IMPRISONMENT: YOUNG PACIFIC WOMENS' EXPERIENCES OF LIVING

WITH DEPRESSION

BY

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A thesis submitted to the Victoria University of Wellington

in fulfilment of the requirements for the degree of

Master of Education

Victoria University of Wellington

2015

ABSTRACT

Research has shown that depression is prevalent in adolescence. This descriptive phenomenological study explored the lived experiences of young Pacific Island (PI) women (17-25 years of age) living in New Zealand. Phenomenological interviewing was used to capture the lived experiences of depression with the aim of developing a deeper understanding of what it is like to be a young depressed PI woman. The essence of being depressed was imprisonment. Young PI women described how family and cultural pressures, experiences of failure and abuse led to their depression. They experienced rejection, being labelled, misunderstood and silenced by others and their circumstances and depression trapped them. The women managed their depression by finding their voice in writing journals, listening to music, reading bible scriptures, prayer and connecting to others with similar lived experience. The implications of the study are discussed in relation to improving parent education and culturally relevant support for young PI women. Recommendations for future research include developing approaches to research that include a more specific cultural and gender focus.

Key words: depression, pacific youth, phenomenology

ACKNOWLEDGEMENTS

'*I can do all things through Christ who strengthens me.'* **Philippians 4:13**

With my upmost gratitude, I want to thank God for his endless love and guidance throughout my studies. This by far, has been the most difficult thing I have encountered. He did not give me an easy journey, but the courage to endure a difficult one. For this, my heart is filled with thankfulness.

Despite not being raised in my mother land of Samoa, I will never forget the villages that I, my family and ancestors hail from, the beautiful villages of Safa'ato'a ma Faleāse'ela, Lefaga. Le Pa'ia i le 'Āiga Sātuala, susu o Tapa'au Lavasi'iuta ma le Lavasi'itai, le Afio o Le Uso ma le 'Ailaoa, Mamalu maia 'oe Tuisavailu'u ma lou Nofoitu'āiga. Le Pa'ia i le Taulagi ma i la'ua Matua, mamalu i le Faleaa'ana ma tagata o le Vavau.

There are a few people I would like to acknowledge and thank, people who have paved the way for me to be in the position I am in today. To my late grandfathers, Tuimua'i'ava Ioane Mua'i'ava and Leatuāvao Fa'alata Leatuāvao and grandmothers Asosa'asa'a Mua'i'ava and Tagisia Leatuāvao. To my uncles and aunties, lau Tofā i le Tafa'ipa'ia Tuimua'i'ava Toso and Tai Mua'i'ava; Leatuāvao Atonio and Taua Leatuāvao, Leatuāvao Vito and Silafa'i Leatuāvao; Le'au salilōaPetelo and Maima, Taualumaga Kitiona Mua'i'ava and Finao, Lilomaiava Iulio and Fa'asalafa Pati; Le'ausalilōuTasi and Asofa, Tausaga Leatuāvao and Leota; Molia Mua'i'ava; Selau Lologa; Auala Enele Mua'i'ava; le Susuga le Fa'afeagaiga Motuga Matagi ma le faletua ia Sioi; Tuiataga Fa'afili Fa'afili; Silia Mua'i'ava Kuka; Falepauga Toso; Silia Pa'usisi Finau; my late uncles and aunties Le'ausalilōuAmeto and wife Alofa; Fa'asalafa and Leiataua Tokuma; Finau Pa'usisi, Fofoa Tafa,and all my cousins, thank you all.

To the best parents one could ever ask for, Rev. Elder Malaki Mua'i'ava and Rosalili Mua'i'ava of the E.F.K.A.S Wainuiomata. Mum, Dad, ou te alofa tele mo oulua. Ua tele galuega lelei ua oulua faia mo a'u. Fa'afetai mo le a'oa'oina o a'u ina ia fa'amuamua pea le Atua i mea uma oute faia. Fa'afetai mo le una'ina o matou i le a'oga aua se lumana'i o 'aiga, nu'u ae fa'apea le galuega Pa'ia a le Atua. O la'u tatalo ina ia fa'afualoaina lo oulua soifua ma ia avea lenei tusitusiga e fai ma fa'ailoga o lo oulua alofa moni mo a'u. Also, to my siblings, Semisi and wife 'Ula; Susana and husband Peter; Le'ausalilō Sadat and

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CHAPTER ONE: INTRODUCTION

Introduction to the problem

The mental health of young New Zealanders has been an ongoing concern for those involved in education, health and social welfare. The New Zealand Mental Health Survey (Oakley Brown, Wells, & Scott, 2006) found that many people in New Zealand experience and struggle with a mental health problem at some stage of their life. Out of the 13, 000 New Zealanders (16 years and over) that participated in this survey, 40% experienced a mental disorder. Anxiety was the most common disorder (lifetime prevalence of 25%) followed by depression (20%). The survey showed mental disorders are often identified in adolescence and before the age of 18 and females have reported a higher lifetime prevalence rate of major depressive disorder (42%) in comparison to males (37%) (Oakley Brown, Wells, & Scott, 2006).

In New Zealand, the Pacific population is estimated to reach 480, 000 by 2026. This projection is an increase of 180, 000 which is 2.4 percent over the 2006 estimate of 300, 000 (Statistics New Zealand, 2010). In relation to mental health, Te Rau Hinengaro (2006) have found that overall, Pacific people experience higher rates of mental illness than other ethnic groups living in New Zealand. Within the Pacific community, Pacific youth aged 16-24 years are more likely to report they have experience of a mental disorder that is classified as 'serious' or 'severe' compared to older Pacific Islanders.

Pacific youth also are also exposed to more negative life outcomes because of their higher rates of mental illness. For example, Pacific people aged 16-24 years, have higher rates of suicide ideation (4.5%) and attempts (1.2%) in comparison to the general population (Oakley Brown, Wells, & Scott, 2006). This survey has also found that Pacific people (25%) are less likely than general population (58%) in New Zealand to seek or receive treatment from mental health services for depression, suicidal ideation or suicide attempts which are often associated with depression.

In an early study, Petersen and colleagues (1993) found depression was most likely to occur during adolescence. Adolescence and emerging adulthood are characterized as times of increased life stress, moodiness and pre-occupation with the self. While there is an abundance of research that has contributed to what is known about the risk factors for

adolescent depression, possible causes and contributing factors, effective treatment, and some research on recovery, little qualitative research has focused on describing how young people experience depression – their lived experiences of the phenomenon itself.

Furthermore, little is known about how gender, family and culture may influence how depression is experienced in young people. The majority of the research on depression has been quantitative in nature with a focus on the experience of depression in American adolescents. While there is a growing body of national and international research that explores how depression is experienced by young people, there are few studies that specifically focus on how young women experience depression, and the meaning of that experience. Furthermore, there is a paucity of qualitative research that focuses on the experience of depression within young people from different cultural groups and ethnic minorities, including Pacific Islanders, who are living in New Zealand.

Definition of Terms

Developmental psychologists such as Arnett (2013) have described the years from late teens (15-17 years) through to emerging adulthood (17-25 years) as a time of profound change. It is a period where young people have to make decisions based on future desires and goals. The dependency of adolescence is left behind and replaced with the exploration of possible life direction in love, work, and worldviews as they enter into young adulthood (Arnett, 2001). In western cultures, 'young adulthood' or 'emerging adulthood' are often characterized by gains in relative independence from social roles and normative expectations (Arnett, 2013).

The term depression has been used in a number of ways within the research and literature and refers to a range of mental health phenomena. It can refer to a transient emotional reaction that everybody will experience from time to time but it can also refer to a clinically diagnosed symptom or illness (Shargass, 1981). Depression has also been defined as a significant lowering of mood; feeling of guilt, hopelessness and a drop in one's self esteem (Parker & Hickie, 2007). Furthermore, it has also been used in research to refer to different phenomena; this makes drawing conclusions and comparing studies on adolescent depression. For example, Peterson et al., (1993) identified three different ways depression has been classified or used in the literature: depressive mood, depressive syndrome, and clinical depression.

There is no set definition of who a Pacific Islander is. Instead the term Pacific Islander is used to group together people from many distinct ethnicities, those who use one or more of 13 distinct languages and cultural groups. Some of the main Pacific ethnicities under the Pacific umbrella are Samoan, Tongan, Fijian and Tokelauan with smaller numbers in Papua New Guinea (Tukuitonga, 2013). Therefore, because there is no set definition for who or what a Pacific Islander is, this term can be given to an individual who identifies themselves as having cultural heritage from one or more countries in the Pacific (Tukuitonga, 2013).

Lived experience is a phenomenological term used to refer to first-hand experience. It refers to individuals who have lived-through a particular experience. They are able to describe their experience of a particular phenomenon and provide insight into the meaning of those experiences (van Manen, 2014).

Background to the Problem

Over the past decade, adolescent depression has become progressively recognised as a severe mental health condition throughout various countries and cultures (Woodgate, 2006). There is an abundance of international research on adolescent depression (Parker & Roy, 2001), with the majority focusing on American adolescents and quantitative in nature.

In New Zealand, there are only a few studies that have focused on adolescent depression (Denny, Clark, Fleming & Wall, 2004). While there is a growing body of research on Pacific Peoples and mental health (Ministry of Health, 2008, Pulotu-Enderman, Suaalii-Sauni, Lui et al., 2007; Tiatia-Seath, 2014; Vaka, 2014) few studies have focused specifically on how young Pacific Islanders experience depression. Based on previous studies and findings, there is an urgent need to carry out qualitative research to better understand the experience of adolescent depression and how family, culture and gender contexts might shape their experience. This research will help inform the development of 'youth-friendly' mental health services and help parents and other key stakeholders develop a better understanding of the life worlds of young people who struggle with depression.

Focus of the Study

This study focuses on young PI women (17-25) years who have lived experience of clinical or major depression. The focus will not be on their perceptions, thoughts or opinions, but on actual accounts of their own personal experience of depression. It critically examines how contexts such as family, culture and church influence their experience. These contexts have been shown to be important in Pacific Islander's experience. The family and culture system constitutes their parents, cultural and religious community, as well as norms and expectations. These contexts influence both experience and understanding of the world as well as their experience of depression. This study explores young PI women's experience of the onset of their depression, their experience of living with depression, and their struggle for management and recovery.

Purpose of the Study

A review of the international and national research on adolescent depression shows that there is a paucity of qualitative research that explores the lived experience of depression from young people's point of view. Previous studies have shown that there are important gender differences in the experience of depression as well as important cultural differences. Research on adolescent depression has been mainly quantitative and focused on measuring prevalence, identifying risk factors and assessing the efficacy of various treatments for depression. The few qualitative studies that have been conducted have helped advance understanding of issues such as how young people respond to depression, their coping strategies, how family and friends support or create barriers to recovery, and stigma. Few qualitative studies have focused on the experiences of ethnic minorities or single gender groups.

The purpose of the present study is to investigate and explore what it is like to experience depression as a young PI woman (17-25 years of age) living in New Zealand. A descriptive phenomenological methodology was chosen to get to the essence of their lived experience, and to help those working in youth mental health to better understand the challenges young PI women face and the strategies they utilize to support their own wellbeing and recovery.

Chapter Two identifies, summarizes and critically discusses the research and literature on depression in young people including the qualitative research. It identifies key risk and protective factors, effective treatment, prevention strategies and themes in the qualitative research in New Zealand and from overseas. The review includes a critical discussion of the key findings in studies and also identifies the gap in the research and the rationale for exploring the phenomenon using the proposed methodology.

Chapter Three outlines the methodology and methods used in this study. The chapter begins by outlining the objective of this thesis: to describe and develop an understanding of the lived experiences of young PI women with depression and to get to the overall essence of what it is like to be a young PI woman living with depression. Participants were from a community (non-clinical) sample, from within the greater Wellington region. They were 17-25 years of age, and all had been diagnosed with depression and had lived with it from between 1-4 years. They were recruited using a number of strategies including the use of fliers, word of mouth, mass email to PI community groups, and through Pacific Support services that young people often access.

A qualitative research paradigm was chosen because of its focus on describing, exploring and explaining rather than measuring, hypothesis testing, quantifying or predicting lived experiences. In the present study the epistemology was social constructionism (Young & Collin, (2004), which purports that knowledge is a product of social interaction and social and relational processes influence how people construct their social world and reality. The theoretical or philosophical perspective was (descriptive) phenomenology (Cresswell, Hanson, Clark Plano & Alejandro, 2007), and the method of data analysis chosen was descriptive phenomenological analysis (McMillan, 2010). Descriptive phenomenology was chosen in order to explore and understand the experiences of depression by focusing on the participant's perspective, experience, and his or her interpretation of experience (Lopez & Willis, 2004)

Chapter three also outlines the data collection methods which involved qualitative semi-structured open-ended interviews. These were used in order to obtain rich descriptions of the experience of depression. It also described the key stages used in analysing the data including: coding, development of sub-themes and major or super-themes. Finally, the strategies used to ensure reliability/integrity and trustworthiness are discussed along with the ethical considerations of this study.

Chapter Four describes the key findings of this study. The chapter begins by describing the overarching essence or meaning of what it meant to be depressed: *Imprisonment*. The findings of this study are presented thematically under five main super-themes: 1) *Failure* (2) *Rejection* (3) *Imprisoned* (4) *Doing it Hard* and (5) *Freedom*. Each of these super-themes are supported by numerous sub-themes that represent a description of the lived experience and the verbatim extracts from the students' interviews (lived experience descriptors).

Chapter Five is the final chapter of this thesis and includes a discussion of the findings and their significance in relation to relevant literature and research. It also outlines the implications of the findings for supporting and understanding young PI women who are depressed, and suggests the need for psycho-education programs for their parents and community. Suggestions are made about how to build on the findings of the present study and a number of recommendations are made for future research. The limitations of the study are outlined and conclusions drawn about the topic, the problem and the thesis. The next chapter reviews the literature and research on adolescent depression.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The previous chapter introduced the topic of this research study and provided some background on the issue of depression in young people. This chapter provides a critical review of the most relevant and contemporary national and international literature pertaining to the research topic. Scholarly literature and research was included which focused on: depression in adolescents and young people, theoretical perspectives on depression; research on prevalence, risk and protective factors, treatment and recovery. Both quantitative and qualitative research were included and steps were taken to try and find research that included pacific populations.

Defining Depression

Depression as a term has been used in a number of different ways to refer to different but related phenomena and this means comparing research studies is sometimes difficult. Depression can refer to a transient or short-lived emotional reaction (depressed mood) that everybody will experience from time to time but it can also refer to a clinically diagnosed symptom (clinical depression), syndrome (depressive syndrome) or illness (Shargass, 1981). It has been defined as involving a significant lowering of mood; feelings of guilt, hopelessness and a drop in self-esteem (Parker & Hickie, 2007). Depression is also reported to have a significant impact on emotional wellbeing, and involves erratic emotional states such as anger, self-blame and guilt (Ofonedu, Percy, Harris-Britt, & Belcher, 2013).

Peterson et al., (1993) have identified three different ways depression has been classified or used in the literature: depressive mood, depressive syndrome, and clinical depression. Depressive mood is defined as periods of sadness or being unhappy that everyone experiences from time to time as a result of certain situations such as an end to a significant relationship or failure to complete a simple task (getting out of bed or completing homework). The idea of a depressive syndrome is based on the view that anxiety and depression occur as a result of a combination of emotions that transpire together for no apparent reason. Clinical depression is a condition that is defined or

identified by loss of interest in pleasurable activities, weight loss or gains, change in sleeping patterns, abnormal amounts of guilt and repeated suicidal ideation. The difference between clinical depression and depressive mood or syndrome is in the duration of the changes experience. In order to be classified as clinically depressed the symptoms must be persistent and occur over at least a year (Peterson et al., 1993).

The way depression in young people is assessed and reported in the literature also makes understanding the phenomenon difficult. Depressive mood and syndrome tend to be either self-reported or are measured based on the observations and reports of parents and teachers. However, diagnosis of clinical depression is typically based on two diagnostic models (Petersen et al., 1993). The American Psychiatric Association developed the first diagnostic model and the World Health Organisation developed the other method. The diagnostic method developed by the American Psychiatric Association is the one that is used universally which evaluates disorders based on its presence, duration and severity (Petersen et al., 1993). Although clinical depression is unique from depressive mood and syndrome, diagnosis can be difficult due to the overlap that exists in classification of depression (Petersen et al., 1993).

Complicating the issue further is the fact that there are different types of depression that fall under the three categories discussed above, these include: Major Depression, Melancholia, Psychotic Depression, Antenatal and Postnatal Depression, Bipolar disorder, Cyclothymic Disorder, Dysthymic Disorder and Seasonal Affective Disorder (SAD) (Ryan et al., 2010). All these different types of depression have different symptoms. Some are similar in the sense that the symptoms in one form can be found in another form of depression. Some forms of depression have also been give multiple names. For example, 'major depression' is also known as 'clinical depression', 'unipolar depression' or simply 'depression'. Major depression is the most common form of depression found in young people, and it is also the most difficult form of depression to diagnose because its symptoms (mood swings, sadness, irritable or more sensitive) can be seen as part of growing up for adolescence (Ryan et al., 2010). Another type of depression that has similar symptoms is Dysthymic Disorder. It is similar to Major Depression but is considered less severe despite the fact that the symptoms last for a longer period of time.

Abela and Hankin (2008) have also noted that defining depression is problematic. One of the reasons is because symptoms or manifestations of depression may differ throughout the lifespan because of cognitive, social, emotional and biological changes that arise or develop with age and development. Therefore, developmentally speaking, depression and its causes and ramifications may change throughout different developmental stages.

Abela and Hankin (2008) also discussed how quantitative and qualitative research on depression has focused on different populations and this has also made developing understanding of depression more challenging. Quantitative research has focused on depressed individuals and usually focuses on the extent, symptoms and causes of their depression. In comparison, qualitative research has focused on the experience of individuals and compared those who are either depressed or not. Abela and Hankin (2008) have suggested the need for more research to determine whether depression is the same for children and adolescents compared to adults.

A lot of researchers use the term depression without operationalizing or clearly defining which type of depression they are referring to. Others use it as an umbrella term and do not provide clear definitions of the exact phenomena being studied. Some studies make no clear distinction between depressed mood, syndrome or clinical depression. There is a need for studies to clearly define the phenomenon being study so that understanding can be advanced and conclusions drawn about the causes, effects, experience and best treatment for adolescent depression.

Prevalence

Epidemiologic literature reviews on child and adolescent mood disorders such as depression have found that significant levels of depression in adolescence, reporting 20 to 50% of adolescents reporting depressive symptoms (Kessler, Avenevoli, & Merikangas, 2001). Various quantitative studies on depressed adolescents (mostly in high school students) have been carried out in America and have identified an increase in the prevalence of clinical depression during adolescent years (Merry & Spence, 2007).

In New Zealand, the Dunedin Health and Development Study (McGee, Feehan, & William, 1996) and the Christchurch Health and Development Study (Fergusson & Horwood, 2001), are two longitudinal studies where rates of mental disorders in young New Zealanders have been monitored and studied. In the 1996 Dunedin study, prevalence

rates increased from 18% (11 year olds) to 35% (18 year olds). These prevalence rates were later supported in the Christchurch study (2001) which found 18 year olds have a prevalence rate of 42%. Depression is one of the most dominant mental health disorders reported alongside anxiety disorders, conduct disorder and substance abuse showing 40% of 18 year olds had more than one disorder (Fergusson, Horwood, & Lynskey, 1997)

International studies have also found depression to be more common during adolescence (Hetherington & Stoppard, 2002). A higher prevalence of depression has been found in adolescent females (Pinto-Foltz, Hines-Martin & Logsdon, 2010), with gender differences first emerging in adolescence (Nolen-Hoeksema & Girgus, 1994). Studies have shown that there are important gender differences in the prevalence of depression in adolescents and young people and gender has been identified as a key risk factor.

In a systematic review of the research on prevention and intervention of depression, Merry and Spence (2007) reported that depression is more prevalent in females. They found that some studies reported 20-24% of females suffer from depression by the age of 19. Furthermore, cumulative prevalence of depression by the age of 16 years was estimated at 11.7% in girls and 7.3% in boys but acknowledged that estimates in other studies are lower (Merry & Spence, 2007). Other studies have also shown gender difference in rates of depression in adolescents (Lewinsohn, Rhode & Seeley, 1998).

Petersen and colleagues (1993) have offered one explanation for the gender difference. They claim that young women experience higher rates of depression because girls may experience more challenges in adolescence such as pubertal changes before and during high school. Depression has been linked to body image dissatisfaction in girls. They also suggest that estimates based on self-reports are biased because young women are more likely than young men to seek help for depression, more likely to be clinically diagnosed by their GPs and therefore, more likely to report being depressed.

Cultural differences in the prevalence of depression also exist. Research has shown that depression also seems to be higher in certain ethnic or cultural groups. For example, Oquendo et al., (2001), found that the prevalence of depression were 3.6% in Whites and 6.9% in Puerto Ricans.

Overall, the research shows that that depression is more prevalent during adolescence than other periods of the lifespan and that young women are more likely to experience or

report depression than young men and that certain cultural groups may be at greater risk of developing depression due to exposure to cultural factors that influence mental health.

