions, have already been discussed. The indicator that would be needed when combined with other conditions to be able to provide a necessary and sufficient condition to maintain a traditional Māori health belief is spirituality. Spirituality is the indicator that ties in and binds all the other conditions to maintain a traditional Māori health belief.

CHAPTER V

CONCLUSION

Using grounded theory the narratives were collected and analyzed from two groups based on ages of older or younger than 45 years, with eight participants in each group. The research found that all participants held traditional Māori health beliefs. Those beliefs were compatible with the construct of the Māori health model as presented in *Te Whare Tapa Wha.* This model, along with the participants, presented health as holistic and comprising components of physical, mental, spiritual, and family. The health beliefs as presented by participants showed that there was no evolution away from a Māori view of health and they remained within the cultural components as presented in *Te Whare Tapa Wha*. The conditions that were found in this study to maintain a Māori view of health were time in country, acculturation, enculturation, and spirituality.

Time in Country

Most of the first generation immigrants left NZ before the Māori cultural renaissance (1963-1975). A wide variety of cultural knowledge arrived with first generation immigrants. This provided a base from which enculturation practices of first generation immigrants and following generations could engage. Through processes of transnationalism, both first generation and subsequent descendants maintained ties with family, both in NZ and within the U.S. Transnationalism maintains a flow of cultural knowledge between the two nations to facilitate further aspects of enculturation of participants in the U.S. Time in country and the associated indicators could be seen as a

necessary but insufficient condition of maintaining Māori health beliefs.

Acculturation

Acculturation as a condition included indicators of communication behavior change with non-Māori, personal interaction behavior change with non-Māori, and racism. Participants adapted their communication behavior when they were with non-Māori in ways that facilitated greater understanding. Adaptations were made in the use of language to account for cultural norms of non-Māori and use of existing skills to learn new language to be able to effectively communicate.

In a similar way to communication adaption by participants, personal behavioral interactions were adapted to account for cultural norms of non-Māori along with the use of existing skills to learn new behaviors to facilitate social exchanges. Participants expressed the need to understand the social protocols of both Māori and non-Māori and adapted social behaviors to comply with non-Māori protocols so as to meet social norms of personal behavioral interactions. Acculturation could be seen as a necessary but insufficient condition of maintaining Māori health beliefs based on the indictors of language behavioral adaption and personal behavioral interaction adaption.

Racism was experienced by participants, some to a larger degree than others. The extent of participant exposure was dependent on facial and other characteristics (i.e., skin color). For others, racism was based on mistaken identity (they were seen as being from another ethnicity, which had negative social implications). However, the indicator of racism and the negative experiences that are associated with this behavior could be seen

as a confounding indicator of the condition of acculturation on the maintenance of Māori health beliefs.

Enculturation

Enculturation as a condition had four indicators: opportunity to engage in cultural activities, the location in which they were residing at the time, family and other social supports, and participants' "life course." Opportunities to engage in cultural activities varied among participants. Those opportunities also varied based on the location of participants (i.e., at school, family gatherings). The largest indicator of enculturation was participants' social network support, mainly from family. Participants that reported higher engagement in cultural activities also reported higher family or social support systems. Opportunities to engage in cultural activities, locations in which participants lived, and family/social supports varied over time. Through a process of looking at participants' life course, all three of these indicators varied, providing a range of environmental enculturation conditions. Enculturation can be seen as a necessary but insufficient condition of maintaining Māori health beliefs based on the indictors of opportunity, location, family/social support, and life course.

