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**A Tongan *talanoa* about conceptualisations,  
constructions and understandings of mental illness**

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## Abstract

The New Zealand Mental Health Survey, *Te Rau Hinengaro* (Oakley-Browne, Wells, & Scott, 2006), reported that Tongan people have high prevalence rates of mental illness, do not utilise mental health services, and the risks of mental illnesses were different between Tongan people born in Tonga and those who were born in New Zealand. The risks were higher for those who were born in Aotearoa New Zealand (A/NZ). The overall aim of this research is to explore the meaning of mental illness for Tongan people in A/NZ, and the research question is, what is the meaning of mental illness for Tongan people in A/NZ?

The Tongan cultural framework *talanoa* was used as a conceptual framework to inform this research and also as a method for collecting the data. Using *talanoa* engaged this research in the circular and collective ideologies of Tongan people. Tongan cultural contexts are used to strengthen this engagement and the collection of data, and Tongan concepts are used to discuss the findings. Thematic analysis was utilised to analyse the data. These Tongan concepts construct (*tufunga*) mental illness from Tongan perspectives and interpretations.

This research found that Tongans in New Zealand perceive and interpret mental illness in three ways: through traditional Tongan interpretations, through Western and biomedical influences, and also through an intersection of Tongan interpretations and Western/biomedical influences. These interpretations are presented as themes. These themes were *tufunga faka-Tonga* (Tongan constructions of mental distress); *tufunga faka-paiōsaikosōsiolo*

(biopsychosocial constructions of mental distress), and the *tufunga fepaki mo e fetaulaki he vaha'a 'o e tufunga faka-paiōsaikosōsiolo mo e tufunga faka-Tonga* (intersections between biopsychosocial and Tongan constructions of mental distress).

The research findings, therefore, highlight challenges associated with applying a biomedical linear, individually focused Western mental health system to a traditional Tongan, circular, and collective community in A/NZ.

## **Dedications**

*To users of mental health services and indigenous traditional healers and health providers*

*To my grandparents, Lavenita Vaka (RIP) and Univā Si'ulua Vaka (RIP), Soane Tātuila  
(RIP) and Makalita Pusiaki Tātuila.*

*To my parents, Malakai and Tu'ifua Vaka*

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## Glossary

akafia	migraines, associated with spirits. A form of sickness / illness thought to be caused by conditions of the dead, as in a bad back ache in a living person linked to tree roots running through the back skeletons of a dead person
alea	discussion
ālonga	very slow, form of mental distress and mental illness
anga	behaviour
angaangaua	two characters or personalities, form of mental distress and mental illness
‘anga	suffix denoting place, fitness or suitability
‘atamai	mind, brain
‘atamai tuai	slow brain
‘atamai vaivai	weak brain, weak mind, form of mental distress and mental illness
au	coconut leaves net
‘auhia ka e kisu atu pē	struggling to reach shore and taking on water, symbol or <i>heliaki</i> for one who does not give up in the face of adversity.
‘āvanga	psychotic behaviours interpreted as being possessed by the spirits, form of mental distress and mental illness
‘āvanga fēmaleleaki	bipolar affective disorder
‘āvanga motu‘a	schizophrenia
‘ave	carried away, taken

‘āvea	spirited away, obsessively thinking, taken away
fa‘ahi kehe	the other side, the side or dimension where the dead dwell as opposed to the living
faingamālie	opportunity
faito‘o	treatment, removal, process of healing
faito‘o faka-Tonga	Tongan traditional medicine
faito‘o faka-Pālangi	Western medicine
faito‘o konatapu	illegal drugs
faivamālie	good work of art
faka‘apa‘apa	respect
fakaheka	on-board, the beginning of the application of Tongan medicine, especially of some herbal nature
fakahihī‘anga	sloppy, form of mental distress and mental illness
fakakaukau	thinking
fakalou‘akau‘i	voodoo magic
fakamalu tēvolo	mushroom, psilocybin – thesis
fakapo‘uli	darkness, being filled with darkness.
fakasesele	stupid, fool, idiot, silly, form of mental distress and mental illness
fala	mat
fale	house
fa‘unga	reality
fa‘unga me‘a	creating and/or collection of tangibles and intangibles
fa‘unga mo‘oni	bodies of truths

fa'unga sino	creating and/or collection of tangibles
fēmaleleaki	running forward and backward abruptly
fofola	roll out
fofola e falá ka e alea e kāinga	roll out the mat for the relatives to dialogue, symbol or <i>heliaki</i> for the primary importance of the collective interests of the group over those of the individuals
folo	swallow, swallowing something
fono	village and/or family meetings
haafe meti	half mad, half mate (mate or first officer on a ship), form of mental distress and mental illness
hē (lost/astray)	hē (lost/astray)
heliaki	metaphor, proverb, simply saying one thing but meaning another
hu'unga	directionality
'ilo	eat (term for chiefs/nobles), knowledge, knowledge production
kai	eat (term for the commoners)
kāinga	extended family, kin
kāinga lotu	church community
kaungāmālie	well-attended
kaukau tuku	last bath, made up of herbal extracts marking end of healing process
kava	plant - <i>Piper methysticum</i>
kava circle/gathering	ceremonial or social gathering drinking <i>kava</i> (see <i>kava</i> )