Theories/Perspectives on depression

A number of the theories have been purported to explain depression, most of which have a cognitive focus. The primary concern of cognitive theories is to explain the relationship between human mental activity or negative cognitive styles (Calvete, Orue, & Hankin, 2013) and the experience of depressive symptoms and experience. According to cognitive theories, mental processes such as observing, recognizing, and reasoning have a significant influence on the onset or development of depression and its occurrence (Abela & Hankin, 2008). It is important to note that cognitive theories usually draw upon diathesis-stress models. These models suggest that people have a predisposing cognitive vulnerability, and assume or hypothesize that depression occurs as a result of the interaction between an individual's cognitive vulnerability and environmental factors that act as stressors. Stressors such as negative life events may trigger or predispose people to depression and include but are not limited to, death of a loved one, loss of employment and abuse (Mazure, Bruce, Maciejewski & Jacobs, 2000).

One of the most recognized and supported cognitive theories of depression is Beck's Cognitive theory (Abela & Hankin, 2008). Calvete, Orue and Hankin (2013) comment that according to Beck's theory, cognitive vulnerability to depression in children and adolescents consists of cognitive schemas associated with negative events or biased views about the world (feeling insignificant), relationships with oneself (feeling unloved) and others (feeling unworthy).

Another cognitive theory, that is similar to Beck's theory and also widely recognized in relation to explaining depression, is Hopelessness Theory (Abramson, Metalsky, & Alloy, 1989). According to Hopelessness theory, depression is caused by a tendency to characterize negative events to internal, global and stable causes, the impression that negative events will have a huge impact on all areas of their life and lastly the inclination of viewing the self negatively following the impact of a negative event such as the end of a relationship (Abramson et al., 1989).

There are a lot of similarities between Beck's cognitive theory and Hopelessness theory.

Both claim that depression is caused by negative views of one's self rather than depression provoking these negative views. However, it is also important to acknowledge that there are other theories and perspectives that aim to understand depression. These include psychological theories and behavioral theories that focus on the negative beliefs that individuals have about them and their future (Street, Sheeran, & Orbell, 1999).

Risk Factors

National and international research on adolescent depression have led to the identification of a number of risk factors that increase the probability of young people experiencing depression. These factors exist within a number of different domains and fall within the following categories: biological and genetic (individual factors) (Hankin, 2006); familial factors (Joronen & Astedt, 2005); peer group influence (social factors) (Parker & Roy, 2001); psychosocial factors (Aslun, Nilsson, Starrin, & Sjorberg, 2007), and adverse life events (Keller, Neale, & Kendler, 2007). The following section outlines some of the key risk factors for depression in adolescents.

Familial factors

During adolescence, family can serve as an important risk factor in relation to depression. These risk factors include, familial hostility (discord, conflicts & divorce), death of a family member, excessive dependency (Joronen & Astedt-Kurki, 2005); and having depressed parent(s) (Parker & Roy, 2001). Psychosocial family factors include conditions and life events such as lack of parental support and stressful life events (child maltreatment) within the family environment, which also appear to increase the risk of depression (Fatori, Bordin, Curto, & de Paula, 2013).

Parker and Roy (2001), have stated that parents often contribute to the development and onset of adolescent depression through behaviors, including a lack of warmth, lack of parental support and a limited parental involvement (Hoskins, 2014). These result in adolescent insecurities and parental attitudes that increase low self-esteem and decrease resiliency in young people. Hoskins' (2014) review of the literature on parenting and adolescent outcomes found that these behaviors are a result of certain parenting styles.

There are four major parenting styles: authoritative, authoritarian, permissive and uninvolved parenting styles. The two styles often associated with increased risk of depression are authoritarian and permissive parenting styles. Authoritarian refers to parents who are low in responsiveness and highly demanding. They emphasize and expect obedience and conformity without question (strict control), which eliminates any pathway for open communication. Furthermore they have little or no trust and engagement with their children. Permissive parents are affirmative or supportive of adolescent's impulses and actions. They avoid exercising any behavioral control setting few behavioral expectations or no rules at all (Hoskins, 2014).

Authoritarian and permissive parenting styles have particular effects on young people's development (Bornstein & Zlotnik, 2008). Children of authoritarian parents depend more on their parents (this is more common for girls), are less socially competent, less confident and less driven to achieve academically in comparison to children reared in authoritative homes. They are hostile and extremely shy with high levels of aggression. They tend to rebel against parents in attempts to express their frustrations relating to strictness, control and lack of understanding. Children of permissive parents experience less academic achievement and have higher levels of drug and alcohol use. They are likely to lack maturity, have poor impulse control and lack self-reliance. They lack self-determination, have no purpose in life and depend heavily on their parents for guidance. Both authoritarian and permissive parenting styles minimize opportunities for their children to learn to cope with stress effectively. For authoritarian parents, this is achieved through limiting autonomous decisions made by their children. Permissive parents fail to implement standards or guidelines for acceptable behavior (Bornstein & Zlotnik, 2008).

Qualitative studies have also explored how family factors may influence depression. For example, Joronen and Astedt (2005) found that strict parenting styles were the core cause of family-child disagreements and resulted in poor school achievement and delinquent behavior in adolescents. Some of the young people in the study commented on how their familial involvement often became overwhelming and minimized their ability to make decisions on their own. They were often forced to seek parental help and lacked independence and autonomy. This study of white middle-class families did not explore

how culture might influence the adolescents' experience of parenting and family factors and their depression.

Muris, Schmidt, Lambrichs and Meesters (2001) found adolescent depression to be the result of high levels of parental rejection, negative attributions, passive coping, low levels of active coping and self-efficacy. Furthermore, parental rejection and lack of emotional warmth was suggested as leading to children believing that the world is negative and there is little they can do to change it. These studies suggest that authoritarian and permissive parenting styles that discourage open communication and encourage strict control and obedience without question may contribute to adolescent depression. However, both studies relied on adolescent self-reports and may have been subject to bias.

Culture may be an important modifying variable in the development of depression in young people. A quantitative study of 232 Pakistani students (19-27 years of age) from five different colleges and universities investigated the relationship between perceived parenting styles and levels of depression, anxiety, and levels frustration tolerance (LFT) (Ijaz & Mahmood, 2009). It hypothesized that authoritarian and permissiveness will have a significant positive relationship with anxiety, depression and LFT. However, the researchers found that there was a negative association between paternal and maternal permissiveness and depression, anxiety and LFT. It contradicts the view that authoritarian and permissive parenting styles result in higher levels of depression. The researchers suggested that in Asian and Islamic cultures these two types of parenting styles include parental love, concern and involvement and may not lead to an increase in depression. Parenting styles in these cultures include other behaviors and are based on additional cultural, social and religious beliefs. This study suggests that authoritarian and permissive parenting styles may differ across cultures and may have different effects on young people across different cultures.

Vaka (2014) highlighted the diversity of Pacific people in relation to their ethnic backgrounds. Each Pacific nation has their own traditions, customs and beliefs, therefore, culture has a huge impact on mental health because culturally it is viewed differently. Furthermore, Vaka (2014) stated that for Tongan people, mental health is viewed differently for those born in Tonga to those born in New Zealand. This is because parents who were born in Tonga believe in traditional ways of illness in comparison to first generation Tongan born who were raised as Tongans but exposed to Western ideas and

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beliefs about mental illness. Vaka (2014) demonstrates how the term Pacific hinders the acknowledgement of culture as an influence on mental health as it does not recognise ethnic and cultural differences. This is in turn makes it difficult to establish adequate responses to cater to the different ethnicities under the defined Pacific category in New Zealand.

Parents with mental illness.

Research has also identified having a depressed parent is a risk factor for adolescent depression (Petersen, et al., 1993). Research by Gershon et al., (2011), has shown that children of depressed parents are more likely to experience depression and other psychiatric disorders than children with parents who do not have mental health issues. This longitudinal study found that daughters (n=22) of depressed mothers were more likely to develop psychiatric disorders, particularly depression, in comparison to daughters of mothers with no psychiatric illness. This finding is supported by other quantitative studies (Gershon, Hayward, Schraedley-Desmond, Rudolph, Booster & Gotlib, 2011; Letourneau, Tramonte & Willims, 2013). The link between parental depression and increased risk of depression in adolescents has also been found in studies that have examined child maltreatment (Kelley, Lawrence, Milletich, Hollis, & Henson, 2015), and studies of coping strategies in young people who live with a depressed parent (Foland-Ross, Kircanski, & Gotlib, 2014).

It is not clear, however, how parental depression affects adolescents and whether the transmission of depressive disorders is a result of parents passing on a genetic predisposition for mental illness or because of the emotional unavailability of parents and dysfunctional parent-child interactions. A community-based study conducted in America traced the life course of 354 predominantly Caucasian participants found both biological-genetic and environmental factors to be important in influencing adolescent depression (Reinherz, Paradis, Giaconis, Stashwick, & Fitzmaurice, 2003). The risk of adolescents developing depression is even higher if both parents have experience of depression (Parker & Roy, 2001). Despite quantitative research studies and reviews of research strongly suggesting parental factors play an important role in adolescent depression, many of the studies have not explored parental depression influences in diverse cultural or ethnic groups. These studies offer an understanding of risk factors in the Caucasian

experience of depression that is not generalizable to adolescents who belong to other ethnic or minority groups.

According to Vaka (2014) culture informs beliefs and behaviours including those about mental illness. For Pacific parents, the diagnosis of a mental illness in their children is often seen as a form of deviance from the norm, the result of 'being bad' and regarded as shameful for the individual and family. The diagnosis of their children's mental illness is often compared against what they consider as cultural norms and behaviours (Vaka, 2014). At times, the person with a mental illness is labelled and described as 'being possessed'. Cultural beliefs and norms shape ideas about mental illness in PI people and their behavior towards those diagnosed with a mental illness.

Child maltreatment.

Quantitative studies of family environments have often shown a link between child abuse and neglect and increased risk of adolescent depression. Brown, Cohen, Johnson and Smailes (1999) American longitudinal study found that children who experienced neglect and abuse were three times more likely to become depressed as adolescents in comparison to those with no such history. The study concluded that the family environment and parenting practices were the most significant contributing factors to the occurrence of neglect and abuse which then increased the risk of depression.

A systematic literature review by Maniglio (2010) on child sexual abuse in the etiology of depression found that child maltreatment was a significant factor for depression. This systematic literature review analyzed four reviews, including approximately 60,000 subjects from 160 studies. Other studies have also found a positive relationship between child sexual abuse and increased risk of depression. For example, a quantitative study of an Israeli population (Mansbach-Kleinfeld, Ifrah, Apter, & Farbstein, 2015) that consisted of 906 mother-adolescents in a community based sample of 14-17 year olds, found a link between child sexual abuse and increased risk of adolescent depression. Mansbach-Kleinfeld et al., (2015) found that victims of child sexual abuse are 4.5 times more likely to be depressed and 3.8 times likely to have internalizing disorders than those not exposed to child sexual abuse. They also found that child sexual abuse was associated with high risk of suicide ideation, suicide attempts, other mental disorders, bullying behaviors and the overall lower wellbeing in victims.

Other quantitative studies have also looked at the effect of child abuse on children's development (Hildyard & Wolfe, 2002), suicide ideation (Kwok, Chai, & He, 2013), health risk behaviors (Lin, Li, Fan, & Fang, 2011), treatment and care for sexually abused victims (Edinburgh, Saewyc, & Levitt, 2008) and the impact on academic achievement (Buckle, Lancaster, Powell, & Higgins, 2005). Many of these studies fail to differentiate between physical and sexual abuse and childhood neglect and do not investigate whether the relationship with the perpetrator, frequency and severity of abuse/neglect impacts on adolescent depression.

Psychological factors and negative life events.

The literature on adolescent depression also shows that a key psychological risk factor for depression is young people is having a negative cognitive style or way of thinking (Young, LaMontagne, Dietrich, & Wells, 2012). Negative cognitive style has been found to lead to low self-esteem, self-criticism, and helplessness. These are some of the most significant psychosocial factors found to have an impact on adolescent depression (Parker & Roy, 2001). A review of research by Bermaher (1996) found that adolescents who are exposed to stressful events who have a negative cognitive style of interpretation are at a higher risk of developing depression. Parker and Roy (2001) suggest that negative cognitive style is a result of family and development factors (biological and environmental factors and interpersonal relationships).

Negative life events.

Negative or stressful life events such as transitioning to a new school, loss of loved ones, disasters and family violence have also been identified as risk factors for depression (Kraaij, et al., 2003). Kraaji and colleagues (2003), in an investigation using a multivariate approach, aimed to test how adverse events and cognitive personality style were related to the onset of depression. They found that adverse life events are risk factors for the onset of depression. Other studies have also investigated the association of different adverse life events on depressive symptoms. For example, Keller, Neale and Kendler (2007) in their longitudinal study of 4,856 individuals (53% female) who experienced depressive symptoms were assessed over a 12 year period. They found that different types of negative life events influenced different types of depressive symptoms. Both of these studies clearly show the positive association between negative life events

and depression. However, one of the ongoing challenges in the research on depression and negative life events is determining causation and why some of those young people who experience negative events develop adverse health outcomes such as depression and others who experience the same events do not.

Young and colleagues (2012) designed a study to attempt to explain why adverse events lead to depression for some individuals and not others. This cross sectional, descriptive correlational American study investigated the association between three cognitive vulnerabilities (dysfunctional attitudes, negative inferential style and ruminative response style) and negative life events on depression (Young, LaMontagne, Dietrich, & Wells, 2012). Participants in this study were 7th to 8th grade students who were recruited from two middle schools in a rural county in Tennessee. Not only did this study look at the influence of psychological factors and adverse events, it also supported findings of research mentioned earlier investigating psychological factors and adverse events separately. The researchers concluded that adverse events can lead to depression for some and not others because of cognitive vulnerabilities within certain individuals.

Comorbidity.

Adolescence is characterized as a period of rapid physical and psychological growth and development and a time when many psychiatric disorders begin to emerge (Karlsson, et al., 2006). Comorbidity is generally known as the co-occurrence of two or more distinct disorders in one person (Bonavita & De Simone, 2008). A literature review by Cummings, Caporino and Kendall (2014) found that anxiety and depression often co-occur and that their comorbidity is more common in adolescents.

 Lewinsohn, Rhode and Seeley's (1998) review on the depression in older adolescents (14-18 year olds) found that substance use disorders appeared to be the most common comorbid condition and was one that led to significant difficulties for young people who were depressed. Other studies (Lewinsohn, Rhode & Seeley, 1998; Boschloo, Vogelzangs, Smit, van den Brink, Veltma, Beekman & Penninx, 2011) have also found substance abuse and alcohol use disorders (abuse and dependence) to be common comorbid disorders. Having depression and a substance abuse or other comorbid disorders has been shown to have a significant impact on academic problems, treatment utilization, suicide attempts and can lead to increased conflict with parents (Lewinsohn,

Rhode & Seeley, 1998). Other studies of adolescents with depression have shown that anxiety and behavioral disorders are far more common in young people with depression compared to ADHD or substance abuse (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015).

Protective Factors

While a great deal is known about risk factors for depression and the effects on adolescent development, health and wellbeing, relatively little is known about the protective factors for depression. Some factors such as parental emotional warmth, self-efficacy and active coping (Muris et al., 2001) have been identified to help buffer young people from the effects of depression. A number of studies have also found a correlation between social support and sense of mastery (Colman, et al., 2014), physical activity (McPhie & Rawana, 2015) and a lower incidence of depression.

Research on mental health in PI youth has shown that the family can act as a risk factor, source of conflict and contributor to depression in young people but it has also shown that family inclusion is important in the process of recovery (Tiatia-Seath, 2014). Tiatia-Seath (2014) found that family inclusion is imperative when working in Pacific communities to prevent suicide. Working with PI youth in a holistic way and recognising the multiple aspects that make up identity and self can also help promote recovery and wellbeing. Pulotu-Endemann (2007) suggests that healthcare workers need to be aware that the sense of self for PI is collective rather than individual and is made up of a blend of religious and cultural beliefs, values, and practices that are based on traditional Pacific Christian and non-Christian beliefs.

Treatment and Prevention

Research shows that adolescents turn to a number of different people and services when seeking treatment and support with their depression. These include, general practitioners, counsellors, mental health specialists or services, family members and peers (Jorm, Wright, & Morgan, 2007). There is consensus within the research that best-available evidence shows that the most effective treatment for depression is Cognitive Behavioural Therapy (CBT). In CBT, therapists or psychologists work alongside patients to identify particular negative thoughts and feelings and help them change how they view and react to these (Oakley Brown, Wells, & Scott, 2006).

Cognitive Behavioural Therapy has two important components (Spirito, Esposito-Smythers, Wolff, & Uhl, 2011). The first is the cognitive component, which emphasizes the identifying and challenging schemas, automatic thoughts, and cognitive distortions that view the world in an overly negative manner. The second component focuses on behaviors and skills deficits such as coping skills, interpersonal relationships, social problem solving and participating in pleasurable activities. CBT is commonly used alongside antidepressant medication (ADM) often taken for symptom relief (DeRubeis, Siegle, & Hollon, 2008). Research has found that both ADM and CBT work for many patients; however, ADM does not reduce the risk of the return of symptoms in comparison to CBT (Hollon, Thase, & Markowitz, 2002).

A comparative analysis in the US examined the effectiveness of CBT for adolescent depression (Weersing, Iyengar, Kolko, Birmaher, & Brent, 2006). This study compared treatment outcomes in 80 young people, predominantly female (77%) and Caucasian (85%). The comparison was made between young people treated with CBT in an outpatient depression specialty clinic, the Services for Teens as Risk Centre (STAR) and 'gold standard' CBT research benchmark. The results showed that CBT had significant effects in reducing depressive symptoms in young people over the course of treatment.

Another form of treatment for adolescent depression are Family-Focused Interventions (Hughes & Asarnow, 2011). Family focused interventions shift the focus from the depressed adolescent to enhancing adolescent-parent relationships. It focuses on orienting the family to the model of understanding depression, and attempts to reduce negativity by encouraging positive family interactions through active listening and open communication. Family focused intervention has the potential to address environmental and familial risk factors for depression as well as alleviate symptoms of depression. CBT is an individual therapy; it does not address or change the influence that their families may have on the onset or maintenance of depression. Family focused intervention, however, addresses the role of the family on adolescent depression and assists in their role to recovery as a family rather than just the depressed adolescent.

More recent research has focused on help-seeking and barriers for accessing appropriate treatment and support. Barriers to help seeking include stigma (Reichert, 2012); cultural influences (Ting & Hwang, 2009; Uebelacker, Marootian, Pirraglia, Primack, Tigue, Haggarty, Velazquez, Bowdoin, Kalibatseva, & Miller, 2012), embarrassment or shyness

(Yap, Reavley, & Jorm, 2013), and identity (Farmer, Farrand, & O'Mahen, 2012). Factors that support and encourage young people to seek help for depression and that aid recovery include, supportive family and peers (Frojd, Marttunen, Pelkonen, von der Pahlen, & Kaltiala-Heino, 2007); (Griffit, Crisp, Barney, & Reid, 2011); and adolescents engaging in regular physical exercise (Kinser & Masho, 2015)

There is a body of research that indicates what treatments help young people recover from depression, and why they may work, however, there is a lack of studies that show whether these treatments work for specific ethnic groups and how culture influences people's experiences of mental health services. However, in a recent study Tiatia-Seath (2014) in a recent study explored Samoan's experiences of a Pacific health service. She found that the health was perceived as positive because it was responsive to particular cultural needs and it delivered its service within specific settings that allowed for rapport building based on cultural perspective rather than a clinical one. While there is growing interest in how different cultural groups experience mental health services, there is little national or international research that investigates outcomes of treatment within diverse populations of young people. There is also a paucity of research that explores how culture, family and community factors might shape the experience of and treatment for depression in young people.

Qualitative Research on Adolescent Depression

Much of the research on adolescent depression has been quantitative in nature and has focused on the efficacy of clinical treatment and interventions (Emslie, et al., 2002). Some of these studies have shown that adolescents with depression are reluctant to seek help; specifically in relation to health related issues, others have shown that there is generally poor health literacy among young people and an almost non-existent public profile for youth services (McCann & Lubman, 2012)

International qualitative studies.

In the last ten years there has been a growth in the number of qualitative studies that have focused on depression in adolescents and youth some have investigated the lived experiences of adolescent depression (Farmer, 2002; Jackson, 1998, McCann, Lubman & Clark, 2012; Ofendu, Percy, Harris-Britt & Belcher, 2013; Woodgate, 2006). Other

qualitative studies have explored adolescents' understanding of their depression (Wisdom, Clarke, & Green, 2006) young people's view of communicating their depression (Issakainen, 2015), adolescents' views of family support (McCann, Lubman, & Clark, 2012) and recovery (Jensen & Wadkins, 2007).

These studies have used a variety of research methods including phenomenology (Farmer, 2002) and ethnography (Pinto-Foltz, Hines-Martin, & Logsdon, 2010) to explore and examine the lived experiences of depression in young people. These studies have identified some key themes in young peoples' experiences of depression including; fear, strategies for maintaining wellbeing, and the importance of relationships (Pinto et al., 2010), and how taking responsibility helps recovery (Woodgate, 2006). Others have focused on their experiences of aloneness, and anger at being diagnosed as mentally ill (Ofendu et al., 2013), the rejection young people experience from friends and families and what contributes to the process of getting well (Farmer, 2002).

Pinto-Foltz, Hinez-Martin and Logsdon (2010) carried out a grounded theory investigation on how adolescent girls understood and managed their depression. This investigation included students (13-15 years) from an urban high school in the United States who were mostly Caucasian and the data was collected during two focus groups. The girls were asked questions that related to behavior, feelings and their understanding of depression within their peer groups. The study showed the girls lacked the ability to apply knowledge of depression to themselves and were confused about their depression despite being able to identify symptoms of depression. It also showed that peers were curious about why their friends acted certain ways.