Religion and Spirituality

Religion and spirituality were seen as being mutually exclusive by most of the participants. A smaller minority saw it as being mutually inclusive. While some participants saw connections between spirituality and religion, others saw connections

between spirituality and Māori culture. Religion was seen as being based on institutions, whereas spirituality was more personal based. Unlike religion, spirituality was universally expressed as the most important element of participants' lives and the key elements of their health beliefs. Participants articulated that spiritual behaviors were something they would engage in when seeking help for both physical and mental health issues. The narratives of participants articulated what participants did when seeking help for health and were congruent with what participants said were important in their health beliefs. Religion and spirituality combined as a condition of maintaining health beliefs of participants could be seen as necessary but insufficient. However, spirituality as an element could be seen as the key indicator, and when combined with other conditions, was both necessary and sufficient to maintain health beliefs of participants.

Summary

Health beliefs of Māori who live in Utah, U.S. have not changed over the three generations from the arrival of this family group to the U.S. These beliefs are in harmony and have not deviated from traditional Māori health beliefs as presented in the Māori model of heath *Te whare tapa wha*. This model presents elements of health as physical, mental, spiritual, and family. Participants saw health as holistic, with all elements interconnected and spirituality being the key element that binds all others as well as the most important aspect of their lives. Conditions that maintained this belief were: time in country, acculturation (with racism being a possible resistance to that condition); enculturation, and spirituality. This study did not examine correlations of the different

conditions and indicators of the health belief of participants. It is hypothesized that the origination of the spiritual condition, whether coming from within Māori culture or from some other source, is immaterial. The key condition of the Māori holistic health belief presented in this study is the spirituality of participants.

Enculturation as a necessary but an insufficient condition of Māori health beliefs is based on indicators of opportunity, location, family and social support, and how these indicators play out over the life course of individuals. The most important indicator for enculturation was family or other social support for individuals to engage in Māori cultural activities.

Future Research

The participants of this study were from one *iwi* (tribal) group of Māori, who live in Utah, U.S. Generalizability of these findings to Māori in different locations; and, in particular other countries such as NZ or other countries, is an area of important investigation. Correlations between conditions or indicators of those conditions are still to be investigated. Such as, time in country could translate into investigations about time in rural vs. urban country for Māori in NZ along with its associated indicators. Although this study presents findings that may support a hypothesis that could include variables of; time in country, enculturation, acculturation and spirituality, to maintain a traditional view of health by Māori: As well as, a hypothesis that could include variables of; mental, physical, spiritual and family to define a Māori view of health: And, a hypothesis that could include variables of; location, opportunity, family or other social support and how

these variables are viewed over a life course, to facilitate enculturation. This study has no generalizability to other Māori or indigenous populations, but it does provide a base from which further investigation can start.

Usefulness of the Research

This study was completed with the intention of providing information for my own *hapu* (subtribe) and *Iwi* (tribe). It was designed to be investigatory and descriptive. People from other *hapu* and *Iwi* may find it interesting. Health services to Māori, both in the U.S. and NZ, may also find this study interesting and in the light of "*Whanau Ora"* (a new health service for Māori in NZ), which is being launched in NZ, it may be useful in service delivery investigation. Other indigenous peoples may find this study helpful in undertaking similar investigations with their own peoples, both in research design and to make comparisons. Having had the opportunity and privilege to make contact with my own family in Utah, U.S. this study may assist them in future decisions about engaging in health services. They may also use this in planning enculturation processes or looking at effects of acculturation in the future.

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APPENDICES

Appendix A

Demographic Questionnaire

Demographic Questionnaire

This is a non self-administered questionnaire

This section collects some of your basic background information

1) Are you Male □ Female □

2) Your age? _____

3) Marital status? _____

4) Number of children / grandchildren? _____/ _____

5) Where were you born? _____

6) What city or area do you now live in? _____

7) How long have you lived in the U.S. _____

8) How long has it been since your family moved to the U.S. (generations) _____

9) What is the extended family make up of your household? (Please list)

10) What has been your main daytime activity in your life?

11) What has been your highest educational attainment?

Some high school □ High school graduate □ Some College □ College Degree □

College Graduate or professional Degree □

12) Please indicate your yearly income range?