In an earlier study, Woodgate (2006) took a hermeneutic phenomenological approach to explore the lived experience of depression in 14 adolescents (13-18 years old) in Western Canada. She focused on what it was like for these young people to live with depression. Data was collected through open-ended individual interviews and focus groups. 'Living in the shadow of fear' emerged as the essence of the participants' experience. The adolescents lived in fear of their depression returning, they feared not surviving and feared not knowing where to get help. The study also highlighted that the adolescents

lived in fear of the future implications of their depression despite having some sense of control over their illness. It also showed they coped with their depression by using self-directed strategies. The researchers recommended that adolescents need access to relevant resources and support during their experience of depression. This study included a majority of female participants (only 3 of the 14 participants were males) and they were mostly Caucasian. This mirrors the gap presented in previous studies that have focused on majority ethnic group's experiences of adolescent depression by not including a culturally diverse sample.

Another phenomenological study on adolescent depression was conducted by Farmer (2002), which aimed to describe adolescents' experiences of 'major depression' from the adolescent's viewpoint. Participants were five clinically depressed adolescents (aged 13-17 years), three females and two males (representing Caucasian, Hispanic, and African American ethnicities). They participated in in-depth 1:1 interviews which were then analyzed according to procedures outlined in Colaizzi (1998). Analysis gave rise to eight themes and the study showed the importance of anger. Anger was not only directed to themselves but to family, peers and teachers. The participants in this study did not discuss other feelings often linked with depression, such as sadness and crying, instead they talked more about how their depression was expressed through anger and physically through aggression towards others and in damaging property.

While the findings of this study cannot be generalized to a wider adolescent population, Farmer's (2002) study shows the importance of examining the phenomena from the point of view of those living through it and focusing on their accounts of prominent aspects of their experience. Farmer's study showed that symptoms such as anger require further investigation and that future studies should focus not only on anger but adolescents' responses to their family unit and the role of spiritual beliefs.

Despite the growing number of qualitative studies on adolescents' experiences of depression, only one study was found to focus solely on the experiences of depressed females (14-17 years) (Shaw, Dallos, & Shoebridge, 2009). Six severely depressed

Caucasian females participated in open-ended interviews that were all audio recorded and analyzed using Interpretive Phenomenological Analysis (IPA). Three key themes emerged from the analysis of the data: communication, hurt self and difference. These themes were related to communication with family and peers, being hurt and how depression influenced identity development during adolescence. The study showed that the young women had difficulty communicating and disclosing their feelings with their families. The authors identified that the type of family processes and also the depression could have had a significant impact on their difficulty in expressing their feelings. This study reinforced the importance of conducting research that aim to understand adolescent depression from the point of view of adolescents and the need to focus on how gender might shape adolescents' experiences of depression.

In a more recent interpretive phenomenological study, Ofendu, Percy, Harris-Britt and Belcher (2013) found that culture also shaped young peoples' experience of depression through the experience of cultural conflict and criticism. This study aimed to investigate how inner city African American youth described their experience of living with depression. A total of 10 participants (four males and six females) aged 13-17 years, were recruited from an outpatient mental health clinic in Maryland, in the United States. Data was gathered through interviews which were then analyzed using the Giorgi and Giorgi's (2003) method as a guide. The study showed that there were differences in how the young people experienced depression even within the same cultural group and affected all dimensions of the African American youth's lives. They also found adolescents took steps to hide their depression or sadness because it was culturally seen as a weakness. Instead of voicing their experiences of their depression, the participants would demonstrate irritability and anger to shield themselves. The participants used anger, irritability and aggressive behavior to cope with their depression in comparison to feelings of sadness and lack of energy that is often linked to adolescent depression. This finding supports the findings in Farmer (2002) in relation to the use of anger among adolescents of ethnic backgrounds.

While phenomenological studies and studies that utilise other qualitative methodologies have explored how gender and culture may shape the experience of depression in young people, this review found no studies that focused on the experiences of PI adolescents

(boys or girls). The research by Ofendu and colleagues (2013) did highlight the need to study phenomena within particular cultural/ethnic groups and it raises the question of whether other Black youths in another geographic location would have the same experience. These types of studies are important because they often lead to new research questions and are exploratory in nature. They also highlight the need for investigating phenomena within ethnic groups in order to understand their experiences better and in more depth and to inform culturally appropriate treatment for ethnic at risk adolescent populations.

Other qualitative studies have focused on adolescents' experiences of treatment and recovery from depression. For example, McCann and colleagues, (2012) investigated what Australian adolescents found supportive in their recovery from depression, using (IPA) to analyze their data. Their study focused on the lived experiences of 26 adolescents (16 females, 10 males) aged 12-25 years and the role their family and significant others played in aiding them with coping with their depression (McCann et al., 2012). Data was collected through the use of in-depth, semi-structured interviews (30-60 minutes) and resulted in two major themes, (i) supportive family and significant others and (ii) unsupportive family and significant others.

McCann et al., (2012) found that supportive families were accessible and provided various forms of support that ultimately contributed to coping with their depression. Unsupportive family and significant others, denied the illness, were critical and created conflict, and these undermined the adolescents' ability to cope with their illness. The researchers recommended that mental health services engage with and encourage family and significant others to support adolescents who are depressed. Participants were also recruited through clinicians and the study showed that these young people were actively engaging with mental health services. The researchers suggests that future studies should focus on non-clinical populations and perhaps focus on those adolescents who have not engaged, are less engaged or have disengaged from support services and treatment.

In an earlier (2007) study that focused on recovery from depression, Jensen and Wadkins examined the experiences of 20 adolescents (11 females and 9 males) adolescents who were customers of mental health projects in the United States. The aim of this study was to investigate participants' success stories to recovery and data was collected through in-

depth 1:1 interviews. The researchers identified common themes in their analysis: finding acceptance and developing an understanding of mental illness; redefining their identity; preventing relapse; and finally, finding a way to decrease stigma and assist others on their journey to recovery. This study highlighted factors and processes that aided recovery but also some of the barriers adolescents encountered. These barriers included a lack of communication within and among agencies relating to what services they could receive. Participants also reported frustration because of the stigma they experienced not only from the service providers but from the public. Jensen and Wadkins' (2007) and McCann et al.'s (2012) studies both shed light into how family, significant others and mental health services can become barriers to adolescent with depression seeking help. The time between when these studies were carried out, suggests that these factors have not yet been addressed and that these issues are still a key part of young people's experience of depression and recovery.

New Zealand qualitative studies.

In comparison to international studies, there is growing body of research that has been conducted in New Zealand in relation to adolescent depression. Of the few New Zealand studies that have been conducted these tend to be quantitative in nature. For example, longitudinal studies have investigated the comorbidity between depression and nicotine (Fergusson, Horwood, & Lynskey, 1997), and the link between depression and suicide among depressed adolescents in New Zealand (Fleming, Merry, Robinson, Denny, & Watson, 2007). Quantitative studies have shown that young people with depression often withdraw from others and become aggressive (Denny, Clark, Fleming, & Wall, 2004). One study found that young people with depression often live in fear that their mental illness will be revealed to others (Bennett, Coggan, & Adams, 2003) supporting the findings of previous international studies on stigma.

Denny et al., (2004), in a quantitative study aimed to examine the risk and protective factors for depression in a social environment. They recruited 268 students from 36 Alternative Education schools in the North Island of New Zealand. The questionnaire was administered online with multivariate analysis demonstrating a strong link between family and peers as protective factors. Poverty, violence in the home and bullying were

identified as key risk factors. Overall, it found that part of the daily struggle of living with depression involved young peoples' attempts to protect their sense of self from the ongoing and negative emotions associated with depression.

In an earlier 16 year longitudinal study of a birth cohort of 947 New Zealand children, Horwood, Fergusson and Lynskey (1996), investigated the comorbidity between depression and nicotine dependence and whether this dependence was a result of risk factors such as family social position, life events, parental attachment and self-esteem. Like previous international studies on comorbidity, it concluded that the comorbidities between depression and other disorders can be explained by the fact that they have common risk factors. Denny et al., (2004) also showed that depression is associated or correlated with other health compromising behaviors. Both studies demonstrate how the same risk factors can lead to different health issues for adolescents, including depression and smoking.

In one of the only qualitative studies on adolescent depression carried out in New Zealand, Bennett, Coggan and Adams (2003) showed that two major discourses influenced how young people understood and responded to depression. They analyzed the contribution of depression in the suicide attempts of 30 young people who identified themselves as New Zealand European. Participants were sixteen women and five males (who were less than 20 years of age), and the seven women and two males (who were 21-25 years old). Interviews and data analysis revealed that suicidal tendencies occurred as a result of overwhelming feelings of sadness and usefulness associated with depression. They also found that two major discourses shaped the young people's experience of depression. The two discourses were: (i) the medical discourse, which valued the voices of mental health professions who construct depression as a disease, and (ii) the moral discourse, which viewed depression and suicidal behaviors as personal failures on the part of the individual. The young people expressed how they feared the stigma of being viewed as someone who has a disease or a failure. The research showed how the two discourses could prevent young people who are depressed from seeking help from mental health services.

Fleming, Merry, Robinson, Denny, and Watson (2007) carried out a survey that investigated the association between depression and suicide in New Zealand adolescents.

This study examined risk factors within the individual, family, school and community domains and their impact or contribution on rates of suicide attempts. The study included 9570 randomly selected 9-13 year old students from 114 schools across New Zealand. The sample was made up of NZ Maori (24.7%), Pacific Island (8.2%), Asian (7.2%), NZ European (55.3%) and Other (4.6%). It found that depressive symptoms alongside other risk factors such as family violence lead to an increase in rates of suicide attempts. Of the young people who reported making suicide attempts, females reported higher rates (10.5%) in comparison to males (4.7%). This study highlighted the importance of conducting quantitative research on adolescent depression in order to reduce the risk in this group. The researchers, did however, suggest the need for qualitative studies to further explore how adolescents experience these risk factors and how they contribute to risk.

The research on adolescent depression in New Zealand has followed similar patterns to that in the international research. Early studies have been quantitative and focused on assessing and measuring the prevalence of depression in adolescents. Later studies have focused on risk factors and assessed or measured their correlation with the onset of depression. Current studies have begun to focus on effective treatment and intervention with New Zealand adolescents but few studies have examined what it is like to be depressed from the adolescents; point of view. In other words they have aimed to quantify, measure and hypothesize about depression and have not sought to explain and understand what it is like to be depressed. The majority of the participants in the New Zealand studies were New Zealand/European, and represent the majority cultural group (like those samples in international studies). No New Zealand studies have focused on how gender and culture might shape the experience of adolescent depression. These studies have made an important contribution to understanding depression within the New Zealand context and have been used to make recommendations on the establishment of mental health services. However, none of the research in New Zealand, has examined the experience of Pacific youth with depression living in New Zealand.

Research on Mental Health and Wellbeing in Pacific Youth

The literature on the lived experience of Pacific youth also helps inform an understanding of the factors and contexts that may shape the lived experience of young Pacific people with depression. For example, Tiatia (2012) found that the expectation to uphold cultural

values in Pacific culture is of great importance in understanding young people's development, health and wellbeing. Her work showed that young Pacific people often experience cultural pressures and demands that are different to those experienced by young people from other cultures. These cultural pressures and demands can be demonstrated through a Samoan adolescent, where the value of the Samoan way is to respect. Respect results in submission to authority, perceptions of gender roles and the tradition of giving money. These values ultimately dictates how young Samoan youth act and react in everyday life (Edwards, et al., 2003)

Tupuola (2004) has also found the one aspect of Pacific youths' lives that influences all areas of their development is their family. Her work and examination of research in New Zealand and the USA on identity status in youth showed that Pacific youth might experience unique and additional challenges when transitioning to adulthood. These challenges reflect the difficulty Pacific youth often face in relation to their identity. According to Tupuola (2004), Pacific youth are faced with weaving between their cultural identities and their personal identity. They weave between two identities in order to avoid conflict, but when they are unable to weave between the two, it can result in identity confusion. Tupuloa argues that identity confusion can be detrimental during their transition from adolescence to young adulthood. This is because this is when adolescents need to explore, develop and make a commitment to a sense of identity as they transition into adulthood (Arnett, 2013).

Scholarly work and literature on Pacific youth development is minimal and has tended to focus on issues around the identity of Pacific youth within New Zealand. Overall, Pacific research has looked at identity status (Tupuola, 2004 & Manuela & Sibley, 2014), cultural ways of knowing (Tupuola, 2004), cultural constructs of emotion (Tiatia, 2012), Pacific youth violence (Fiaui & Hishinuma, 2009), media portrayals of Pacific people and Pacific mental health (Foliaki, Kokaua, Schaaf, & Tukuitonga, 2006). Very few studies have directly focused on Pacific youth's experiences of mental health issues such as depression.

Only a few scholars have examined various mental health issues relating to Pacific youth in New Zealand and have focused on Pacific perspectives. For example Tiatia (2012) examined the cultural construct of emotions (anger and shame) in Samoan youth and found the need for developing culturally competent tools that encourage their expression

of feelings without fear. Others have suggested that in order to understand what constitutes mental health and wellbeing for Samoan people, the Samoan sense of self must be understood first (Bush, Collings, Tamasese & Waldergrave, 2005).

One study that reinforces the importance of understanding the sense of 'self' from a Pacific perspective is a qualitative study by Tiatia-Seath (2014). The study explored suicide attempts or suicide ideation of Samoans aged 18 and over who were engaged in mental health services. Much of the discussion of why mental health did not work was due to a lack of cultural competency, minimal or lack of family involvement and most importantly the conflict between Western views and alternative cultural perspectives of mental illness. The study identified important factors that contribute to effective suicide prevention and mental health promotion and Pacific models of practice and supports the need to understand PI issues from PI perspectives and ways of knowing.

Other researchers and scholars have focused on exploring Pacific models of health delivery in mental health services (Suaalii-Sauni, et al., 2009). Others have drawn attention to the need to develop culturally and clinically responsive practices (Pulotu-Endemann et al., 2007). Several PI models of mental health and wellbeing have been developed that now inform mental health practice. The Fonofale model (Anae, Barnes, McCreanor, & Watson, 2002) is a metaphor of a Samoan house (fale) that incorporates what Pacific consider important such as family, culture and spirituality (Ministry of Health, 2008).

While PI models and perspectives are useful for highlighting and guiding understanding and practice from a particular cultural perspective they, like any perspective or model, have strengths and limitations. For example, the Fonfale model may more accurately describe and re-present PI adult ways of knowing and being in the world. The model was developed out of Workshops with PI adults from the early 1970s to 1995 (Ministry of Health, 2008). The model may not represent the contemporary factors that shape the mental health and wellbeing of young PI. Furthermore, it does not appear to consider developmental, gender or sociopolitical factors that shape people's experience of mental health and wellbeing. Suaalii-Sauni and colleagues (2009) have also suggested the need to look at Pacific youth's experiences and how these may differ from older Pacific consumers. They argue that traditional models of health and wellbeing may represent

Pacific-born values such as the importance of family, church and culture and worldviews. These may not easily fit with the realities and views of Pacific New Zealand-born youth. The realities of NZ born Pacific youth may include the pressures of cultural expectations, living in two worlds and a lack of culturally appropriate support. Suaalii-Sauni et al., (2009) suggest that researcher conducting future studies on adolescent depression need to be careful not to impose theoretical frameworks and perspectives that are not age, gender or culturally relevant to the group who experience the phenomena.

Existing models and perspectives on PI development and wellbeing may also be limited because they do not acknowledge the influences of acculturation, assimilation or differences within specific cultural groups. For example, young New Zealand born PI may see and experience the world and themselves differently to those who immigrated to New Zealand in previous decades or who adhere to and value traditional beliefs, practices and values. For example, Amituanai-Toloa (2009) has identified a need for research that makes more explicit the Pacific ways of living and being and for research that examines differences between New Zealand-born and Island-born Pacific people.

Some scholars and practitioners working in the field of mental health have acknowledged the need to understand and utilize multiple models and perspectives when it comes to mental health issues. For example, one framework that does try to integrate Western and PI cultural views of mental health is the Seitapu Framework (Polotu-Endemann et al., 2007). This model acknowledges the importance of understanding mental health and wellbeing from both perspectives in order to promote culturally relevant, safe and effective practice. At the centre of the framework is the competent worker who needs to be able to employ both cultural and clinical theory and practice in order to have an impact when working with Pacific populations and their families. PI models are not only important for informing clinical practice around mental health but also research practice.

Recently there has been a call from Pacific researchers such as Amituanai-Toloa (2009) for researchers to utilize methodologies that are responsive and culturally appropriate to Pacific populations. She is critical of previous research that has utilized western models and paradigms to understand Indigenous health issues. PI research often draws on PI perspectives but also research Tools such as Talanoa which is often used during data collection and in the interview process. Talanoa is a familiar concept to Samoan, Fijian and Tongan people (Vaka, 2014). Talanoa takes an informal approach to conversations,

it is open in nature with no particular strict agenda. Another tool and concept is the Tongan concept of Tālanga, which refers to conversation, however, it is more formal and structured in nature. This particular concept may be restrictive within the research context and in regards to mental health due to its formal and structured nature (Vaka, 2014). While these PI perspectives, models and concepts were not strictly adhered to in the present study some of these concepts (e.g., Talanoa) were utilized and helped inform the research and interview process.

Despite a growing body of research on depression, and the development of PI perspectives, models and concepts that can be used to inform research, few qualitative studies have been carried out in New Zealand that explore what it means for young PI to experience depression. Furthermore, few studies have utilized methodologies that encourage young PI to reflect and describe their experience so that others can better understand their perspective and lived experience. Of the few New Zealand studies that have explored depression in PI youth, none have focused on the experiences of specific gender groups.

Summary

The review of literature has shown that depression is a serious health issue amongst young people (adolescents and young adults). Young people are at particular risk of depression, young women are more likely to experience depression, and those with comorbid disorders are at higher risk of negative life outcomes. The quantitative research on adolescent depression has identified a number of important risk factors including: parents who are abusive, neglectful, cultural beliefs and dysfunctional family patterns of interaction. Research has also shown that the most effective treatments for depression are Cognitive Behavioural Therapy (CBT) and Antidepressants and that these work best when combined with counselling and interventions that address issues within the family environment.

The few qualitative studies on adolescents' experiences of depression have looked at how adolescents understand and manage their depression (Pinto-Foltz, Hines-Martin & Logsdon, 2010) and barriers to treatment (Reichert, 2012). Few studies have focused on what is it like for young people to live with depression (Woodgate, 2006) and those studies have had mixed age and gender samples, and Caucasian or American samples.

Little attention has been paid to how gender and culture might influence the experience of depression in young adults.

New Zealand research on depression has tended to follow similar patterns to international research focusing on measuring prevalence, investigating risk factors and assessing treatment efficacy. Little research has focused on the lived experience of depression in young people that recognizes that gender and culture may shape the lived experience. While there is a growing body of research on PI mental health, Pacific researchers have called for more research to explore phenomena that influence PI youth utilizing perspectives, methodologies and concepts that are culturally relevant and developmentally appropriate.

Research Question

The review of the literature and research led to the development of the following research question:

What are the lived experiences of Pacific women (17-25 years of age) who have experienced depression?

CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

The previous chapter included an examination of research literature and showed that there is a need for research to explore the lived experience of young PI women who have experience of depression. The review of literature demonstrated that previous studies have primarily been quantitative in nature measuring prevalence, identifying risk factors and examining the efficacy of treatments. The few qualitative studies that have focused on the lived experience of being depressed have focused on coping strategies and young people's understanding of their illness but have not examined how family, culture or gender might shape lived experience of depression.

This chapter outlines the research methodology and methods used for data collection and analysis and provide a rationale for their use. It describes the aims of this study, the rationale for the selection of the qualitative research design used to meet the study's objectives. It outlines methodology and methods of participant selection criteria and recruitment methods; data collection and data analysis methods and strategies used to ensure reliability/integrity and trustworthiness. Finally, the ethical implications throughout the research process are reviewed.

Thesis Objective

The aim of this research is to examine and understand the lived experiences of young Pacific youth between the ages of 17-25 years who are experiencing or have experienced depression.

To reach this objective the study will explore a number of questions:

1. What is it like for young PI women to have depression?

2. How do contexts such as culture, church and family influence young PI women's experience of depression?

3. How do they manage their depression and what has influenced their journey to recovery and wellbeing?

Research Approach

The qualitative research paradigm is appropriate for exploring and explaining rather than measuring, quantifying or predicting lived experiences. In comparison to quantitative designs, qualitative research designs are just as systematic, however, they are more concentrated on gathering or assembling data on naturally developed phenomena (McMillan & Schumacher, 2006).

Phenomenological research falls within the qualitative research paradigm (McMillan & Schumacher, 2010) and seeks to gain an in-depth understanding of the day-to-day experiences of an individual who has experienced a phenomena (Hesse-Bieber & Leavy, 2004). Phenomenology was selected as a methodology because it is recognised as an appropriate and credible approach to the study of human phenomena, lived experience and has made an important contribution to advancing understanding in the discipline of nursing and health (Dowling, 2007). A phenomenological approach was chosen to study the experience of depression because of its focus on describing and understanding life experience (Husserl, 1976) and because it has been used to rigorously study the phenomena of depression (Beck 1992) and advance understanding of mental health issues. It was also selected because it has the potential to be transformative for both the researcher and the participants (con-constructors or co-researchers). Phenomenology:

> "…offers individuals the opportunity to be **witnessed** in their experience and allows them to '**give voice**' to what they are going through. It also opens up new possibilities for both researcher and researched to **make sense of** the experience in focus" (Finlay, 2011, p.10). (emphasis in original).