Less than $20,000 □ Less than $30,000 □ Less than $40,000□ Less than $50,000□

Greater than $50,000 □

13) What cultural activities, are you involved in? (Tangi, hui, kapa haka, weddings, births, family meetings, other please list)

14) How often do you have the opportunity to engage in cultural activities?

Never □ Rarely □ Sometimes □ Often □

15) If you had the opportunity to engage in more cultural activities would you?

No □ Maybe □ Yes□

16) Do you feel you have adequate insurance coverage? Not insured □ yes □ No□

Appendix B

Interview Guide

Interview Guide

This is a non self-administered questionnaire.

Those that are numbered are questions, those with letters and roman numbering are prompts.

The first three themes are to further explore questions in the demographic questionnaire.

Theme: Participants story of time in country

1. In your answer to the question: How long has it been since your family moved to the U.S. You stated _____ can you tell me more about that?

Theme: Participants enculturation practices

1. In your answer to the question: How often do you have the opportunity to engage in cultural activities you stated _____ can you tell me more about that?
2. In your answer to the question: What cultural activities, are you involved in you stated _____ can you tell me more about that?
3. In your answer to the question: If you had the opportunity to engage in more cultural activities would you, you stated _____ can you tell me more about that?
    a. In what other ways do you consider that you identify with your culture?
    b. Have you attended a family reunion?
    c. How often?
    d. Have you participated in extended family activities?
    e. What are they?
    f. How often?
    g. Have you participated in activities that would be considered by people outside of your ethnicity as being part of your culture?
4. In what ways do you maintain contact with your Māori family members that live in New Zealand?
    a. How often do you make contact?
    b. How often do you visit New Zealand?
    c. Do you participate in cultural practices while in New Zealand?
5. In what ways do you see that there is a difference between spirituality and religion, if there is a difference
6. In what ways do you see your spirituality an important aspect of your life?
7. In what ways do you consider yourself to be a religious person?

Theme: Participants behavior change due to acculturation pressures

1. In what ways have you needed to alter your language when communicating orally with non-Māori people in U.S.?
    a. Can you tell me more about that?

2. In what ways have you changed the way you behave or act in comparison to how you behave or act around other Māori?
    a. Can you tell me more about that?
3. In the U.S. in what ways have you experienced racism?
    a. Can you tell me more about that?

Theme: Participants' understandings of health

1. You think that you may be unwell physically. Who would you see/talk to about this first?
    a. Self
    b. Family member
    c. Extended family member
    d. Significant other person in your life
    e. Nurse at a local health clinic or medical center
    f. Doctor at a local health clinic or medical center
    g. Spiritual leader
    h. A person / healer that provides an alternative to western medical processes
        i. Why
        ii. Who would you see/ talk to second?
        iii. Why
        iv. Who else would you see/ talk to?
        v. Why

2. You think that you may be unwell mentally. Who would you see/talk to about this first?
    a. Self
    b. Family member
    c. Extended family member
    d. Significant other person in your life
    e. Nurse at a local health clinic or medical center
    f. Doctor at a local health clinic or medical center
    g. Spiritual leader
    h. A person / healer that provides an alternative to western medical processes
        i. Why
        ii. Who would you see/ talk to second?
        iii. Why
        iv. Who else would you see/ talk to?
        v. Why

3. Do you see the function of physical health and mental health as being two different things or are they the same thing?
    a. Can you tell me more about that?

Appendix C

Letter of Information

***Nga Whaiora Tikanga Roanga*: Māori views of health in Utah**

Introduction/ Purpose Professor Roberts and Syd Davies a PhD student in the Department of Psychology at Utah State University (of Ngati Wai, Ngati Porou decent) are conducting a research study to find out more about Māori beliefs of health. You have been asked to take part because you are Māori (Ngati Wai decent) living in Utah. There will be approximately 16 total participants in this research.

Procedures If you agree to be in this research study, the following will happen to you. You are invited to take part in this project through an interview that is structured around your beliefs of health. As the interviewee you will be asked to retell your experiences or thoughts on the subject of health through personal narrative as well as answering questions. For example, a scenario will be presented of a situation where a person needs help with their health and you will be asked what you would do in this situation. The interview will be organized at a time and place that is mutually suitable to you and the interviewer. It is up to you to decide whether you want family or other people to be present. The interview, with your permission, will be audio taped to assist the researcher to re-listen to responses; however you are free to ask for the recorder to be turned off at any time. This recorded interview will not have your name on the label and will be destroyed no longer than one year after the recording is made.

Risks Participation in this research study involves minimal risk. You may find yourself reflecting on your identity with Māori cultural beliefs in health that you may or may not have done before the participation in this research. This interaction may cause feelings of guilt associated with possible non association with Māori cultural identified groups.

Benefits There may or may not be any direct benefit to you from participating in this study. The investigator, however, may learn more about Māori health beliefs and behaviors in Utah. By way of benefit to the Māori community internationally, this research will stimulate discussion and debate around the transformational process of Māori in U.S. with changes over time of social, political, economical and ecologies of health.

Explanation & offer to answer questions Mr. Syd Davies has explained this research study to you and answered your questions. If you have other questions or research-related problems, you may reach Professor Roberts at 797- 0088.

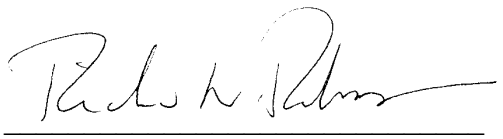
Voluntary nature of participation and right to withdraw without consequence Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence or loss of benefits.

Confidentiality Research records will be kept confidential, consistent with federal and state regulations. Only the investigator and Syd Davies will have access to the data which will be kept on a password protected computer or in a locked file cabinet in a locked room. Personal, identifiable information will be removed from all study records and

stored separately until it is no longer needed for follow-up. All voice recordings will be destroyed no longer than 1 year from the start of this research project.

IRB Approval Statement The Institutional Review Board for the protection of human participants at U.S.U has approved this research study. If you have any pertinent questions or concerns about your rights or a research-related injury, you may contact the IRB Administrator at (435) 797-0567 or email. If you have a concern or complaint about the research and you would like to contact someone other than the research team, you may contact the IRB Administrator to obtain information or to offer input.

Investigator Statement "I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered."



Richard N. Roberts, Ph.D.
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Appendix D

Glossary of Terms

Glossary of Terms

Aotearoa	New Zealand
Hapu	Subtribe
Hinengaro	Mental, mind
Iwi	Tribe
Te Whare Tapa Wha	The four corners of the house
Te reo Māori	Māori language
Tinana	Physical
Whanau	Family, extended family
Wairua	Spirit, spiritual

VITA

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Tertiary Qualifications

2010 PhD, Community Psychology, Utah State University
2008 M Soc Sci. Psychology, University of Waikato
1995 (Start date) Post Grad Dip Counselling (has yet to be completed)
1995 BSoc Sci Hon. Psychology
1994 BSoc Sci (Psychology / Sociology)

Courses Attended

1993 GAIN's Programme (Trained Facilitator)
1993 Youth Suicide (Trained in the "Evaluation of Imminent Danger for Suicide" NZ)

Teaching Experience

2010 Lecturer Psy 4240 Multicultural Psychology (Utah State Uni)
Teaching assistant Program Evaluation, Masters program (Utah State Uni)
2009 Lecturer Psy 4240 Multicultural Psychology (on line course) (Utah State Uni)
2008 Lecturer Psy 4240 Multicultural Psychology (Utah State Uni)
2006 Tutor Statistical Analysis in Psychology (Waikato University)
1994— 1995 Tutor Statistical Analysis in Psychology (Waikato University)
1994— 1995 Facilitator, Seminars on Māori Counselling. (Various organisations)
1990— 1996 Tutor, Computer and Software application. (Private Company)
1976— 2006 Facilitator, Life Skills to Youth (Community organisations)