Within the qualitative research paradigm, Phenomenology is most suited to exploring and describing the ways that young Pacific youth experience depression. It will enable the researcher to capture the voices and ways of knowing of these young people and make them explicit in relation to how they live with and manage their mental illness. The choice

to work within a qualitative research paradigm also informed the selection of methodology and Methods. Although Phenomenology may be considered a western model, it is an appropriate methodology and method to investigate Pacific and other ethnic populations. It is a qualitative form of research that seeks to understand phenomena as perceived and experienced by an individual (Flood, 2010). It takes into consideration the constructs of culture, religion, family and gender as factors that may or may not influence the experiences of individual.

Phenomenology was also deemed an appropriate methodology because it shares many of the ontological and epistemological beliefs that characterise indigenous research approaches (Hart, 2010). For example, it recognizes that knowledge is relational (a product of interactions and relations between people), is often shared through story-telling and can be transformative (for both the research participant, the community and the researcher). A phenomenological approach was also chosen because it has similar values and actions to those identified in indigenous research approaches (Hart, 2010) including: being respectful of community and considerate of differences between participants; being responsible and reciprocating – sharing in the re-telling of experiences; making sure research participants feel safe and respecting confidentiality within community; deep listening and hearing; reflective non-judgement; honoring what is shared; and awareness and discussion of subjectivity and what the researcher brings to the research encounter. Furthermore, descriptive phenomenology is more powerful not only to describe universal structures of phenomena, but also to assist research that aim to develop interventions (Wojnar & Swanson, 2007). It also requires researchers to remain 'open' to phenomena and how they are experienced as well as to the meanings ascribed to that experience (van Manen, 2014).

While other Pacific and indigenous approaches to research uch as those described by Hart (2010) could have been used they would not have led to a focus on describing the phenomena of depression as experienced by PI female youth, utilizing their language and perspective. While a descriptive phenomenological approach was adopted, cultural research concepts such as Talanoa were used to inform the research process and in particular data collection.

Epistemology: Social Constructionism

Social constructionism is the belief that knowledge is based on social practices and institutions or the interactions between relevant social groups (Young & Collin, 2004). This is opposite to social constructivism, which firmly believes that knowledge is based on cognitive processes. Social constructionism, therefore, acknowledges the influence of social factors on interpretations, truth and knowledge (Young & Collin, 2004). Social constructionism is fitting for the proposed study because of the belief that Pacific people believe knowledge to stem from interactions and practices within communities of meaning-making, such as their family, religious and cultural community.

Theoretical Perspective/Methodology: Descriptive Phenomenology

Phenomenology is considered both a philosophical discipline and also a research method. At the root of phenomenology lies the desire to describe, recognize and appreciate phenomena that have otherwise been ignored (Wojnar & Swanson, 2007). It has strong philosophical elements that have been expanded by Heidegger and Merleau-Ponty based on the writings of Edmund Husserl (Cresswell, Hanson, Clark Plano, & Morales, 2007). It encourages researchers to explore the structures of consciousness in human experiences by focusing on the individuals' perspective, experience, and his or her interpretation of experience (Lopez & Willis, 2004). It does this in order to develop a deeper understanding of a phenomenon documented through those who have experienced it (Patton M. Q., 2002). The two main phenomenological approaches used in phenomenological research include descriptive (eidetic) phenomenology and interpretive (hermeneutic) phenomenology.

Descriptive phenomenology focuses on describing the 'lived experience' of individuals and how they make sense of that experience or situation (McMillan, 2010). This approach to inquiry was a result of Husserl's (1970) ideas about how science should be conducted. He is considered to be the founder of phenomenology as a philosophy and descriptive approach to inquiry. According to Husserl, the experience that is heeded or understood by human consciousness should be an object of scientific study (Giorgi & Giorgi, 2003).

Like Husserl, Giorgi agreed that the operative word in phenomenology is 'describe', to describe the phenomena as authentic and exact as possible (Groenewald, 2004). Together, they believed information that is abstract or personal is important for scientists who are seeking to understand human motivation or reasoning because ultimately, human actions are influenced by what they regard to be real. This makes descriptive phenomenology particularly suited to this study as the focus is on how young PI women experience their own depression and how this experience shapes their way of being in the world.

Essential to Husserl's approach to human consciousness is the idea that there are attributes to any lived experience that is prevalent to all persons who have the experience (Lopez & Willis, 2004). In descriptive phenomenology, these commonalities are referred to as universal *essences*. These essences are crucial to describing phenomena under investigation in its true nature. The commonalities in the experience of the participants should be identified and generalized (Cresswell, Hanson, Clark Plano, & Morales, 2007) by the researcher in order for the description of lived experiences to be considered a science (Lopez & Willis, 2004). In this aspect, correct interpretation of experiences is objective and independent of history and context which mirror the values of traditional science (Lopez & Willis, 2004) and indicative to Husserl's attempts to make phenomenology an accurate, precise and rigorous science within predominant tradition (Wojnar & Swanson, 2007).

Understanding of human experiences can only be reached through analyzing and interpreting one-to-one transactions between the objects of research and the researcher. Crucial to this is the ability of the researcher to listen attentively, interact and observe the objects of research in order to create an account or portrayal of reality that was previously misconceived (Wojnar & Swanson, 2007). Furthermore, Husserl (Dahlberg, 2006) later presented the idea of transcendental subjectivity, which can be achieved through applying or utilizing the process of *bracketing*. Moustakas's (1994) transcendental phenomenology expands on the notion of the researcher describing the experiences rather than interpretation in support of the concept of bracketing. Bracketing is a fundamental element of Husserlian phenomenology and is applied to achieve the desire for scientific

rigor. This process requires the researcher to shed all previous, experiential knowledge and personal bias (Cresswell, Hanson, Clark Plano, & Morales, 2007) to eliminate any influence on the description of the phenomena being studied. Successful application of bracketing results in a better understanding of a phenomenon in its pure, universal sense as experienced by those being studied (Lopez & Willis, 2004).

As mentioned previously, Husserl's philosophical ideas gave rise to descriptive phenomenology (Lopez & Willis, 2004) and one of the key principles is to reduce the varied experiences people have of a phenomenon to a description of the universal essence (van Manen M. , 1990). Traditionally, phenomenology encouraged the use of bracketing, where the researcher eliminates past experiences or beliefs about a particular phenomenon (Laverty, 2003). However, contemporary scholars now argue that bracketing is not completely possible and encourage researchers to strive to make their preconceptions transparent (LeVasseur, 2003) and acknowledge their influence on interpretation.

In comparison to descriptive phenomenology and its emphasis on describing universal essences, interpretive (hermeneutic) phenomenology emphasizes understanding the phenomena in context. It views a person as a self-interpretive being rather than a mere representative of the world (Wojnar & Swanson, 2007). Heidegger, who was one of Husserl's successors, contributed to the critique and further development of Husserl's approach. Heideggerian phenomenology, firmly holds the belief that in order to understand human experience, culture, social context and historical period are factors that cannot be eliminated from the process of analyzing and understanding the true nature of a phenomena (Lindseth & Norbeg, 2004). This notion is supported by the works of van Manen (2014), who believed that phenomenology is both a descriptive and interpretive process of the lived experience. Interpretive phenomenology, therefore, goes beyond depiction and explanation of essences to look for meanings ingrained in common life practices (Seigfried, 1976), in other words, how one understands the world is related to how they interpret the world (Wojnar & Swanson, 2007). Overall, unlike descriptive phenomenology, Heideggerian phenomenology researchers actively co-create and understand with participants the interpretations of the phenomena.

The proposed study took a social constructionism approach because this recognizes that realities are fluid and constructed and the perception of these realities are influenced by socio-cultural factors and values (Guba & Lincoln, 1994). It will draw upon the theoretical perspective and methodology of descriptive phenomenology, which has its roots in the philosophical ideas of Husserl and utilized by researchers such as Moustakas (Cresswell, Hanson, Clark Plano, & Morales, 2007)

Research Methods: Data Collection and Analysis

In qualitative research designs, there are numerous ways to collect qualitative data (Cresswell, Hanson, Clark Plano, & Morales, 2007). They include written texts (documents and transcriptions), oral form (interviews), observational form (observing behavior) and documentary data (photographs) (Polkinghorne, 2005). The present study is phenomenological in nature, therefore, data collection involved conducting one on one interviews with participants.

Participant inclusion criteria.

A convenience, purposive sample was utilized (Cresswell, Hanson, Clark Plano, & Morales, 2007) and participants had to meet the following inclusion criteria: (1) aged 17-25 years of age ('emerging adults', Arnett, 2013); (2) identify as a Pacific Islander; (3) have a clinical diagnosis of depression; (4) have experienced depression for 6 months or longer (in order to have enough relevant experience to draw upon) and some experience of management and recovery; (5) be fluent in English in order to articulate their experience.

Previous studies have focused on depression in early or middle adolescents (e.g., high school populations) and there are a lack of studies that focus on depression in young- or emerging-adults. Originally, participation was open to all youth, however, once recruitment began it became clear that the sample was only going to include women. Phenomenological studies tend to have relatively small sample sizes of between 5-10 participants (Johnson & Christensen, 2000). Participants were recruited from a community sample from the |Greater Wellington region as it is the second largest area where a significant population of Pacific people reside (Tukuitonga, 2013). A practical

and opportunistic approach was also appropriated to recruitment (Johnson & Christensen, 2000) where potential participants had the freedom to contact the researcher for further information or discuss the research. No direct recruitment occurred for ethical reasons, to ensure voluntary participation and avoid the risk of coercion.

Recruitment strategy.

A number of strategies were used to recruit volunteer participants from the wider community as well as Victoria University of Wellington. Posters and leaflets (see Appendix A) posting a call for participation were placed in medical centers, counseling and youth mental health services in Wellington or emailed to them with a request that they be displayed or that service providers alert young people to the research. Short presentations were made to staff from community youth services and agencies in order for 'gate keepers' to feel comfortable providing information to potential participants.

Victoria University of Wellington was also chosen as a site for recruitment because of previously established relationships between researcher and staff at a number of Pacific services (e.g., Te Putahi Atawhai) who can help advertise the study. The study was also advertised through undergraduate courses at Victoria University of Wellington where there was a focus on youth or health issues.

Data collection.

Phenomenological studies tend to involve the collection of rich and thick data at the expense of quantity. Data is typically collected through conducting long, face-to-face interviews (1-2 hours) with up to 10 people (Cresswell, 1998). Interviews were the main approach or method used for data collection. A total of six interviews were undertaken and none of the participants agreed to a follow-up interview.

Data collection consisted of open-ended semi-structured interviews, which were conversational in nature. This style of interviewing allowed the interviewer to adapt questions to the narratives of participants and probe for richer accounts of experience (Smith, Joseph, & Das, 2011). The researcher also used reflection, clarification, requests for examples and descriptions and listening techniques (Flood, 2010). This conversational-style of the interview was also utilized by Moustakas (1994) to encourage

the participant and researcher to co-construct the account of their experience of depression and for the researcher to check their understanding with the participants as the interview progressed. The approach to interviews also drew on the concept of Talanoa.

Considering the sensitivity of the topic being studied, the process of interviewing was practiced prior to interviews. This gave me an opportunity to practice my interview technique and to gain feedback on how to manage difficult responses and assess risk and vulnerability. The location of the interview was negotiated and conducted at a place where both the participant and researcher were comfortable and where privacy was sustained. Throughout the process of interviews, I met regularly with my supervisor and debriefed after each interview. During these meetings we discussed issues, the content of the interviews, the process to ensure ethical and safe practice. None of the participants requested follow-up interviews and follow-ups would also have been difficult to conduct due to time constraints on the research. All the interviews were transcribed by the researcher so I could 'immerse myself in the data'.

Interview process.

Upon notification of their desire to participate in the study, a meet and greet was set up. The purpose of this initial meeting was to meet the participant, discuss the study and its purpose. Participants were provided with copies of Information sheets and these were discussed (see Appendix B) and to build rapport with the participant. Building rapport with participants in naturalistic research is crucial. According to Pitts and Miller-Day (2007), the occurrence of these meetings serve as a time for introductions, manage impressions in order to establish or build a trusting relationship with participants under investigation. Furthermore, building trust between researcher and participant ensure the trustworthiness of a qualitative report. Therefore, trustworthiness for any qualitative research is both a desirable and necessary condition to achieve and ensure validity (Pitts & Miller-Day, 2007). The participants were provided with copies of the interview questions before hand so they could reflect on their lived experience and think about the experiences they wanted to discuss (see Appendix C) for a copy of the interview guide and question.

Overall, there were six participants and six interviews with a total of 14 hours. Demographic data was also gathered before the interviews regarding participant employment status, age, marital or relationship status, level of education, cultural and religious associations (see Appendix F) for a description of participant characteristics). All interviews were audio-recorded with the research participants' permission and transcribed by the researcher to ensure data reliability and copies of the summaries were sent to the women to check for both accuracy and the emerging themes.

Participants were asked if they would like a meaalofa/koha (or gift) as a way of honoring their time, experience and sharing of knowledge. However, they refused because they felt that being able to share their stories and inform the understanding and practice of others was an appropriate way of acknowledging their input. Instead food and drink was offered and shared during interviews as a way of connecting and as part of the ritual of story-telling and sharing.

During interviews, observations of how the participants reacted to certain questions and their body language during sensitive details of their accounts were closely monitored. Observation during their accounts was important in informing whether the interview needed to be stopped or rescheduled. Before the completion of the interviews, participants were asked if there was any additional information they wanted to include in their interviews. They were also questioned about how they found the interview process.

Data analysis method.

Data analysis occurred concurrently with data collection and it followed van Manen's (1990) approach as outlined by Woodgate (2006). This approach combined aspects of descriptive and interpretative phenomenology. Analysis was also informed by the steps in thematic analysis outlined by Braun and Clarke (2006). The participants' accounts of their experiences of depression included stories and narratives of particular events, people, places and times and they were encouraged to reflect on how culture, family and church influenced their experience of depression. Upon the completion of the data collection, all interviews were transcribed. The transcribed interviews were checked

through by each of the participants to give them the opportunity to check, remove or add any information they were or were not comfortable with. None of the participants made any suggested changes to the transcripts or to the emerging theme names.

In order to highlight the participants' experience of the phenomena being studied, transcripts were read and reread in order to understand their experience in its purest and most accurate form. An attempt was made to keep an open mind to the phenomenon and to suspend judgment and preconceived beliefs about depression, young PI women and life for Pacific youth. Thematic Analysis (Braun & Clarke, 2006) was also utilized to generate themes that illustrate the overall experience provided by the data collected.

Thematic Analysis is a widely used qualitative analytic method (Braun & Clarke, 2006). It was chosen for the purpose of analyzing the data because it is flexible in nature and it is an easy method to learn. Considering the large amount of data collected, thematic analysis made the process of summarizing key features, highlighting similarities and differences a lot more manageable. I followed the steps outlined by Braun and Clarke (2006). First, after the collection of the data, initial ideas were noted through reading and rereading the data. Second, I generated initial codes by coding compelling features of their narratives in a systematic fashion and assembling data relevant to each to code. The third step was the search for themes. At this stage codes were assembled into potential themes and I reviewed each theme to check if it was a reflection of the entire data followed this. Participants gave feedback on theme names. The final naming of each themes was decided based on the specifics of each theme and the story illustrated by the entire analysis. After all these steps were completed, the overall outcome was the Findings chapter. The last step was to analyze and finalize the selected extracts or participant quotes chosen to support the thematic analysis, showcases the experience and relates to the literature.

Towards the end of the process the themes were re-examined and discussed with my supervisor to ensure that I had set aside preconceived ideas and bias and that the major and sub-themes ultimately supported and provided clear evidence for a descriptive statement of the essence of what it was like to live with depression.

Reliability/Integrity and Trustworthiness

In the qualitative research paradigm, researchers need to ensure trustworthiness and the criteria for meeting trustworthiness are credibility, fittingness, and conformability (Guba & Lincoln, 1994). Later these criteria were refined to credibility, transferability, dependability and conformability. Trustworthiness is essential in qualitative research to ensure the credibility of experiences described by the participants (Krefting, 1991). To achieve trustworthiness, the strategies outlined in Guba and Lincoln (1989) was utilized. These include: (i) conducting extensive interviews; (ii) recording field notes; (iii) checking the accuracy of transcripts against audiotapes; (iv) careful documenting of data; (v) debriefing with research supervisor.

Field notes were taken during the interview process in order to record behaviors of participants when certain questions were asked. These behaviors were noted for future reference to ensure the accurate of recording of data. Three participants got emotional during the interview process at which time the interview was stopped and resumed when the participant said they were comfortable to continue. The participants appeared to trust me, were comfortable speaking about their family, and painful past events and we had a positive rapport. None of the participants showed any dishonesty in what they shared in this study.

I also kept an audit trail of how themes changed, the decisions made about collapsing themes, and kept note of when I was moving away from description and focusing too much on interpretation. The participants focused most of their description on family and cultural factors that led to depression and influenced their experience – rather than on describing what being depressed was like (symptoms and effects) and this made describing the essence of their experience challenging.

Regular meetings with supervisor were crucial for challenging the way the data was viewed in relation to the accuracy of coding and establishment of themes. It was during these meetings we discussed whether or not some of the themes needed to be modified. After modification of the themes, it was then made concrete and absolute as representative

of the lived experience of the participants. Overall, these steps were crucial in eliminating bias and pre-understanding of the phenomena.

Participants were given the opportunity to review and check transcripts to improve the accuracy and interpretation of information (Krefting, 1991). While it is impossible for the findings of a small phenomenological study to be universally transferrable it is possible to obtain a certain level of transferability by describing in as much detail the background and characteristics of the participants (see Table 1 in Appendix F). Providing a thorough account of the research methods and the findings also will help future researchers assess the transferability of the findings (Malterud, 2001).

Ethical considerations

This research followed the guidelines set out by the Victoria University of Wellington Human Ethics Committee and approval was gained (see Appendix D).

Informed consent, anonymity and confidentiality.

Informed consent was gained in writing from all participants and throughout the study (see Appendix E) and assent was sought before and during the interviews to ensure that the participants were still willing to participate. The identity of participants was protected from others through the use of pseudonyms and removing all identifying information (to protect the identities of families, peers and people in the community). All access to identifying information of the participants was limited to the researcher and supervisor.

Protection of students and the reputation of the university from risk or harm.

Throughout the study, confidentiality was maintained at all times. A disclosure process was developed as part of ethics application in order to help protect the participants from any harm and to protect the university, the researcher and the field of research. Participants were informed that if they disclosed they were at risk to themselves or others, a disclosure process was to be followed and support provided for the participant. The principle that the therapeutic imperative would take precedence over the research imperative was also followed. Distressed participants were to be referred to support

services and all participants were provided with a list of agencies they can contact. The ethics protocol included that distressed participants would be provided with an opportunity to withdraw from the study or continue the interview at a later time when they were less distressed.

During the interviews some of the participants disclosed past abuse (n=3) and past self-harm (n=2). This was discussed with participants and confirmed that they had no ongoing concerns. Participants were informed that these incidents would be discussed with my supervisor after the interviews. The decision was made to use the data from all the participants because those who disclosed past childhood abuse and self-harm had a good level of current support and was provided with contacts for further support. They were clear that these events were important contributing factors in their depression and important to include in their accounts. All of the participants requested to remain part of the study and to have their data included. The researcher followed all of the ethical principles and guidelines outlined by the University Human Ethics Committee and regular supervision ensured that the study was thoroughly planned and conducted.

Summary

This chapter outlined the research methodology and methods used to conduct the study. It explained how a descriptive phenomenological methodology and methods were used to collect and analyze the data in order to answer the research aim and questions. The following chapter describes the key findings and themes constructed, which make up the overall essence of the participants lived experience of living with depression.

CHAPTER FOUR: FINDINGS

Introduction

> Home literally felt like a prison, it looked like a prison. The fence reminds me of a prison. My house became a metaphor for a prison to me, which was the state that I got to. My window in my bedroom, they put a lock like my window so it can't open wide, it became like a damn
>
> prison, the blinds in my room looked like bars, the fence looked like bars. I hated that house so much because it looked so damn perfect and it was beautiful but on the inside it was fucking shit and I hated it. I hated that house so much and in my head I kept on replaying it over and over again. (Ana, pg.12, lines, 458-464).

The above quote encapsulates the essence of the lived experiences of six PI women who were living with and recovering from depression. Being depressed was a form of *imprisonment*. All of the women began their interviews by explaining the precursors, family and cultural circumstances, and life events which they perceived triggered or contributed to the onset of their depression. They all experienced childhood abuse and/or neglect and had been subject to authoritarian parenting styles which left them thinking they were bad, people who did not deserve to be happy. Depression was seen as a punishment for crimes the women felt they had committed against their families and parents. These 'crimes' included failure to meet family and cultural expectations, failure to maintain or uphold the image of their families, and living in two worlds.