Research

1993 Principle Researcher, Waikato University, TLDU, "New Start Program and Mature Students"

1994 Researcher, IRTAC, "International Research into the Availability of Counselling"

1995 Researcher, Waikato University, School of Education, "Māori Models of Counselling"

1996 Researcher, Career Services, "Evaluation of Māori Link Programmes"

1996 Principle Researcher "Intra-cultural differences Māori and Marae"

2005 Masters thesis "Kaumatuatanga: Roles of Kaumatua (elderly) and future direction"

2007/10 Research Assistant Early Intervention Research Institute, U.S.U topics on Health Disparities, Community Coalition Building for Children with Special Health Care Needs.

2007/8 Research assistant Coping Competence: A New Measure Based on Learned Helplessness Theory.

2009/10 PhD Dissertation: Māori Health Beliefs in Utah

Presentations and Conference attendance

1995 International Conference of Ethnicity and Multi ethnicity Conference - BYU Hawaii

1995 Utah Mental Health Conference - Deer park, Utah

1995 Māori Health Conference— NZ Ministry of Health, Turangawaewae Marae

2006 Waikato University— Presentation to Summer school Māori research students— "Qualitative Research methods"

2006 Waikato University— Invited guest lecturer Māori Psychology students "Māori Elderly"

2006 American Indian Psychologists Convention— U.S.U, Utah, Poster presentation Kaumatuatanga: Roles of Kaumatua (elderly) and future direction"

2006 International Society of Comparative Psychology Conference— Christchurch, Symposium Chair "The Māori Legacy of the relationship between people and animals"

2006 Waikato University— Presentation, Māori psychology graduate students, "Roles of Kaumatua: Future direction".

2006 Waikato University— Presentation, Faculty of Arts and Social Science, Graduate students research seminar— presentation "Māori Research: Political Mine Field"

2006 Joint Conference of the Australian Psychology Society and New Zealand Psychology Society— Auckland, New Zealand— Presentation "Roles of Kaumatua: Future Direction".

2006 The National Institute of Research Excellence for Māori Development and Advancement— MAI Doctoral Conference, Auckland, NZ.— Poster presentation "Kaumatuatanga: Future Direction".

2007 American Indian Psychologists Convention— U.S.U, Utah, paper presentation "Bio Colonization: A Māori perspective"

2007 Conference on Respecting Tribal Nations and Members when conducting Research. Tulsa, OK— attendee.

2007 Early Intervention Research Institute, Research Day U.S.U, Utah, Poster presentation. "Ethnic Minority Health Disparities for Children with Special Health Care Needs".

2008 Pacific Worlds and the American West. Conference at SLC, Utah. Conference attendee.

2008 Conference on Research Innovations in Early Intervention, San Diego, CA. Poster presentation. "Understanding the "Space" of race/ethnicity in Early Intervention Research and Practice".

2008 Association of Maternal & Child Health Programs Conference, Alexandria, Virginia. Workshop presentation. Creating State Sets to Address Health Disparities.

2008 21st Annual Convention of American Indian Psychologists and Psychology Graduate Students, Logan, Utah. Plenary session "Cultural Safety, A Māori perspective: A call for recognition of prior learning".

2008 XXIX International Congress of Psychology, Berlin, Germany. Plenary session, Kaitiaki: A Māori Perspective of Environmental Science.

2008 American Psychology Association Annual Conference, Washington, DC. Division 8 Poster presentation. Coping Competence: A New Measure Based on Learned Helplessness Theory.