They then went on to describe in-depth how they experienced their depression as a form of imprisonment and their life as prisoners. They described how experiences of repeated rejection left them feeling abandoned, alone, invisible and silenced. Their family and home life was like being stuck in a black dark storm cloud that restricted their quality of life, their functioning and which was inescapable. It followed them around all the time and made them feel unloved, unworthy, and judged. They described how their depression left them feeling drained of energy, isolated, trapped and alone.

The women tried to hide their depression from peers and others and their journey towards recovery was a solitary one because people around them did not understand or want to

acknowledge the reality of mental illness. They used personal and private strategies such as writing, listening to music and praying which made them feel safe and helped them find a voice and express their emotions, thoughts and selves. These strategies helped them gain control of their depression and allowed them to overcome depression at their own pace. These strategies were realistic to them as young PI women because they were culturally appropriate and manageable for them, unlike the strategies offered through counselling which included being encouraged to leave home.

Analysis of the data led to the construction of five major themes: *failure, rejection, imprisonment, doing it hard*, and *freedom*. These themes were interconnected and related to the overall essence of their experience of depression which was *imprisonment*.

Theme 1: Failure

> They were never there. Like when I had a little graduation ceremony in primary… I did one thing wrong at home and I had to basically do all the gardening for the whole day when I was like bloody fucking ten years old. As a punishment all day and it was freezing cold and they made me do that and I missed out on everything. (Ana, pg2, lines48-55).

The women experienced invisibility and punishment growing up and this contributed to their sense of failure and the onset of their feelings of low self-worth and self-esteem. The women felt they could not live up to cultural and family obligations, that their parents failed to support and protect them as children growing up and they failed to live successful in PI and Pākeha worlds. While the young women who participated in this study came from different Pacific backgrounds, families and had different upbringings, their depression was triggered by a combination of common factors and circumstances. They felt aggrieved because their parents were often absent from their lives and/or failed to protect them from neglect and abuse. Parents failed to acknowledge their daughter's individual and personal achievements and yet they made time for religious, cultural and collective activities. The women also felt helpless because there was nothing they could ever do that would be good enough to warrant their parent's praise and encouragement.

They felt like bad people because and things had happened to them and they felt trapped because they were voiceless.

The subthemes of *Failure* include: 'Failure to meet cultural expectations, failure to meet family obligations, a failure to be protected from physical and sexual abuse and failing to live in Two Worlds'.

Pressure to meet cultural expectations.

The women became depressed because they had experienced personal failure. They believed they had failed to live up to unrealistic or unattainable cultural expectations which came from their parents and church. They described being compared to other girls and having to live up to impossible standards and cultural norms. They described this as a no-win situation: *"Like they all talk about how the church thinks, they hold us to a standard that no one can meet, not even themselves. Like the standards that these people hold, not even themselves can meet, its straight Jesus standards!"* (Natalie, pg. 2, lines 76-78). The women wanted to be free of these standards and live like other young people who identified with Western cultural ideals and norms.

They described the pressure of having to constantly demonstrate respect for others, not having a voice, not challenging authority, specifically their parents. They also had to adhere to cultural obligations around always being available to care for younger siblings, and maintaining the household by doing all the chores. These cultural commitments, and obligations to church and family had to be met before anything else. These collectivist ideals left them feeling like they, their personal wishes, interests and individual lives did not matter. They described having no personal time. They were given almost no time for themselves and other activities valued by young people in western culture such as school work, friends or a social life. The pressure to live their lives as others demand was suffocating and stifling and contributed to a sense of helplessness.

Cultural and gender expectations influenced another set of rules that they had to obey and comply with. They were expected to dress conservatively, keep their hair long and uncut and had to perform and to show that they were rich in cultural knowledge and practices at a moment's notice. If they failed to show such knowledge and competency they were

punished and made to feel small, incompetent and useless (often in front of others). The women, believed that the expectation to be rich in cultural knowledge and practices was unrealistic to attain at such a young age and there was no way they could ever succeed and please their parents. Sammy described how she became frustrated when trying to live up to all the cultural expectations that were placed on her and how this contributed to her feeling trapped and imprisoned:

> Like God gave me this life, thank you, but now it's time to live it how I want it to be lived or how He wants it to be lived. Then in comes traditions and its like OBEY, it's like can I breathe? Like tradition is everything like I know Samoa and Tonga, we have our traditions but we're not in the islands anymore. This is New Zealand, you brought us here for a reason, and we have New Zealand customs too. You need to expect we're gonna follow New Zealand customs too. It's just overwhelming to the point where I can't breathe. (Sammy, pg. 4 lines 149-155).

The women also felt like they had failed because they couldn't find an appropriate balance between their heritage and mainstream cultural identities. They felt suffocated and disheartened because there was no way to satisfy their parents *and* themselves. They struggled to develop their own independent identity and live that out as well as meet the obligations and cultural expectations of their parents. For example, in Sammy's mind, her life was given to God, therefore, how she lived her life was between her and God. She believed she should have some freedom to live it out the way she wanted to because she believed God gave people free-will. She felt like she was failing to fulfil her own destiny but also failing to meet the wishes of her parents. Her parents, like many of the women's parents expected her to be completely focus on the way she was culturally meant to be. All the women felt overwhelmed and unsuccessful and trapped because they did not want to disregard any of the two cultures. They tried, unsuccessfully to switch between living in the PI world and the Pākeha world but found they could not succeed in both.

Oppression was a key aspect of the women's experience. They felt maltreated and persecuted, like they were living under the rule of a dictator. They had no opportunity to express how they felt, no voice, and when they did challenge their parents or culture they were punished. The women grew up learning that their personal views did not matter as much *'…that's when I started to speak out when I was younger, but when I spoke out they were like no you're not supposed to speak. Your role is to listen and just mute yourself'.* (Leanne, pg3, lines 99-101). They also learnt to keep quiet, suppress what was inside of them and to subjugate.

Family, church and cultural expectations were primarily put in place and enforced in order to maintain the family's image or status within the church and wider community. The women felt their parents cared more about what others thought about their children than what their own children thought. They described living under the constant scrutiny of parents and that others in their PI community were also watching them and reporting their failures back to their parents. They were constantly under surveillance and their freedom was restricted. They had to be perfect at all times and did not have any room to make mistakes, which they believed young people were entitled to make. Leanne described how she and her siblings all felt the pressure to conform to cultural and religious expectations. She wished she was freer and described how she began to lose a sense of herself and how this impacted on her sense of self-esteem:

> Expectations, pressure and just losing yourself because you care so much about what other people think, especially my parents. They care so much about what other people think that they don't think about what I'm feeling or how my sisters are feeling. They care about keeping up appearances…We don't care about what people think…they are waiting for you to slip up so they can laugh at you. (Leanne, pg5, lines 183-189).

The other women echoed Leanne's lack of concern about what or how other PI people view them:

> I only know Samoans, we are heavily attached to the image of our family, what people are going to say, we care too much about how people think about us and our families and I think that's why it's harder for us to talk. Samoans care too much about our image. (Kate, pg. 9, lines, 344-348).

They were more concerned about developing their own individual self and were not worried about the status or mana of the family. The women felt trapped and frustrated because their parents were still living according to traditional cultural norms. They were unhappy that their parents had not adopted and did not value the New Zealand customs and individualistic values that the young women are exposed to in their everyday lives. The women felt it was unfair and unjust for their parents to expect them to constantly meet traditional and unrealistic expectations as well as be successful within the Pākeha/dominant western culture. They felt like they were punished even when they tried their hardest and that their parents did not understand the pressures they were under.

Not being able to express their frustration or 'talk back' to their parents led to acts of resistance which tended to make their situation worse. For example, Natalie stopped attending church. This was a turning point in their relationships with their parents because Natalie describes church as the core or the foundation of every Samoan girl's life. Not attending church meant she was going against the wishes of her parents, and a failure. She felt like it was her only option, took a big risk and made a personal sacrifice to separate herself from the pressures that is associated with her church: *"Halfway through the year I just stopped going to church, and this is someone who would go early as every day and not even miss out during the weekly stuff."* (Natalie, pg. 2, lines 78-81).

Others who felt they could not resist and experienced an ongoing sense of personal failure. They began to doubt themselves and question whether they could ever live up to

expectations and became dispirited. The women internalized their failure to meet others expectations and developed feelings of unworthiness, self-hate and failure:

> Just feeling unworthy pretty much. There were a lot of times where I was just like why do you even exist? Like why am I even here? Just feeling complete unworthiness because I could not meet everyone's expectations. Everyone held such high expectations and it's because from a really young age my parents held really high expectations from me, then my church started putting expectations on me. When I couldn't meet them that's when I was like 'man you're useless like you couldn't even do that one simple thing.' But it's that one simple thing on top of all these other simple things that were placed on me to do (Natalie, pg.3, lines 109-120).

The women fed their despondency when they started to internalize the perceived and actual negative messages they got from others. They started to tell themselves similar things and to believe that they were no good, failures, and started to doubt their own self-worth and existence. They felt like they had failed others and failed themselves and would continue to do so in the future. They began to develop a sense of hopelessness and intense self-hatred.

What was even more frustrating for the women was that even when they did meet the standards and expectations of their culture and family they still were not encouraged, praised or rewarded. No matter how hard they tried to succeed it was never enough and they this made them feel discouraged and invisible. The women felt they missed out on being recognized and were undervalued and this contributed to their hopelessness. They started to question why they even bothered trying to please their family and meet the standards set out in their culture:

> Even like my grades like I worked hard to get honours and stuff and everything like to get the best grades and she never took notice. I'd bring home all these awards and certificates and like nothing. (Ana, pg2, lines 69-71).

The women felt like they were unfairly treated and that they would never measure up and never be worthy of love or esteem. They felt like failures and in turn made the women question their sense of self and their abilities.

Failure to meet family obligations.

Not being able to meet family obligations also contributed to their sense of failure. In PI cultures which are collectivist in nature, there is a strong emphasis for individuals to meet family obligations, which remains strong through the interdependence of its members. As young PI women, the participants were obligated to serve the needs of their parents and the whole family. For example, the women were expected to give their family money, prepare food and do chores, but also take care of younger siblings. In PI culture it is impossible to separate church and family as cultural influences. The most important obligation and pressure on the young women from their family was to attend church and cultural events as these were also part of them meeting their family obligations.

The pressures of being committed, giving up their time and the pressure of constantly having to carry out all these duties robbed them of their childhood and their youth because they were forced to take up adult responsibilities such as caring for younger children at an early age. It also left very little room for the women to grow as individuals because they were always having to think about their family. They felt despondent because they had to give up dreams and their hopes of doing things they wanted to do. They felt that what they wanted did not matter and began to become indifferent and dead inside:

> The things that they did to me, it made me hard and numb and I didn't
>
> get to be like a child, or a normal human being cause everyone always
>
> says that I'm a lot more mature than my age and I'm a lot more mature
>
> than I look. So I guess they took away my childhood. (Kate, pg4,
> lines 139-148).

Even when the women did carry out all their family obligations, they were often worried about failing to meet their parent's and family's standards and the negative consequences for them. It made them anxious and stressed:

They put all this responsibility on me and like every time I go to make

a decision I always have to think about the consequences. I just can't

do something, it's really hard, it's like the inner conflict, I can't not

think about it. I live my life in a worried state and for me that's not

good.' (Kate, pg4, lines 139-148).

Their parents punished their children harshly when they failed to meet expectations and verbally abused them: *"I don't think our parents realize how harsh their words are. They've scarred me."* (Natalie, pg5, line 162). The women reacted submissively, taking their punishment quietly and without resistance as they were expected to because resistance meant the punishment could become more severe. Ana described how as an elder daughter, she felt her parents set higher standards for her and treated her differently to her siblings. Her experience of physical punishment led her to withdraw and detach, create emotional distance between herself and her parents and just do as she was told:

I was in intermediate, there was always a distance between me and

my family. It was me, mum, dad and sister, this was before my

brother was born. I would like to say we were a happy family, maybe

the love went on to the younger ones not on to me and I always felt

like the outsider or the excluded one or the one that nobody cared

about. I was denied a social life, with me it was always strict, if I

done one thing wrong it was like you're in the wrong line. I use to get

the worst hidings as well, at a really young age. From then on I was

always kinda quiet and just went with the flow. (Ana pg. 1, lines 5-

17).

Being treated differently, unfairly and being denied a social life led her to feel like she was different, a stranger in her own family and that she didn't belong or deserve warmth and care. She felt alienated, like an outsider and the punishments she received made her want to withdraw further into herself and away from her family. The women were also alienated by other family members who distanced themselves in order to avoid being

implicated or receiving even more unwanted parental attention. Essentially, the young women felt that the family expectations were impossible to meet, were unfair and took away their freedom. What they thought, wished for or wanted did not matter.

Failure to be protected.

Being depressed was associated with long-term problems and historical physical and sexual abuse within the families of four of the young women. All the women had grown up with strict parents, physical punishment and discipline. Their homes were defined by their parents imposing a rigid structure of rules upon their children. In the homes of these young women, parents expected them to follow rules without question, there was little or no room for negotiation, a lack of warmth, communication problems and a sense of parental betrayal because parents had failed to protect and keep their children safe.

Being punished and in some cases physically abused as children, left the women living in fear but also feeling let down because their parents had failed to protect them from harm. They knew that the norm in other Pākeha families and in wider NZ society, is that parents are supposed to love, cherish and protect their children from harm, and that physical abuse is illegal. The women felt that they deserved better but also that they were different from other young people because it had been drummed into them that their family and culture was different and most important. For example, Ana was fearful of upsetting her parents, therefore, she was *'always kinda quiet.'* She was constantly afraid that her feelings, thoughts or actions might be criticized or punished by her parents and so she withdrew from them to try to protect herself. The women did not confide in their parents when they encountered problems they could not resolve themselves or when they felt vulnerable and so were left alone to deal with issues by themselves.

The women had to keep their experience of family physical abuse and punishment secret. They knew they could not share this with their non-PI peers and teachers at school because there might be negative consequences for the family and for themselves. If they disclosed their experience of abuse and punishment they would be going against their parents' wishes and the norm of keeping quiet. As a result the young women tried to shut down how they felt about their experiences and hide their disappointment in their parents.

They also felt angry and disappointed that they did not have the same intimate family relationships they observed in their Pākeha peers:

> Emotionally I was distant. The primary school I went to there weren't other people like me, it was mainly a Pākeha school and if they heard the word abuse, like I could never ever ever ever open up about my life to anybody, my life was a secret not only to my friends but to my teachers. I had to look as if I was like normal like everybody else… I use to feel so jealous of other kids at how close they are with their parents or the fact that their parents are even interested in their kids' lives.' (Ana, pg. 1, lines, 22-33).

The young women wanted a different type of relationship with their parents, one that was more affectionate, caring and where parents respected and showed an interest in their children's lives. Their reality was very different. They felt emotionally distant from their parents and maintained that distance to protect their parents and themselves. Like all the other women, Ana showed great respect to her parents and their wishes but she also felt pressure to appear to be the same as other non-PI young people when culturally, she was very different. The daily struggle was to exist in and to fit into both the Pākeha and PI world. Despite their efforts and attempts to keep these apart it was evident they had failed to meet the standards of either world. Ana described how unhappy she was about having to keep secrets about her home life:

> Sometimes they use to ask me questions cause when I was younger I use to have bruises, then the teachers would question that and then I have to always come up with a lie because it's not okay to nark on your parents so I never did. (Ana, pg. 1, lines, 30-33).

Keeping their experiences of physical abuse secret contributed to the young women's experience of anger, feelings of sadness, and fear. At times the women felt like they were

the ones to blame for the abuse inflicted on them, that they deserved their punishments. This was reinforced by the perpetrators who did not take responsibility for the abuse. They lacked any hope that this would change and that the family would acknowledge and rectify what had happened to them. The three women who were sexually abused were disheartened and felt dejected when they told others about the abuse. Their disclosure (to family members) were met with reactions that left them feeling even more isolated, alone and like a failure:

> I don't really know how to talk about my family without going into
>
> dark details. When I was 13 my dad molested me. I'm sure there's a
>
> lot of good stuff, but that obviously changed things. When I told my
>
> mum at 15 she sided with my dad. So in terms of family I don't really
>
> have a lot, that's definitely a thing that I feel differently about when
>
> it comes to family and Pacific Island settings. I don't have that strong
>
> support base and stuff. I told my boyfriend at the time, who had left
>
> me since and she found out I told him. She kind of lost her shit, it's a
>
> bit of an abusive cycle in my family like its real um keep the secret
>
> within you. (Jane, pg1 lines 3-11).

The women felt that they had been betrayed by their family. They either experienced cruelty, physical and/or sexual abuse at the hands of family members who were supposed to love and protect them, or were made to feel dirty, to blame and ashamed because of what had happened. In Jane's case, the one person who she felt she should be able to trust with her secret was her mother, but her mother did not believe or support her. This caused a lot of tension in her home, and upon disclosing what had happened to her boyfriend. It angered her mother because it was meant to be kept a secret. Now she brought shame upon her family and on herself for not keeping her abuse secret.

Keeping secrets that are traumatic, painful and life-changing caused a breakdown in communication within the families of some of the young women. Because their parents failed to protect them or to address what happened, the women felt personally responsible

for the adversity they had experienced. The secrets ignited feelings of suspicion and resentment and their ability to trust was severely compromised. Having their claims rejected and being forced to keep these traumatic secrets inside them resulted in excessive stress and guilt for the young women. They were in a dark place and had to carry the burden alone. Overall, the young women had to keep everything that happened to them within the four walls of their homes and this fed their experience of entrapment and imprisonment. They were expected to remain silent about the abuse and they began to doubt themselves, their worth and whether they were loved even within their own family. They began to feel hopeless about their situation and helpless because others were not prepared to help them change it.

A failure to live in two worlds.

Living in two worlds created problems for the young women and a sense of failure because they were not able to succeed or feel that they fully belonged in neither the PI nor the Pākeha world. The women felt unsure of their roles in life (how they should act at home and in public) and most importantly felt like they did not know who they were. They had two identities and tried to navigate in both worlds but felt no sense of belonging in both worlds. Natalie described feeling inadequate or a failure as someone who struggled with balancing her Samoan identity and her identity as a young Samoan woman growing up in the New Zealand context:

> We been brought up Kiwi, but at the same time we have been brought
> up with the conflicting Samoan values too. This is how I felt all my
> life, it's like what we say an identity issue. I belong to my Kiwi world
> sometimes and I belong to my Samoan world sometimes. And so I
> got these two conflicting expectations and then the battle, if that
> makes sense and you can't find your middle ground.' (Natalie, pg. 4,
> lines 140-144)

This battle between their cultural heritage and the dominant culture with which they live in, lead to feelings of failure, confusion and lack of identity. They felt that they would never measure up or manage to succeed, and a lack of belonging. It is important to note that none of the woman talked about peer relationships, breakups, and isolation or school

problems when talking about life before their depression and yet these have been issues associated with depression in previous literature and research on non-PI populations.

The women experienced multiple failures – they felt that they could not live up to and meet traditional family, church and cultural obligations nor the expectations of the Pākeha world. The expectations of their parents were unrealistic and unattainable and when they failed they were punished, and when they succeeded in the Pākeha world their accomplishments were ignored at home because they were not valued. Their failures and the failures of their parents were internalized by the women – they were taken on board, owned and attributed to personal deficiencies. The women felt negatively about themselves and their identity. Negativity towards the self and their identity was purely a result of a conflict of trying to fit in two worlds and to be successful in both. The next theme explores the women's experiences of rejection and how this contributed to their depression and despondency.

Theme 2: Rejection

The women agreed that they had been denied a happy childhood, and they were weighed down by the constant pressure to meet family and cultural expectations. Their failure to meet their parents' ideals left them feeling dejected and hopeless. The women felt that their parents were not only cold and unaffectionate but that they were also hostile and aggressive. They felt neglected by their parents and in turn they began to feel like they were a burden on their family. For four of the women, this contributed to their departure from their family unit, leaving their homes which is the one place they can identify with despite the inner conflict it creates for them. Feelings of loneliness and isolation emerged as they could not share their troubles with others and therefore felt unsupported. Furthermore, they felt their parents and families did not understand the impact their actions had on the young women and that the burden they were carrying was something they expected them to carry.

The subthemes of *Rejection* include: 'Invisible and Unrecognized, Denial and Abandonment and Self-Punishment and Self-Harm.' These subthemes, as explained by

the women will be described to reinforce the grand theme of *Rejection*. Not only did their families reject the women and their eventual diagnosis but the women also came to see themselves as something that deserved to be rejected.

Invisible and unrecognized.

One of the key experiences that contributed to their experience of depression was parental rejection. The women explained how they were constantly ignored and made to feel invisible or were criticized by their parents, despite their best efforts to achieve and please them. Their parent's lack of encouragement, support and warmth meant they felt unimportant, peripheral and they became unsure of themselves. For example, Sammy described how she was always trying to be seen and heard by her parents and how her invisibility made her feel unloved and down. She tried unsuccessfully to get their attention by going for different roles at school and joining sports teams. She wanted her parents to be proud of her but no matter what she did it was never enough:

> Before my depression, it was like happy family but for me it felt fake.
> To them (parents) they might still think yea we are, but for me it was
> like you don't listen to me. They don't know what's going on
> underneath it all. They were pretty strict parents. My parents were so
> strict… I try and go for leadership roles, which was my main thing.
> It was my way of being like 'mum, dad I'm doing something for you
> guys!' like, 'I'm trying to make you proud and all this stuff.' So
> college was basically my way of like showing my parents like 'look
> at me! (Sammy pg. 1, lines 4-9 & 22-25).

Ana, described a similar experience when she was at school. She craved her mother's recognition and would always try her best but she could not meet her parent's unrealistic expectations and was left feeling hopeless and that her achievements did not matter:

…I never ever went to award ceremonies when I got made house

leader in high school. I told my mum because she picked me up that

day and she didn't even give a shit, she's like WHY? You know

you're not going to be able to do it… even like my grades, I worked

hard to get honours and stuff, like to get the best grades and she never

took notice. I'd bring home awards and certificates and like nothing.

I would go up to her and be like 'look mum I got you honours in

graphics and then she'd be like yup.' She's my mum, you know?

You're meant to be close with your mum like where else am I

supposed to get guidance from? (Ana, pg.2, lines 60-63 and 69-79).

The women felt that their parents failed to acknowledge or approve of their efforts and their successes. Even when they did experience some success their parents remained emotionally detached and failed to praise or encourage them. As a result they felt rejected and started to become hopeless and believe that there was no point even trying to please their parents.

Denial and abandonment.

As the women struggled to deal with their invisibility and their rejection they started to feel more alone even though many of them lived in a house full of people. They also felt isolated and marginalized because they could not share or open up about their feelings to others. Furthermore, when the women became aware that they had depression they could not share this with their parents or family. They believed their parents would not be empathetic and would react negatively because they had little knowledge of what depression was or how it could affect young people. For example, they described their parents as individuals who did not see depression as a mental illness and discussed how there was a lot of stigma attached to mental illness within PI culture. The women described how having a family member with a mental illness would reflect badly on the family. The women turned to their GP's for confidential help because they felt they could not talk to family or teachers (who would share their problems with parents). It was

through their encounters with their GPs that they learned about depression and its symptoms. They were assessed and were diagnosed with depression but kept this a secret from their family. This further added to their sense of isolation.

After the women had been clinically diagnosed with depression they agonized over whether they should tell their parents or not because they feared their reaction, whether it was going to be received with anger, denial and or shame. Also, there was fear surrounding judgement or stigma that could impact the family reputation in their cultural community. The women had observed how some people in the PI community had attributed mental health issues and other teenage problems to be a reflection of poor parenting or family functioning. From this, the women were able to conclude that their failure in developing depression would be attributed as a failure within their family.

The women were also worried that because their parents lacked mental health literacy they would have their diagnosis rejected. Many of their parents did not believe that depression was a 'real' illness because it was not a physical illness. They explained that both they and their parents were ignorant and uneducated when it came to mental illness. The women described how they were worried that their parents would deny their illness because they don't understand mental illness and believe people 'choose' to have emotional issues. They kept quiet because they thought their parents would not believe them or would dismiss their depression as something that their daughters could overcome or get rid of through willpower or changing their mind-set:

> I didn't even know what depression was. I knew it was something
>
> because I had always heard about it because I'd seen those ads. I'd be
>
> like that's pretty stupid, you're just sad. Like that's dumb. To my
>
> family and in our culture, depression is nothing. It's not a big thing,
>
> it's not a sickness. It has to be physically seen or something."
>
> (Sammy, pg.1 lines 38-41).

For three of the participants, the potential for parents to reject their mental illness and to be rejected again was too much. To not be acknowledged and not be supported was more

than they could bare and so they decided to carry the burden of their depression by themselves rather than risk rejection. Two of the women told their parents and the parents of one of the participants were later informed by the women's GPs or counsellors. The women who disclosed their depression to their mothers, did not get the supportive reaction they hoped for. They were rejected as they feared they would be and were told to keep it quiet and that they would have to deal with it on their own. For example, once Ana's parents found out that she had depression, they lectured her and told her they expected her to change and to stop being depressed for the sake of the family's reputation:

> They've seen how I been upset and then I'd just get the lecture that
>
> you should change, this is what you should do, this is how you should
>
> be in order to be happy but really that's just contributing to the happy
>
> family picture that they want to paint. It doesn't really necessarily
>
> mean that I'm happy, I'm just contributing to the picture that they
>
> want. (Ana, pg. 4, lines 139-143).

Bianca was also painfully rejected by her mother when she disclosed her diagnosis. She was forced to reach out to others and the system for support: *"I only told mum that I was dealing with depression earlier this year and she had a cry and then said 'I'm sorry I can't be on this journey with you.' So yea she's picked her side hence why I'm a system's kid like I throw myself to WINZ and everything else like that, I need to."* (Jane, pg. 1 lines 32-36).

All of the women experienced some form of parental rejection when their depression came to light. What made their experience of rejection even more painful was that they carried a belief that their parents would love and support them unconditionally. Even Jane, who expected her mother to show more understanding, care and support because she worked in mental health was bitterly disappointed by her mother's reaction. She could not understand how her mother could reject her own daughter and how a

professional could reject someone in need of care and support. She expected more from someone who worked with people with mental illness and whose role required helping patients/consumer's meet their needs. The women were saddened that their parents once again put their own needs and concerns before those of their individual children. For Jane, this rejection was heart-breaking and the last-straw. She had been rejected by her mother twice, first when she disclosed the sexual molestation by her father and second when she told her about her depression. Her mother chose not to stand by her on either of these occasions and this left her feeling deserted and isolated. Jane's reaction, like all the women who were rejected, was not to give up, and to become more self-reliant. She threw herself into the system to make use of whatever support was available within the wider community. This helped her create some distance from a dysfunctional family and get support to carry her burden. The other women also found their own solutions and resources for managing their depression, but they had to do this alone, and without family support.

Sammy had a different experience of 'coming out' to her parents because they were present when she was diagnosed with depression. But even then they still could not fully accept the diagnosis or that their daughter had a serious issue. Sammy's parents were aware that something was not quite right with their daughter but they did not understand what was wrong and could not put a label on it. Sammy explained how her parents thought that her depression was a reflection of their poor parenting, and their own failure. Her depression was evidence of their inability and dysfunction and brought shame to the family: She said *"When they were listening to me saying my answers like one, two, they were just like what have we done as parents to do this to our daughter?"* (Sammy, pg2, lines 60-63). When her parents finally accepted her clinical diagnosis and that she was not being sad, moody or just a teenager, they felt bad that they had dismissed her earlier attempts to talk to them about how she was feeling and that they had downplayed the seriousness of her condition:

> …when they heard, they were crying, my mum felt bad. My
>
> dad just felt even worse cause I had approached him so many

times. But he'd be busy with work or my mum would say you

know the typical 'oh just have a Panadol.' I'll be like Panadol

doesn't fix everything, like they think Panadol is the cure for

cancer… my parents were just so shocked and upset that they

didn't listen. All they had to do was listen and hear me out.

(Sammy, pg. 2, lines 76-87).

Many of the parents turned a blind eye to what the women were experiencing, and even with a formal diagnosis, many of them refused to accept that their daughters were depressed. The parents had ignored key responsibilities such as care, support and love both leading up to and after their diagnosis. Many of their parents made no effort to educate themselves about depression or attempt to understand it so they could support their daughters. It made the women feel that they and their depression were invisible and their rejection lead to feelings of being denied and abandonment.

Self-punishment and self-harm.

Being rejected and having their diagnosis rejected left many of the women feeling utterly alone and discarded or at the least misunderstood and unsupported. They began to feel that they perhaps deserved to have their depression and the rejection of others. The responses of their parents coupled with their own self-doubt and low self-esteem started to create a negative self-talk. The women could not get over their feelings of guilt about letting their parents down, not living up to expectations, having depression and bringing shame upon their family. The women started to believe that they were a bad person who deserved to be rejected, unhappy and punished and it began to consume their thinking:

You become depressed in everything, the way you are, your attitude

and you begin to withdraw yourself from things because like I started

believing my parents. And internally punishing myself like I deserve

this because I'm this bad or like I'm going to hell. I use to believe

them as well that I was a bitch and I was just a bad person and I didn't

deserve to have the same fun as everybody. It use to always take up

all my mind space. (Ana, pg. 3 lines 101-110).

The rejection and denial they experiences encouraged the women to believe that perhaps their depression was not real. Four out of the 6 women sought to externalize their inner pain to make it real to themselves and others by engaging in acts of deliberate self-harm. They used their self-harm to communicate or to show their parents that they were going through was serious and upsetting. They also wanted to give their depression a physical and visual presence so that their parents would take it seriously. For example, Leanne used her self-harm to get a reaction from family members but it was also motivated by her desire to externalize the pain of her childhood sexual abuse, and to find a voice because she had been unheard. Her self-harm had a communicative rather than self-punishing function but it may also have been a way to punish her parents and family, if she died. She was desperate, overwhelmed and in a dark place but the pain she experienced allowed her to feel. It enabled her to experience a different type of pain, anything other than the despair that was part of depression and the numbness she had developed as a result of blocking out her past childhood sexual abuse:

Yes I self-harmed. Like the pills, I started vomiting blood after taking

so many pills, but when I was doing the self-harming and stuff I wasn't

thinking about anyone else. I was in my own little world, it's really sad

but I feel like I needed to see my sister react before you know, that

bubble popped. Oh I remember how hurt she was like oh my God she

was like trying to get stuff to stop the bleeding. I didn't mean for her

to see it but I don't know I just went to a really bad place. It was just

to feel a different kind of pain.' (Leanne, pg.5, lines 197-208).

All the women demonstrated different levels of rejecting themselves and their depression by thinking about or attempting suicide. They described engaging in self-harm because they felt trapped: trapped in their negative thinking, trapped with unresolved past issues, trapped with ignorant, unsupportive and uncaring parents and families. This made them feel as if there was no escape from their realities, the reality of experiencing and dealing with depression alone: *'Grey. Dark grey. Like a cloud, it just feels like, I remember it use*

to just follow me around. It was my own cloud. I just had it there, to follow me everywhere, that's so sad'. (Leanne, pg.4, lines 147-149). Their self-harm and suicidal thinking were also their way of rejecting the world that had rejected them.

Some of the women cut themselves, when they wanted to punish and reject themselves and when they wanted to externalize and communicate their inner distress to others. However, this behavior was also met by parental denial, coldness and in some cases, ridicule. For example, Ana described how her mother made her feel even worse by labelling her and her behavior 'mental' and accused her of learning it from her white friends:

> 'I cut myself, oh my God, so I cut myself when I was punishing
>
> myself because I was so bad like when my mum got mad at me I was
>
> like, so I cut my legs. Yea I cut them and one day my mum walks
>
> into the shower and she sees the scars, and instead of saying like you
>
> know, what happened? And even if I said that you know this is why
>
> I did it, she literally just said that you're mental, like she didn't even
>
> bother. That was the main thing, she just decided to label me, like
>
> she's always labelled me if I do something wrong, you know on top
>
> of stupid and bitch, all of the other like, now I'm officially 'mental'
>
> and like she laughed at me. She laughed, she's like 'Oh my God, you
>
> learnt that from your white friends.' I was like are you serious? And
>
> so after that I just isolated myself some more. (Ana, pg.9, lines 362-
>
> 371).

Ana and the other women often felt angry, hurt and upset that their parents belittled their pain and suffering and tried to blame them for their own distress or shifted the blame for their daughter's depression onto their non-PI friends.

The women experienced rejection in both their childhood and teenage years. Before their diagnosis they felt they were denied and abandoned by their parents in relation to care,

support and love. This rejection and feelings of unworthiness and burdensomeness were further reinforced after they were diagnosed when their parents rejected them and their diagnosis. They felt invisible and abandoned. They struggled to manage their depression alone and developed distorted views about themselves. They began to internalize the negative messages they had received. They rejected themselves and turned to self-punishment and self-harm, to try to externalize their inner distress and convince their parents they needed help and to make their depression visible and real. Their attempts at securing help and care were unsuccessful when their parents rejected them again, labelling them as 'mental' and dismissing their behavior.

Theme 3: Imprisoned

Being depressed was a lonely experience for the women and one that made them feel trapped and imprisoned. They were trapped in an impossible situation and they felt powerless, voiceless and helpless. They had no one around them who understood and cared, and although they were surrounded by their family members they were silenced and confined. They could not talk about their experience and if they did they were dismissed or punished by family members who did not understand. They also described being imprisoned by their depression. They were trapped in thinking that there was no hope, no point in trying to recover because in their minds there was no escape. They had to endure the rejection of their families and the depression on their own.

The subthemes of *Imprisoned* found during analysis include: Silence, Hiding it, and Trapped. These subthemes, as explained by the young women, will be described to reinforce the grand theme of *Imprisoned*. The young women had to endure their depression in *silence*, they had to keep it *hidden* from others and they were kept hidden by their families and they felt *trapped* because of the ignorance and uncaring nature of their families.

Silence.

The women explained how they were silenced by their depression and were unable to speak about their experience to others because of family sanctions and because no one spoke to them about it. They were left with nothing to hear except empty, echoing voices that replayed over and over again in their minds, the sexual abuse, the mental abuse and

rejection they had experienced. The women described their homes as being like a silent prison. They were not allowed to speak unless they were spoken to, they had to do as they were told, follow the rules and were not allowed to challenge their parents who were seen as the prison guards. They had to obey the prison rules at all times or they would be punished and further ostracized. For example, Kate kept silent but described how she lived in fear of letting her secret out and what would happen if people found out her mother was a contributing factor in her depression:

> Maybe I was numb from everything, when you have a lot of secrets
> you have to keep and you can't talk to anyone about it. You don't
> really want to talk because you don't want to let it slip. I wasn't
> allowed to talk about it. She knows that a lot of the stuff she's done
> in life has caused my depression and maybe she didn't want anyone
> to hear about it. (Kate, pg. 1 lines 24-35).

There was a cultural expectation for the women to listen, obey and remain silent but over time the women also learnt to stay silent because of their depression. For example, Leanne said she had learnt that there was no way for her to discuss her depression with her parents in a respectful way and no room for negotiating with her parents or communicating her individual needs without insulting them. She said she had learnt *'…to listen and just mute yourself.'* (Leanne, pg. 3, line 101). The women also chose to isolate themselves from others and were made to keep up the appearance of being happy when out in public. This contributed to their silence and isolation because it meant they could not talk to their friends, extended family, teachers or people who might understand and support them. They were alone in their experience and because no one in the PI community spoke about mental illness they felt that they were the only ones who had ever experienced depression and that they were abnormal. Ana shared her experience of suffering in silence:

> Yea I thought it was only me who had a problem, like only me who
> was the misfit in society. If you come from a community that's so
> embedded in culture like on the outside they make it look like being

depressed is wrong, if you're depressed that is just crazy, you should

be normal. What is normal? For a long time I bottled it in, then

suddenly when I've had enough it just explodes. That's really bad, so

yea I think that's also because of the family because they like shut

you up for so long, they want you to be like the person that you see

but don't hear. (Ana, pg. 5, lines 193-200).

Being silent and isolated meant they had no one to share their burden with, they could not develop or access supportive or therapeutic relationships. No one acknowledged their pain, or their mental illness. No one affirmed them or gave them any hope that things would improve. Suffering from depression in silence meant that the woman did not have the parent-child relationship that is crucial to any child, especially in time of need, and they had no support and love. Losing that relationship, that contact, meant the women lost a part of their identity, the identification that any child will have when they think about or see their parents. They became nothing because they were connected to nothing and saw no end to their isolation.

Hiding it.

The women were pressured to hide their depression because of the stigma that is associated with having a mental illness within the PI community. They did not want to give their parents a 'bad name' or for people to blame their parents for their depression.

They also hid it because of self-stigma: they were worried that other people might think they were abnormal, crazy and different. They did not want others to think they were weak, vulnerable and deficient. They struggled to hide the symptoms of their depression from others but also avoided contact with people in case they were noticed. The combination of the two meant the women lived within the confines of the silence. However, sometimes they failed to keep silent and contain their emotions and they broke down but this was usually in private, at home, or in their rooms:

They (parents) understand emotions, and that's like one of the main

things that trigger depression, is when we bottle up our emotions.

And then when we can't get it out and it all comes out and it's like

four seasons in one go… I remember I use to hide from everyone

because I didn't want to see anyone and then when I'd see people, I'd

find somewhere else to hide. For me it's the reputation I carry for my

parents, not so much my last name but my family because I got so

much expectations put on me. (Natalie, pg5, lines 162-175).

Hiding their depression made it very difficult for the women to access support from those around them including those within their community. The women had to constantly put their family's needs and reputation before their own – they were made to be martyrs, to bear their pain for the sake of their family and suffer in silence. They also hid their mental illness because they were made to feel that they had let everyone else down:

They're worried about what people are going to think about them

(parents) like didn't they do anything to try and help her? They're

also worried about what people are going to say about me

now…you've humiliated yourself, you're such a disgrace like

everyone prayed for you, about your school and now look, you've

just gone and chucked everyone's prayers back in their faces. (Kate,

pg10, lines 387-397).

Hiding their depression was hard work and being depressed felt like being weighed down, it was a burden, a hardship as well as a punishment. The women were often tired, lacked energy and motivation and struggled to even complete the basic tasks of living: '*Heavy, I feel so heavy like there's something pressing down on me and then there's also something weighing me down like I can't function, my whole body'. (Jane, pg. 8, lines 307-309).* They also struggled to continually appear normal to their friends and peers at university and work. They were exhausted in both mind and body from pretending to be happy. It

drained them of energy and spirit and made it difficult for them to concentrate. When their depression threatened to overwhelm them and they felt they might not be able to hide it any longer, they retreated from people to keep safe:

> I have a real part time life. So Monday, I'll be at uni, and it's usually
>
> draining, Tuesday I'm in bed all day and I'll get up and I'll eat and
>
> then I'll be tired again. I just get like a massive surge you know like
>
> with pregnant women? I reach my limit and like it usually happens if
>
> I have to do like any emotional kind of lying, like if I'm around
>
> people and I have to put on like a good face like you'll just see me go
>
> like… and then I just zone out completely and then it's like time to
>
> go home. (Jane, pg. 5, lines 178-185).

Jane described this experience as both living a fake life and only being able to live 'part time'. They were constantly anxious when in social situations because they were fearful of being found out by people who know them well and that they would not be able to hide their depression. They felt like frauds, outcasts and that they didn't belong amongst other 'happy' young people: '*I'm fucking four seasons in a day... I find that being around groups of people who are really close makes me quiet, it triggers me a lot to go into a bad head space, just cause I feel like I don't belong (Jane, pg5 lines 199-205).*'

Hiding their depression meant hiding how they felt behind a mask. This mask contained and held back their depression but it also confined and imprisoned them. Wearing the mask allowed them to always appear happy, like they had everything together, and that everything was perfect with them and at home and they were happy. But wearing the mask meant staying silent. The women also described that it was like putting on different masks according to the situations they were in. When they are at home, they have to act like they are fine and around their peers they had speak highly about their family in order

to keep up appearances. The women felt like hiding everything by wearing different masks and remaining silent about their true feelings contributed to being imprisoned.

Trapped.

Part of being depressed was being trapped in a pattern of negative thinking. The women were imprisoned in their own homes, and even when they were out, they still felt trapped because they had to follow the rules, remain silent and hide their depression. They felt like they were living a lie and that there was no way out. They described their home life as being like solitary confinement in prison, and how this made them angry. They began to hate their family and their home, they wanted to reject them but this left them feeling confused about what they would do and who they would be if they were no longer connected to their family. They also felt exhausted and emotionally scarred and doubted whether they would have the energy to make it alone or if they would ever escape or be accepted for who they were. They felt like their family and their situation was slowly killing their soul and they were trapped in a hopeless future: *"I was upset, that's how most depressed people would think. In that mind space you wouldn't think there's any other way out. The depression gets into you and literally takes over your life."* (Ana, pg3, lines 101-105).

The only thing the women had in their solitary confinement was their depressive thoughts. They would ruminate on what others had done or said to them, and they started to believe what they had been told about themselves. The depression fed off their negative thinking and without a reality check and someone to question their thinking they started to believe it. They had no self-worth and it didn't matter where they went or who they were around, their depression followed them everywhere. It was constantly on their mind and it infected their soul leaving them feeling hopeless and dispirited.

While all of the women did at times feel hopeless not all of them were helpless. Over time they came to understand their family situations and family dynamics as much as they came to understand their own depression. They learnt to know what to expect and how their depression affected them. This gave them a sense of power because there was some

predictability to their depression and they knew how people would react and respond to it around them.

Jane described her depression as like being trapped in a storm cloud and how she was born into it: *'I was born into a storm cloud. I've lived its patterns and I know now not only what punches coming next but also how to change the direction of its swing.'* (Jane, pg9, lines 372-373). Her family were a part of that storm cloud, they were in there with her, causing her problems and she was in there causing them problems. The only difference was that she did not believe that her family were aware that they were trapped in their way of being in the world and that they were partially to blame for the problems they all experienced. Jane described how she came to understand her depression and her awareness that her family was in her storm cloud of depression and their sense of joint helplessness: *'Yea that definitely relates to the people in my life like my mum and dad are a bit nuts and I think they're in there, yea they're in the storm cloud and don't really know how to get out of it and have never tried to. Yup haven't tried, total key.'* (Jane, pg11, lines 415-418). Jane's parents like many of the other parents were trapped by their ignorance, denial and their lack of willingness to support their daughter's recovery.