2008 American Psychology Association Annual Conference, Washington, DC. Poster presentation. Habitual Self Control: A brief Measure of Persistent Goal Pursuit

2008 Six National Conference on Quality Health Care for Culturally Diverse Populations. Minneapolis, MN. Three World Views: Understanding CSHCN Quality Health Care Through My, My, My, Eyes. (Accepted to present)

2009 Association of Maternal & Child Health Programs Conference, Washington, DC. Workshop presentation. Public Health Data to Address Disparities: Meeting the Challenges.

2009 22nd Annual Convention of American Indian Psychologists and Psychology Graduate Students: Māori model of health vs. Western model of health.

2010 Nga Pae o te Maramatanga International Indigenous Conference 2010; *Nga Whaiora Tikanga Roanga*: Māori health beliefs in Utah.

2010 23nd Annual Convention of American Indian Psychologists and Psychology Graduate Students: PTSD In Native American Communities

Publications

1993 Davies, S., Elkington, A. & Winslade, J. (1993). Putangitangi: A Model for Understanding the Implications of Māori Intra-Cultural Differences for Helping Strategies. *New Zealand Journal of Counselling. XV. 2, 2-6*.

Publications under review

2009 Schroder, K., Davies, S. (2009). Habitual Self-Control: A brief Measure of Persistent Goal Pursuit.

2009 Richards, R., Davies, S., (2009). Ethnic Health Disparities for Children with Special Health Care Needs: What does it Look Like?

2010 Book Chapter: Historic Trauma Indigenous peoples; An introduction.

Submissions

2007 Letter to the editor Maxim Institute (published) "Aboriginal rights in the face of Australian government policy".

2007 APA submission (Accepted) on "Criteria for the Evaluation of Quality Improvement Programs and the use of Quality Improvement Data".

Reviews

2008 Review for Person Arts and Science Allyn, Bacon/Longman, Book proposal Multicultural Psychology

2008 Review "Multicultural Psychology" (2Ed), Hall, G., Prentice Hall.

2009 Reviewer MAI Journal (Aotearoa/New Zealand)

Memberships

NZPsS New Zealand Psychological Society
ICPA Institute of Community Psychology Aotearoa (New Zealand)
NZCCP New Zealand Collage of Clinical Psychology
ISCP International Society of Comparative Psychology
SIP Society of Indian Psychology
SCRA Society for Community Research and Action, Div 27 APA
APA American Psychological Association
APS Association for Psychological Science

Research Interest

Cultural Identity, Indigenous psychology, Multicultural psychology, Indigenous counselling Psychology (methods), Community Psychology, Developmental Psychology, Historic trauma

Community Involvement (paid and un-paid)

2003-2006	Trustee, Ngati Rehua ki Aotea Ngatiwai Trust Board, tribal development
2000-2003	Co-ordinator of building wharekai at Iritekura Marae
1996-1997	Founding Board member Te Tai Tokurau MAPO (Māori health funding NZ Gov Body)
1996-1997	Kaunihera Board member on Northern Regional Health Authority (NZ Gov Body)
1998-1998	Chairperson Standards Committee, KASSITO (NZ Gov Body)
1995-1998	Executive member, KASSITO (Industry Training Organisation for Social Services, NZ Gov Body)
1994-1995	Co-ordinator Māori Heath and Social Services, Ngatiwai Trust Board
1994-1998	Counsel member, KASSITO (NZ Gov Body)
1994-1998	Member Standards Committee, KASSITO (NZ Gov Body)
1994-1994	Member Ministerial Committee for Social Services (NZ Gov Body)
1994-1996	Executive member, Te Whariki Tautoku (Professional body of Māori Counsellors).
1993-1994	Steering committee on “Creating an academic path way for Māori Counsellors”.
1992-1996	Te Tetakura A Tane, Counsel member and Counsellor
1986-1990	Māori business persons Ass. President, Vice President, Committee member.
1986-1990	Scouting Assistant. NZ, Ventura Scout Leader.
1985-1986	Aotea Ngatiwai Trust, Founding chairperson, tribal development
1984-1985	Auckland City Council, steering committee; Street Kids