Theme 4: Doing it Hard

The women were angry and frustrated because their parents made their experience of depression harder to manage than it needed to be. The expectations of their parents, their home life and their thinking imprisoned them. What made it even harder for them was the way they were treated, the things that were said or left unsaid and a lack of understanding. The women felt imprisoned and the prison officers were there parents. Their experience of going through their depression was shaped by their experiences within the prison. They felt persecuted and under constant surveillance by their parents who carefully guarded the family secret, dictated to them how they should behave, and enforced the rules. They felt uncared for, unsupported and controlled. They felt that they simply had to endure their depression and that they had little support to help them recover or rehabilitate. The subthemes of *Doing it hard* found during analysis include:

misunderstood, privacy and *labelled*. These subthemes, as explained by the young women, will be described to reinforce the grand theme of *Doing it hard*.

Being misunderstood.

The women described having a strong desire for those around them to understand what they were going through. However, they felt they were misunderstood and that others did not understand depression or what helps people recover or manage depression. The women wanted understanding and validation that what they were experiencing was real and serious, but they also wanted someone to communicate to them that there was hope. That things would and could improve. They wanted their parents and other adults (including health professionals, school counsellors) to not only understand their experience of depression but to accept it and be able to support them through it:

> 'The understanding. I guess it's hard to tell parents and like a church
>
> to have some understanding for the person that's going through
>
> depression especially if they're Samoan born because of what we
>
> talked about earlier, the family image and that. Families need to
>
> understand or pick up on when their child is having a valley and just
>
> doing what they want from you.' (Kate, pg. 17, lines 701-704)

The women described what it was like to be misunderstood and to not have their needs acknowledged or met by friends and family. For Kate, she explained that her depression involved deep troughs or valleys and this was like falling into a deep dark hole and being stuck in there with no way out. The women were frustrated because they wanted people to just listen to them and validate their experience. They were prepared to explain what it was like for them to be depressed but no one was prepared to listen. They felt people did not want to listen or understand what it was like from their point of view and this was very hard for them to accept and painful:

> I think cause no one was listening. I kept trying to say something but
>
> no one was listening and my parents would always, Oh my gosh I'm
>
> going to cry. You know the reason why I'm sad about it now is

because I've never talked about it before like I've never explained

this to anyone before. I've learned to, I've just kept it, and I feel like

I been trying to hide it, and to forget and make it like it's not part of

my past. Or of who I am. But it's a huge part actually. (Leanne, pg.

2, lines 76-80).

The women felt that their family's lack of understanding and support made their depression more difficult to deal with by themselves. They were frustrated that their burden could have been minimized if others just took the time to understand and become educated about depression: *'…annoyed that I kinda have to carry this kinda burden of being the person who's like got depression or whatever while there's a whole team of people who could be making me feel I'm not on my own'* (Jane, pg. 6 lines 216-218).

The women also felt misunderstood by counsellors who did not take the time to get to know them and understand their experience and who lacked an understanding and awareness of Pacific cultures, PI families, and their beliefs. Those who pursued understanding and help from counsellors did not commit to it long-term because they felt that counsellors lacked cultural understanding and sensitivity. They felt they and their families and culture were being judged.

The women described how some counsellors looked at depression and their problems through a western or Pākeha lens. They became frustrated and angry when counsellors made suggestions for action that did not take into account the PI way of life and values. They showed no understanding of the dilemmas and conflict the women felt being part of two cultural worlds. For example, some counsellors suggested that the women should simply leave or walk away from their family because they were the source of their problems and depression. They suggested that they could become more self-sufficient and receive help from various government agencies. This, however, was not a realistic option for most of them and the pressures that made living with depression difficult and their life complicated:

They don't understand how important it [Church] is because they
look at God and think God wouldn't want a church to do this and
that… it's not easy for us to look at it that way. For us it comes in the
same bowl. Pacific Islanders don't want to talk to someone that's not
going to understand, who's going to spend the hour telling them about
how hitting is not ok or to tell them about how you don't have a
problem. They don't want to talk to someone who's going to say your
problem is that you live with a family, with parents who treat you
like this so fix the problem and get out. No one wants to hear that
because it's not a reality for us, I can't just leave home. I would tell
professionals that telling us to leave home to fix our depression is not
going to work. (Kate pg. 18, lines, 748-758)

The counsellors did not understand how the women's identities were connected to their
family, church and culture and how these were inseparable. Walking away from one's
family meant denying their identity and who they were. They also unhappy that
counsellors could not understand that their individual actions would affect the image and
reputation of their families and this was still a concern for them. The solutions they were
offered were not practical, realistic and would result in further problems for the women
because they would be interpreted as culturally disrespectful. They wished counsellors
were knowledgeable of Pacific cultures and how being Pacific is multi-layered:

…they need to learn or get some information from people in their
community that can actually relate to what Pacific Islanders are going
through, it's not just school and home, there's always going to be
other things happening, like church commitments and you know
Samoan community commitments, its multifaceted stuff. (Leanne,
pg. 11 lines, 434-438).

The women also felt they misunderstood depression and lacked knowledge of how depression could affect them emotionally, cognitively and behaviorally. For example, the women did not understand their mood swings and wanted better education and access to information about their 'overflowing' emotions. They did not feel that they were educated enough following their diagnosis about the different symptoms of depression:

> Tired. I feel so heavy like there's something pressing down and on me and then there's also something weighing me down. I've had days where I can't get out of bed, I'm amazed at how much it affects my body, I just can't believe that no one really gives you that information either, warn you that you're gonna feel like you're carrying the whole of Wellington on your shoulders. Yea it's just ridiculous. (Jane, pg.5, lines 273-279).

Not being warned about the influx of feelings as a result of being depressed made it harder for the women to manage their depression. The women struggled to both understand and control their depression including the negative emotions. They realized that it was important to acknowledge these negative emotions and thoughts and that it was their mind and body's way of reminding them that they still had an ongoing problem.

There were two main things which made depression harder for the women to manage. First, a lack of personal understanding about the symptoms of depression and what to expect, and a lack of understanding in their parents, health professionals. Second, a lack of culturally appropriate or sensitive support and strategies that were unrealistic, and impossible for the women to implement. The women were left alone to draw upon their own resources and come up with their own solutions.

A lack of privacy.

A lack of privacy at home also made depression more difficult for the women to manage. All the women, except one grew up in homes that were full, not only with their siblings

but extended family members: *'I grew up with my entire extended family around me. So you know everybody was just there all the time'*. (Leanne, pg1, lines 9-10). This meant the women had to share bedrooms with others, or were living in homes that were not big enough to cater for everyone's needs, especially their need to express their emotions: *'And its hard at home at the moment we are only in a two bedroom, I can't really go to the room and cry cause me and my sister share a room'*. (Natalie, pg. 3, lines 119-120).

A lack of privacy meant they found it hard to hide their depression from other family members. The women felt they had had no safe space to recover in, to work in, or space where they could think, create, reflect or express themselves where they would not be disturbed. They had nowhere where they could go and 'breakdown', be vulnerable, or get any respite because there were always people around that they had to be mindful of.

The women also felt that a lack of privacy and personal space impacted on their ability to focus, to dream, to plan, to calm themselves and reenergize and this meant they struggled to 'carry on'. For example, Natalie shared how upset she was that she had nowhere to go where she could let her guard down and express what she was thinking or feeling:

> I can't really go to my room and cry. So I've just moved out of the
>
> bedroom and I'm in the lounge and still I can't go cry in the lounge
>
> cause that's where we all meet. So the only other place I can go it the
>
> toilet but I can't sit there for ages or else my mum will be like why
>
> are you in the toilet for ages? (Natalie, pg.3, lines 120-123).

Not being able to express themselves and release stress and tension at home meant the women had to find alternative spaces and that when they tried to secure their privacy this was met with suspicion and caused conflict:

> There was one time where I was in there (toilet) for ages crying and
>
> my mum knocked, she was like what's happening and I didn't answer

her. And she almost knocked the door down, I think she was worried

but I wiped my eyes and said I was going for a shower.' (Natalie,

pg.3 lines 123-125).

The women found it hard to manage their depression because they were imprisoned, sharing space and under constant supervision and surveillance. They had no private or individual space. This made is difficult for them to process what they were experiencing, express themselves and added extra pressure to their daily lives.

Being labelled.

Some of the women feared being labelled and the associated stigma that came with being diagnosed with a mental illness and they chose to hide it from others for that reason. They did not want to accept that they had depression because this would mean that they would be labelled, they could be put in a box, categorized and treated like all the other people who were depressed:

So getting the questionnaire you do, I had real issues with the whole

being put in a box thing. I texted my friend the one I was telling you

about? I texted her and I was just like, I've joined the world of boxes,

I've got severe depression and I now tick the mental health box so if

you haven't kicked a box today in the arse, go get a cardboard one

and just punch it please. I just hated the thought of having to tick the

mental health status thing.' (Jane, pg.10, lines398-403).

For these young women who struggled to be seen as unique, individuals with their own traits, needs and strengths – being labelled as depressed, given a diagnosis meant they would be treated like everyone else with depression. They were also afraid that their peers and friends might reject them and that would be unbearable give the rejection they had already experienced from their parents. On the one hand, they wanted to stand out, be seen as an individual (not always be considered just part of their family or collective) but on the other hand, they also wanted to fit in with other young people and just be accepted

as 'normal'. A fear of being identified and labelled also meant the women did not seek help or information about their depression.

The women felt trapped and imprisoned by their depression and family/cultural circumstances. Misunderstanding, a lack of privacy and fears of being labelled meant the women had to do 'hard time'. They had little support and few resources they could draw upon when trying to learn more about and manage their depression.

Theme 5: Freedom

The women broke free from the constraints of their depression and began their journey to recovery by finding their voice, connecting with others, drawing on their spirituality and their resilience. The women used a number of strategies to deal with their incarceration and to manage their depression. These ways of coping helped them accept their mental illness, learn about their depression and find ways of keeping mentally and spiritually well. The subthemes of *Freedom* found during analysis include: *finding a voice*, and *hearing the voices of others*. These subthemes, as explained by the young women, will be described to reinforce the grand theme of *Freedom*.

In relation to depression, the most common form of help is seeking counselling. However, for these young PI women, this was not helpful for them. They resorted to other methods such as poetry, blogging and music to escape their prisons.

Finding a voice.

While the women felt that they had been silenced by their families they found other ways to express how they felt and yet maintain their public silence. For example, some of the women put their thoughts and experiences onto paper. By doing so they were able to see their experience, acknowledge it, but it also gave them the opportunity and power to change the way it looked. Writing was a cathartic experience, but it also helped them organize their ideas and to see possibilities for change. Some chose to change the words they wrote to describe their experience and to make their situation look 'beautiful'. The women gained control through writing and having a voice:

Find an outlet. So I have my poems, whenever I feel the way I feel I just write. I just pretty much spew the words onto the paper and then after that I feel much better cause everything that was going on in here (head) and in here (heart) is on paper. And then I can see clearly, and cause when it's all in here (head) it's like a battle field and it's you're not good enough kinda words being thrown in my head. It just looks prettier on paper than in my head. It's my creative outlet. (Natalie, pg. 9 lines, 346-352).

Writing was empowering for the women because they got to determine the ending and could turn their negative situation into a positive simply through their choice of words. They gave themselves hope by writing in a way where their story always ends with them in a happy place, with all their problems resolved and everyone around them is happy, *'It turns this yucky negative feeling into something really beautiful that one day I will share. I've shared some of my poems, but they're the ones that just scratch the surface. You're only getting the surface of my feelings.'* (Natalie, pg. 9, lines 354-356). They also had hope that one day someone would read their words and would understand them, connect with their experience and have empathy for them.

The women tended to keep their inner experience and thoughts private to protect their family but did allow some others to see and witness their suffering while keeping their anonymity. For example, Bianca, used blogging as a way to escape her prison, her depression. In her writing she was free from the constraints of culture, family, church and home. Free to explore ideas and possibilities and use language they wanted to and focus on topics that they wanted to explore. They did not have to worry about social stigma, taboos or punishment. The women always started off writing about how dark their life was but they would always make sure the ending was positive and this gave them hope and fed their spirit. Writing was their way of communicating, breaking the silence, and was the only time they felt total freedom in expressing what they were enduring alone: *"I wrote something, so I like make a thing of writing, like that's definitely one of my coping*

things. Its dark, it definitely makes me a lot more dark, but it also just communicating. I definitely manage it through writing. "(Jane, pg. 7, lines, 290-293).

Although writing about their past and painful experiences often brought back issues and trauma that were never resolved, the women found comfort in their writing. It allowed them to learn about their depression, to make sense of their emotions, and also allowed them to feel they were not alone in their journey as their writing was the closest thing they had to communicating with a human being.

While writing about their depression, some of the women realized how depression had become a part of them and their creativity. They started to see depression as something that had certain benefits. It gave them a different lens which they could see the world through. It gave them an ability to access raw emotions and this was something that not many young PI people had because they were encouraged to remain silent and restrained. It was also something not many PI women had, it was liberating for them as young PI women. The women also found that their writing freed them of some of the anger and disappointment they felt towards their family and their fear:

> Every time I've let go of something more and it's like saying goodbye
>
> to a friend kind of, it's how I've always understood things and the
>
> lens I see things through, and also that creative space that happens
>
> with depression, I'm scared to lose that, I love, I love the productivity
>
> that comes out of it, it's this productivity that you don't experience
>
> anywhere else cause it's so dark and you're so close to it and there's
>
> almost no fear of it. (Jane, pg. 10, lines 396-402).

Hearing the voices of others.

All along, the women would discover a variety of ways to deal or help with their recovery. One was hearing the voice of others in relation to listening to music. Plugging into their favourite music or song assisted the women in reducing awful and sad emotions. It was an outlet that allowed them to express things that they otherwise were unable to put into words or communicate with others. It was also something that they used to boost

themselves as well as relaxing after a long day. They would listen to all sorts of music and different genres of music served a different purpose for the women:

> Music was just my everything, it was my everything. You can tell
>
> my mood with the mood of the song and my playlist, I'd have those
>
> broken hearted jams, that playlist was my everything. I know they
>
> say that bad songs make it worse, but for me it was listening to the
>
> lyrics through music. It was just to make that mentalness calm down.
> (Sammy, pg.7, lines, 273-277).

For Sammy, listening to 'broken hearted' music made her feel like she was not the only one in the world that was feeling sad and broken. Hearing the sad experience conveyed in the song gave the women comfort that they were not alone in feeling sad and it also offered the women a safe proxy to work through their own emotions. The women showed appreciation in listening to sad music because it allowed them to feel their sadness, work through their negative emotions and releasing it at the end of the song.

Others found that finding a deeper connection spiritually helped them in their journey to recovery. This was through daily prayer and scripture readings. For the women, having a deep connection with God through prayer provided a sense of comfort and support. They were aware that God does not speak to you directly, but they did have a belief in a higher power that gave them hope, feel gratitude and be compassionate:

> I'd always come back, like bring it back to God. It's not like a golden
>
> ticket, once I read scripture, once I pray the depression would be
>
> gone. But it's like a step towards getting over it. For me that's enough.
>
> So I feel like He's helping me slowly, slowly but surely. (Kate, pg.
>
> 14, lines 574-578).

Prayer and scripture reading for the women was hearing another voice. A voice that does not have a physical entity, however, its presence is felt by the women through prayer. Reading scriptures to the women is also hearing another voice telling them to keep strong, and taught them to forgive. Forgiveness was something that was crucial to the women in

their recovery, it allowed them to let go of the blame they had put on their parents and families, and also the blame they had on themselves. Most importantly, forgiveness learnt through praying and reading scriptures reduced their feelings of anger and hurt, ultimately changing it to hope and new beginnings. Most of the women felt that prayer and scripture were things that no one could take away from them, it was something they could hold on to, turn to, and be sure that it would always be there throughout their lives:

> I just had to have faith because God is not a real person, he's like a
>
> spiritual guidance, a spiritual guide. When you can't see the person
>
> that's really hard to say depression I'm going to battle you with this
>
> like I'm going to use God to battle you. You can't see him, he can't
>
> reply to you but he's been there every second, every minute. (Kate
>
> pg. 15, lines 591-596).

Some of the women's experience in hearing the voice of others was found in places they never thought to seek help from. Ana found comfort and support with her recovery from speaking to someone that was the same nationality as her and had similar experiences with family, upbringing and expectations. She had met her at university and was a Pacific staff member, she found a deep connection with this lady that made her comfortable enough to share her experience and also acknowledge that there was someone else that went through the same experiences and has conquered mental illness.

> I was talking to someone, one of the Pacific staff when I left home,
> that was the first time that I actually fully talked to somebody about
> my problems and I wasn't afraid, this person was a stranger. When I
> had somebody listen to me for the first time it felt really good and it
> also made all the battles in your head seem smaller. The lady that I
> talked to went through the same thing as me, we came from the same
> cultural background and for the first time I felt there was somebody
> that could understand me, I was like wow there are other people like
> me. (Ana, pg. 5, lines 180-189).

The women, no matter what type of strategy they found helpful in their recovery felt like it was their choice. They felt like they could finally do something they chose themselves, whether its writing, listening to music, praying, reading or finding someone that was like them in terms of cultural background. All these strategies they used to assist in recovery are connections that they made by choice, it made them believe that overcoming their situation and depression was a possibility, and most importantly made them believe in themselves. Overall *Finding a voice* and *Hearing the voices of other*s made the women feel a sense of contentment, giving them the ability to deal with stress and freedom to rebuild self-confidence and high esteem. It was their way of escaping, it was finally freedom.

Summary

This chapter presented the findings from the analysis of the students' interview transcripts. Five themes with multiple sub-themes were presented and discussed under the title: *depression is a form of imprisonment*. What this analysis revealed was that being depressed: 1) was the result of *feeling like a failure* 2) *being rejected by family* 3) involved being trapped or *imprisoned*; 4) suffering or *doing hard time*, and 5) *freedom* and recovery involved finding a voice and hearing and connecting with others.

This analysis showed that depression was the result of childhood adversity and young women growing up feeling they are failures. The parents and families of the women failed to protect them from abuse and neglect and their harsh and authoritarian parenting styles sent messages to the women that they were failures. They felt like personal failures but also cultural failures because they could not meet unrealistic familial and cultural expectations. Second, the young women experienced rejection and felt they were invisible and had been abandoned. They were not only depressed about their family situation and life but began to see themselves as unworthy and some engaged in acts of self-harm. Third, cultural and familial factors meant the women had to keep silent about their depression and this meant they had to hide their mental illness from others and contributed to their sense of entrapment. Fourth, living with depression was like doing hard time in prison – they were misunderstood, labelled and had no privacy, no space of their own in which to express and make sense of their experience. Finally, the young women found Pākeha counsellors unhelpful because they lacked understanding of their

situation and cultural backgrounds, beliefs and norms. They found their own ways of managing their depression and found their voices through the use of writing, in music and in connecting with other PI women who had similar experiences. The following chapter discusses these themes and some of the major findings in relation to relevant research and literature and the implications of the study.

CHAPTER FIVE: DISCUSSION

Introduction

The present study, explored the lived experiences of young Pacific women in New Zealand diagnosed with clinical depression. The analysis showed that the essence of being depressed for these young PI women was ***imprisonment*** − their family circumstances, cultural beliefs and expectations trapped them in situations that contributed to a sense of personal and cultural failure, helplessness and hopelessness. They felt alone and isolated in their experience because they were encouraged to remain silent to protect their family's status and to protect themselves from stigma.

The findings clearly indicate that the experience of depression is affected by all dimensions of their being, physical, psychological, interpersonal, social, spiritual and cultural. This chapter discusses the circumstances and challenges the young women faced and other findings in relation to relevant research and theory. This chapter also discusses the limitations of the study, its implications for future research and makes recommendations for improving the health and wellbeing of PI young women. This chapter and study concludes by suggesting that parents could benefit from psycho-education on depression, professionals need more training on how to deliver culturally responsive support and young PI women need access to peer support.

Childhood abuse and neglect

Child abuse and neglect were one of the main factors found in the analysis that contributed to the onset of depression in the young women. The child abuse (physical, sexual and emotional abuse) and neglect (child maltreatment) occurred from a very young age for all these PI women. This abuse and neglect seemed to have an ongoing effect on these young women, silencing and trapping them because none of these events were addressed or resolved. This lead to an internal chaos that was very exhausting and disheartening, helplessness and to a lack of hope.

The impact of child abuse and neglect found in this study is further reinforced in a 30 year longitudinal study in New Zealand (Fergusson, McLeod, & Horwood, 2013). In examining the associations between childhood sexual abuse and developmental

outcomes, it found that it contributed to mental disorders, sexual risk-taking and impacted physical health. More specifically, those who experience sexual abuse were more likely to be depressed and have suicide ideation. This could be explained by Beck's theory (Abela & D'Allesandro, 2002), where cognitive vulnerability to depression is associated with obscured views of the world as a result of negative events such as sexual abuse.

Parenting styles and PI women's experiences of depression

The young women's experiences of authoritarian parenting were a major influence on their experience of depression and the challenges they faced on their journey to recovery. Research has shown that authoritarian parents value obedience and conformity without question eliminating any opportunity for open communication, establishment of trust and engagement (Bornstein & Zlotnik, 2008). The parents of these young Pacific women all appeared to be authoritarian. They were very much involved in their daily lives but in a controlling manner and had clear ideas of standards they expected to be met and rules they expected to be followed. They also lacked emotional warmth and individual closeness. They were more concerned about the cultural and religious expectations that had to be met by the young women in order to maintain family appearances and status within their cultural communities. To the parents, these expectations were crucial to the development of these young women. They expected them to obey and not question or talk back. The effects of having authoritarian parents made their experience of depression more difficult because they received no parental warmth and parental care. Instead they were made to be silent by their parents. The authoritarian parenting styles the women experienced were also shaped by cultural norms and beliefs.

Other studies have also found that there are often strong cultural expectations for young Pacific women and these include respecting and obeying their parents. These expectations often stem from religious teachings and beliefs (Fiaui & Hisinuma, 2009). Research has also shown that authoritarian parents increase the onset of adolescent depression because of high levels of overprotection, lack of warmth, parental support and parental involvement (Duriez, Klimstra, Luyckx, Beyers, Soenens, 2012). Authoritarian parents use of strict discipline practices and the disagreement of adolescents with these practices has also be shown to create increased parent-child conflict and distancing. Adolescence

in many Western cultures is often a time of exploration and when adolescents are striving for and being awarded increased levels of independence. Adolescents often experience conflict with parents who lack understanding and negotiation skills which are often found in authoritarian parents. Consequently, depression can be a product of this conflict between parent and child (Duriez, Klimstra, Luyckx, Beyers, Soenens, 2012).

The young women reported that from their perspective parenting style influenced their experience of depression, recovery, and wellbeing. This perspective is supported by previous studies of PI youth. For example, Schoeffel and Meleisa (1996) examined the perceptions 25 Pacific families in South Auckland in 1994. The aim was to gain an understanding on the cultural attitudes that shape and determine how parents socialize and discipline their children. The main concern they found among the parents was the desire to maintain cultural values and transfer this on to their children who are growing up in a multi-cultural setting such as New Zealand. The most substantial fear the parents carried was that their children would grow up in New Zealand knowing their rights about personal freedom to make choices, which in turn influences certain behaviors that are considered culturally inappropriate (going out and not attending church). Parents were concerned that their teenagers would engage in behaviors that were disobedient and disrespectful and that they needed to discipline their children to protect them and the cultural values that Pacific parents try to instill into their children. The researchers found that the concept of love was demonstrated through PI parents applying strict discipline practices often seen in authoritarian parenting styles. These practices are utilized by Pacific parents to achieve obedience and respect of elders. Therefore, in the eyes of Pacific parents, love is demonstrated through hard work and service.

Not all research, however, shows that authoritarian parenting has negative effects on the health and wellbeing of adolescents. Research in non-western cultures has shown that authoritarian parenting can lead to positive outcomes for young people. For example, Ijaz and Mahmood (2009) found that in Pakistani cultures that authoritarian parenting – which

is often characterized by overwhelming parental involvement – can show adolescents that

their parents care, are concerned and love them. Researchers need to be cautious not to over generalize about parenting styles across different cultures and future studies should further investigate the relationship between parenting styles and increased risk of depression in adolescents of varying ethnic backgrounds.

Cultural expectations and depression

In their everyday lives, these young PI women described being overwhelmed by their parent's involvement and the family and cultural expectations that were placed upon them not only as women but as PI women. The women were expected to do chores and care for younger siblings while keeping up with school work and extracurricular activities. In public, culturally, they were expected to attend all cultural gatherings, have expert knowledge of their cultural practices and to uphold the image of their family at all times. In regard to their depression, they were expected to keep quiet and not bring shame or a reduction in status to the family. This meant their parents often denied their formal and clinical diagnosis and that they failed to acknowledge and support their daughters. This often led to anger, hatred and self-harm. The link between the lack of parental emotions and depression found in this study is supported by previous research on depression as well as non-suicidal self-injury (Baetens, et al., 2013)

The young women also experienced a number of negative and stressful life events directly related to their family and home environments which contributed to their depression. This finding is consistent with earlier research (Patton, Coffey, Posterino, Carlin & Bowes, 2003; Keller, Neale, Michael, Kendler & Kenneth, 2007), that shows that negative or stressful life events are associated with depression and other mental disorders across diverse cultures. The women in this study described how these events influenced their view of their lives, family, culture, religion and most importantly themselves.

The PI women's' experiences of a change in views is in line with (Carpenter, Laney, Mezulis, 2012) a prospective study, which found negative life events do change the worldviews of individuals into emerging to adulthood, but do not necessarily change their views about God or religion. The PI women in the current study had become more depressed in their views about their family, their futures and their ability to escape. They also changed their views about God, in the sense that they began to question why negative life events were happening to them and why they had depression. The change was not necessarily to question their beliefs or faith in God.

Stigma

Part of the women's experience of depression was the fear of stigma and the silencing they endured which trapped them within themselves and in their depression. They did not talk to teachers, friends or other adults in the public realm in order to avoid the perceived stigma associated with their illness and to protect their families from scrutiny among their cultural communities. They also feared what being diagnosed and labelled 'depressed' would mean for them. Some thought this would lead to relief, understanding and parental support, but instead they were often disappointed because their parents refused to accept the diagnosis and forced them to keep their mental illness hidden. Their parents were concerned about the social stigma attached to mental illness and the young women also experienced personal stigma – and were concerned about developing a negative identity.

The stigma associated with depression has been widely discussed in the literature and been shown to have an impact on help seeking (Ting & Hwang, 2009; Griffiths, Crisp, Barney & Reid, 2011). The young women in this study were reminded by their parents about the stigma that their families would experience if they were to seek professional help or if their cultural community learned of their depression. Their experience of depression involved being silenced by others and being made to feel abnormal. Reichert's (2012) review also found that one of the main reason why stigma prevented help seeking was because of the socially constructed image of those who have depression as being 'not normal'. The finding that there is a connection between stigma, culture and family in young PI women's lives is also supported by the New Zealand Guidelines Group (2008) who discuss how these social and cultural contexts can create barriers to individuals seeking help for mental illness. Tupuola (2004) also found that family is a major influence on Pacific youths' lives and influence all areas of their development.

Help-seeking and experiences of support

Despite the evidence base that shows the efficacy of CBT and the use of antidepressants, only one of the six young Pacific women in the present study found this type of treatment

helpful. The majority did not find the help and support offered by professionals such as counsellors and GPs either effective or realistic. The strategies offered by counsellors did not take into account their familial and cultural obligations and beliefs. The strategies offered were also based on a western understanding of youth, and a view of youth that emphasises their need to be independent, autonomous and self-reliant.

Other authors and studies have also found that there is a lack of accessible, culturally relevant mental health services for young people (Ting & Hwang, 2009). More culturally relevant services and adequately trained staff are needed to improve help seeking attitudes and behavior in young people who have depression. Other studies have also noted that mental health professionals lack cultural understanding and current training is inadequate (New Zealand Guidelines Group, 2008). There is a need for the establishment of training programs to educate counsellors and mental health providers to deliver their services in ways that consider the values and the role of family in the lives of PI youth and which take into account gender norms and expectations.

Coping strategies

The young women used a number of strategies to cope with their depression but which still enabled them to protect their family's reputation and status within their community.

They used poems, songs, blogging, scripture reading and prayer, and talking to other PI women who shared similar experiences to help them express their depression and make sense of their experience. These personal and individual strategies provided the women with a voice to express themselves and enabled them to acknowledge and validate their depression when their family around them denied it. They also provided them with hope and enabled them to envision a positive future that helped combat their helplessness and hopelessness.

Previous studies have identified a similar range of coping strategies that young people use to manage depression, including sharing their experiences with others such as peers (Waller, Silk, Stone, & Dalh, 2014) and engaging in physical activity (Harris, Cronkite, & R, 2006). Previous studies have also highlighted the positive impact of prayer and scripture on reducing symptoms of depression (Carpenter, Laney, & Mezulis, 2012). The PI women in this study also identified that connecting with others who shared similar cultural background and who relevant lived experience of mental illness was helpful in

their recovery. It helped them feel less alone and gave them someone to talk to who also validated their experience and helped them experience some hope.

Implications and Recommendations

There are a number of implications from this study for developing a deeper understanding of what it means for a young PI women to experience depression and for improving the health and wellbeing of young PI people.

Understanding the lived experience of PI women who have depression.

The phenomenon being studied was depression in young PI women. Future research into depression needs to consider research methods that are culturally sensitive and appropriate. In conducting this study, it was evident that there was hesitation in young people volunteering to come forward to share an account of their depression. Recruitment was specifically difficult due to their fear of stigma, fear of being identified and the impact that disclosing their depression will have on their family (particularly in men). Therefore, there is a need for culturally sensitive and appropriate research methods is specifically important in order to encourage young depressed PI population to voice their experiences. Researchers might wish to consider combining cultural approaches (Hart, 2010) and methods such as Talanoa (Vaioleti, 2006) with other methodologies such as phenomenology to gain better access to PI participants and their lived experiences.

More studies also need to be conducted on the lived experience of depression, specifically in ethnic and minority 'at–risk' populations. In order to gain a deeper understanding of how gender expectations and norms also shape lived experiences more studies need to be conducted that focus on different genders. This will assist in understanding how depression is understood and the meanings they ascribe to it and how these might be different to adults with depression.

Future researchers may also wish to consider exploring the importance of family as a risk factor and ongoing influential context that affects the recovery of young people with depression, especially ion those from different cultural backgrounds. The knowledge that will come from this type of research may be beneficial for educating, informing and guiding the establishment of culturally appropriate services for adolescents of ethnic

backgrounds but also informing psycho-educational interventions for families who have young people with depression. More needs to be known about the coping and management strategies used by PI youth, what factors and contexts in their view assist or hinder recovery and what are their experiences of barriers to seeking help and receiving effective treatment and care.

Promoting mental health awareness and parent education.

The aim of the present study is to capture and describe the essence of what it is like to experience depression from the point of view of young PI women. The findings showed that the parents of these women were ignorant and uneducated about depression. Parents lacked the skills, knowledge and desire to support their daughters and this added to their children's distress and isolated them from support and care. PI parents and families could benefit from culturally relevant psycho-education on mental illness, stigma and ways to support their young people. Parents need to learn more about what depression is before they will be able to accept that depression is a legitimate, absolute and undeniable mental illness that is common among adolescents from all cultures. They also need to learn how abuse, neglect and particular parenting styles can contribute to the onset of adolescent depression and learn more practical ways to support their children in order to contribute to treatment and recovery (Karatzias, Ferguson, Chouliara, Gullone, Cosgrove, & Douglas, 2014).

Improving access to culturally relevant and sensitive support services.

The present study also supports the work of Pulotu-Endemann et al. (2007) around improving cultural and clinical competency and suggests that there is a need to improve training for GPs and counsellors, so that they better understand the lived experience of PI women and the cultural and familial contexts that shape their realities. Mental health providers need to work alongside PI youth rather than impose interventions and strategies that come from a Western perspective and are based on evidence and research with non-PI populations. They need to work collaboratively with PI health providers to establish interventions that are culturally appropriate and realistic for young women. Culturally relevant and sensitive support services should include confidential one stop shop health

care which can encourage PI youth to seek help, by providing free, confidential services in settings where PI youth can have their needs met in a holistic way.

Youth mental health services could also help provide PI young women with access to culturally-based peer support groups that are professionally or peer-led that help promote the use of narrative to allow young PI women to express themselves in confidence without fear and stigma. Such groups could also be an effective conduit for helping young PI women learn more about effective coping strategies and meet other young people who are on their journey towards recovery and wellbeing. Such interventions and support could also help reduce the overall feelings of isolation and imprisonment that the young women experienced as part of their depression.

Limitations

One of the limitations of using descriptive phenomenology as a research method is the difficulty in ensuring pure bracketing. Any researcher conducting a phenomenological study will have difficulty in preventing researcher induced bias (Tufford & Newman, 2012). Furthermore, the subjective nature of the data leads to difficulties in the reliability and validity of the accounts provided. Phenomenological research also tends to have small sample sizes, and this limits the generalizability of findings. However, the benefits of understanding in-depth the experience of phenomena means researchers often find this methodology incredibly powerful and helpful for generating new insights, understanding, research questions and lines of future inquiry.

All research studies have their limitations. Participants in the present study were a non-clinical sample. It was restricted to a specific geographic location which limits the generalizability of findings. The participants were all women and the majority were between the ages of 20-25 with the exception of one who was under 20 years of age. Because the sample were all women, the findings cannot account for PI young men's experiences. The inclusion of men may could have helped to advance understanding of any the gender differences in the experience of depression for young PI youth. A larger and more diverse sample of women may have also contributed to a more complex understanding of the nature of depression, its management and the recovery process.

Furthermore, the nature of self-reporting could have lead in an exaggeration of circumstances and challenges. An additional limitation to the present study is the participants identifying with different cultural backgrounds, therefore, the findings are not specific to a particular Pacific group. Unfortunately, follow-up interviews were not conducted with participants and this limited the richness of the data collected. It also meant there was no opportunity to further check the developing themes with participants or to work with them on developing an exhaustive description of their experience. Future studies need to consider carefully the investment and time required to build relationships with participants and for collecting and analyzing data.

While some Pacific concepts were used during the research, this study did not adopt a PI or Indigenous methodology. Indigenous methodologies and approaches can make a valuable contribution to understanding phenomena. They should be carefully considered for their merit, as a way of addressing marginalization, helping produce new world views and knowledge and providing opportunities for communities to control and transform themselves through research partnerships (Hart, 2010).

Future directions

The present study focused on the lived experience of depression in young PI women within New Zealand. Researchers wishing to extend and build on the findings of this and other phenomenological studies may wish to consider some of the following questions which arose during this study:

- What are the experiences of depression in other young Pacific women both New Zealand and Island born?
- What are young Pacific men's experiences of depression?
- What are young PI women's experiences of mental health services in New Zealand?
- How does parenting style, family and cultural expectations influence recovery from depression in young PI?

Future studies may also wish to explore parents, mental health providers and counsellors'
experiences of providing help and support to PI youth in order to examine their
experiences of the challenges of providing support and treatment to PI youth and working
with PI families. The experiences of siblings and family members who live with a PI
teenager who has depression may also be beneficial.

Conclusions

This chapter discussed the findings of this study in light of previous research and literature
on adolescent depression and mental health. The essence of being depressed was being
imprisoned. This captured the essential experience of six young PI women who
experienced depression and lived through it. The present study highlighted that parenting
styles, negative life events, and family and cultural expectations lead to their depression.
The lack of mental health literacy among their parents and families coupled with the lack
culturally appropriate and sensitive mental health services made depression difficult to
cope with and recover from. Instead, the young women found their voice through writing
journals, online blogging, listening to music, reading scriptures and prayer to help break
free, take control and overcome their depression.

All PI young women need to be forthcoming with their mental illness, specifically
depression. In order for that to occur, Pacific families and communities need to be
educated on the impact depression can have on their child and their families. This
understanding could prevent depression, benefit future generation and assist mental
health providers in creating prevention and intervention programs that are culturally
appropriate and sensitive. Perhaps a first step in breaking the silence that surrounds PI
depression is this study is found in the shared experiences – the women showed their
bravery, courage and set appositive example for other PI youth and provide valuable
lessons for PI families and health care providers.

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APPENDICES

Appendix A – Recruitment Poster

Appendix B – Participant Information Sheet

VICTORIA

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

Participant Information Sheet

Pacific youth living with depression

Are you Pacific, 17-24 years of age, and have had depression for 6 months or more?

I would like to talk to YOU about YOUR experience of living with depression, how you cope and manage, what has supported and challenged you and how family, peers and church influence your experience and identity

Why is the research being done?
• Pacific people have higher rates of mental health issues than the general New Zealand population.

• Few studies have been focused on what depression is like from the perspective of young people and from Pacific perspective.

• Research shows that family, church and peers have an influence on depression. I want to know how these social contexts influence your experience.

• This study will be used to help educate professionals who support the development, health and wellbeing of Pacific youth and inform the development of health education and support services.

What will participation in this study involve?
• Participation in this study is completely voluntary. You may wish to talk to family, friends and/or healthcare providers before you decide.

• Once you have given your consent I will arrange to make a time to interview you about your experience.

• You can withdraw from this study at any time before or during the interviews. You may also withdraw your data from this study up to two weeks after the final interview.

• It will not cost you any money to participate in this study and you will not be paid for participation.

• Your participation in this study will be confidential and no one will know that you are taking part of this study or are being interviewed without your consent.

What will happen in the interview?
• The interviews will be conversational in nature and will take place where you feel comfortable and where privacy can be assured.

• During the interviews I will ask you to describe your experience of depression. You are allowed to bring your own images or objects to assist you in telling your story and with your permission I would like to photograph these.

• All interviews will be audio-recorded and will be about 1-2 hours long. Interviews may be broken down into shorter lengths if you wish.

- You will be provided with a transcribed copy of the interview to check and will have the opportunity to have a follow-up interview.
- You will also be provided with a summary of key themes from your interview and the overall study.

Why should I take part? (Benefits and Risks)
- Some people may find it beneficial to talk about their experience and tell their story. This helps them make sense of their experience and helps acknowledge what they have been through.
- Your experience will inform a better understanding of Pacific youth and the development of support for young people with depression.
- If at any time during the interview, you feel uncomfortable, we can stop the interview and have a break or reschedule for another time. You also have the right to withdraw from the study. I will also provide you with a list of counselling and support services.

Privacy and confidentiality
- All identifying information and names will be removed from files, transcripts and notes. You will be able to choose your own pseudonym or fake name.
- All files and information will be saved in a secure filing cabinet or password protected file on the computer.
- If during the interviews or any other time I become concerned about your wellbeing, or you disclose that you or others are at risk of harm, I will stop the interview, we will discuss options and with your consent I will share information and get advice from my supervisor.

What will the research be used for?
- Information from this study will be used in the completion of a Masters of Arts thesis.
- The results of this study may be published in journals and other academic publications.
- Short quotes and some de-identified data may also be used for teaching purposes, workshops and conferences.

Research Rights
In New Zealand, all research involving human participants must be approved by an Ethics Committee, you may contact the Ethic Committee if you have any concerns. Ethics approval has been granted for this study by the Victoria University of Wellington Human Ethics Committee. 21025

If you have any questions or would like to volunteer for the study please contact me:

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Appendix C – Interview Guide

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

Interview Guide (Appendix C)

1. Please tell me a little about yourself and your family.

   - Please describe for me what you and your life was like before the depression.

2. Tell me about what it was like when you first realized you were depressed?

   - How did you and others react/respond?

3. In your own words, please describe what being depressed is/was like for you?

   - What was a typical day in your life like?

4. How does being Pacific influence your experience? How might living with depression be different for other youth?

   - Can you describe for me how depression has affected you and your life (physically, spiritually, mentally, and culturally) over time?

5. Can you tell me how you are managing your depression today and/or what has influenced your journey to wellbeing/recovery?

   - What has been supportive?

   - What has been the most challenging?

6. Is there anything you have learnt from this experience that you would like to share with others?

   - What would you say to other young Pacific youth who are depressed?

   - Do you have any knowledge or wisdom, advice to pass onto parents and family? Or to people who belong to your church or wider community?

- Do you have any advice to give to friends of young people who are depressed?

- Do you have any advice for professionals who want to support young Samoans who are depressed?

- How have you found this research/interview process and talking about your mental illness with me? Would you like a follow-up interview?

Appendix D – Ethical Approval

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI

VICTORIA
UNIVERSITY OF WELLINGTON

MEMORANDUM

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TO	Aotearoa Muaiava
COPY TO	Chris Bowden
FROM	Dr Allison Kirkman, Convener, Human Ethics Committee

DATE	22 August 2014
PAGES	1

SUBJECT	**Ethics Approval: 21025** Living with depression: A phenomenological analysis of Pacific youth experiences

Thank you for your request to amend your ethics approval. This has now been considered and the request granted.

Your application has approval until 3 March 2015. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with your research.

Allison Kirkman
Human Ethics Committee

Appendix E – Participant Consent Form

Living with depression: A phenomenological analysis of Pacific youth experiences

Principal Investigator: Aotearoa Muaiava

I have read and understood the Information Sheet on **Connected but not supported: A phenomenological analysis of Pacific youth experiences with depression.**
I have taken the time to think about the study and/or discuss the study with family and friends.

1. EXPLANATION OF THE RESEARCH and WHAT I HAVE TO DO:
- I understand I have volunteered to participate in a research study of Samoan youth who have experienced depression.
- I understand that participation will consist of one to two hour recorded interview and a possible follow-up interview.
- I understand that there is no payment for my participation in this research.

2. YOUR RIGHTS TO PARTICIPATE, SAY NO, OR WITHDRAW:
- Participation in this research is completely voluntary.
- I have the right to say no, change my mind at any time and withdraw up to 2 weeks after interviews.
- I understand that I am able to choose not to answer specific questions and stop participating at any time during the study.
- I understand that all information provided will be kept confidential to the researcher and her supervisor.
- I understand that all published results will not use my name or any information that could reveal my identity or that of my family or friends.

I agree to the interview being audio-taped.   Yes/No

I would like to check the transcript of my interview/s   Yes/No

I would like a summary of the main themes that come from my interview/s.   Yes/No

I would like a summary of the overall findings of the study.   Yes/No

I……………………. hereby consent to participate in this study.

Signature: …………………………………

Date: ……………………………..

Appendix F – Participant Characteristics

Table 1: Demographic Characteristics of Participants

Participant	Age	Ethnicity	Religion	Occupation	Diagnosed
Kate	24	Samoan	Christian	Student	2 years
Jane	25	Tongan/NZ	Catholic	Student	3 years
Ana	19	Fijian/Indian	Hindu	Student	11-12 years
Sammy	19	Samoan/Tongan	Catholic	Student/Teacher	2 years
Natalie	24	Samoan	Christian	Student	3 years
Leanne	25	Samoan	Presbyterian	Student/Teacher	10 years