kava club	group of regular kava drinkers, identified group of people drinking <i>kava</i> , for example, Vava‘u <i>kava</i> club (group from Vava‘u)
koha	gift in Māori
langa	to raise, rise up, pain
langimālie	clear and peaceful sky, symbol or <i>heliaki</i> for peaceful life or good health.
laumālie	spirit
lohohoho	part of the coconut tree where the coconut fruits hang onto
lolo mai	feelings of numbness, loss of energy and concentration, and abdominal pains with difficulty breathing
loto	soul, heart
Lotoleveleva	a place where Queen Salote took her son
lotomālie	middle point
lotu	religion, prayer
lotu motu‘a	old religion
loufātai	fatai leaf
māfana	warmth
mafuli	overturn/ed, form of mental distress and mental illness
mahaki fakamahaki	spirit related illness, form of mental distress and mental illness
ma‘i pālangi	illness introduced to Samoa by foreigners (Samoan language)
ma‘i Samoa	Samoan illness (Samoan language)

mahaki	sickness, illness, forcefully emptied
mahaki faka-tēvolo	spirit related illness, form of mental distress and mental illness
mahei	tilt, form of mental distress and mental illness
mala	curse, form of mental distress and mental illness
male‘ei	incline, form of mental distress and mental illness
mālie	harmony, beauty, harmonious/well done
masoli	chip/ed, form of mental distress and mental illness
matilo	crack/ed, form of mental distress and mental illness
matiti	crack/ed, form of mental distress and mental illness
matoli	chip/ped, form of mental distress and mental illness
maumau faka-‘atamai	broken/injured mind/brain, form of mental distress and mental illness
me‘a	thing, something
me‘a mo‘oni	true thing/truth
me‘a‘ofa	gift
meimei taimi vave	nearly fast timing, form of mental distress and mental illness
meimei tei	meimei means nearly and tei is Tongan transliteration of ‘day’ referred to someone in the night with little light, form of mental distress and mental illness
metikolo	Tongan transliteration of medical as things pertaining to medicine

mihimihi	Māori greetings
mo‘oni	truth, reality
motu‘a	old
mo‘ui lelei	good life, good health, healthy
namu tēvolo	smell like a ghost or spirit
napangapangamālie	well balanced
noa	sense of balance, harmony, zero, without concealment
nonu	plant – morinda citrifolia
‘ofa	love
paiō	Tongan transliteration of bio as abbreviation for biological as things pertaining to biology
paiōmetikolo	Tongan transliteration of biomedical
paiōsaikosōsiolo	Tongan transliteration of biopsychosocial
pālangi	Caucasian, white person
poto	skilful, wisdom, knowledge application
puke	un-well, illness, seized
puke faka-‘āvanga	possessed by spirits, form of mental distress and mental illness
puke faka-‘atamai	an illness of the brain, form of mental distress and mental illness
puke fakamahaki (fakamahaki)	possessed by spirits, form of mental distress and mental illness
puke faka-tēvolo	possessed by devil/s, form of mental distress and mental illness

Pulotu	Afterworld, world of the dead
saiko	Tongan transliteration of psycho as abbreviation for psychological as things pertaining to psychology
saikosōsiolo	Tongan transliteration of psychosocial
satulō	Tongan new term for mental illness referring to the devil
sesele	silly, eccentric, superficial, form of mental distress and mental illness
sino	body
sino‘i me‘a	visible body/object
sino‘i mo‘oni	body of truth
sōsiolo	Tongan transliteration of social as things pertaining to society
suei	sway/ed, form of mental distress and mental illness
tā	time, to hit, strike, beat, hit, pace, rate, motion, movement
tā‘anga	temporality
taimi	time, Tongan transliteration of time
taimi tuai	slow timing, too slow, form of mental distress and mental illness
taimi vave	fast timing, too fast, form of mental distress and mental illness
tala	to tell, told, telling
talanoa	talk, talking
tālanga	formal conversation with an agenda and structure
talatala ‘i fale	tell it in the house

tamasi‘i vale	ignorant, innocent and inexperienced boy
taula	anchor
taula‘eiki	person who communicated to the lords or gods who resides on higher grounds from the land in the sky
taumafa	eat (term for kings)
tā vā	time-space
te‘ia	physically abused as in slapped, smacked, or smashed by a spirit, form of mental distress and mental illness
temeniō	Tongan transliteration of demons
tēvolo	Tongan transliteration of devil
tofoto‘o	consultation, to operate
tofu	accurate, calm, peace, harmony
to‘o	remove
toutai	fishing, main fisherman of the ūloa (see ūloa)
tu‘a	commoners , outside
tufa	distribution
tufunga	construction, construct, also term for material art, for example, <i>tufunga langafale</i> (material art of house-building), <i>tufunga lalava</i> (material art of <i>kafa</i> (strings) sennit-lashing), <i>tufunga fonua</i> (material art of social engineering)
tufunga faka-Tonga	Tongan constructions
tufunga fepaki mo e fetaulaki he vaha‘a ‘o e tufunga faka-	intersections between biopsychosocial and Tongan constructions of mental distress



paiōsaikosōsiolo mo e tufunga faka-Tonga	
tufunga faka-paiōsaikosōsiolo	biopsychosocial constructions
tui	faith and referring to believing in God
tuki	collection sack
tuku	stop
tukuto‘o	stop removing, discharge phase, marking the end of the healing process
tu‘umālie	wealth
tu‘unga	positionality
ua	two
ūloa	type of fishing, a communal fishing technique used in Tonga
‘ulu	head
‘ulungāanga	way of life, way of living, culture
‘uto	brain
vā	space, relationship
vale	ignorance, inexperience, unskilled, crazy, stupid, mental illness, form of mental distress and mental illness
vave	fast
waka	Māori for transport, canoe

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# Chapter One: Introduction

This thesis explores the meaning of mental illness to Tongan people in Aotearoa/New Zealand (A/NZ). My many years (from 1999 to 2008) of working in mental health services in A/NZ challenged me to think about my position as a Tongan nurse within the Western and biomedically driven mental health system that has been critiqued as not adequately recognising diversity (Bloomfield, 2002; Boddington & Räisänen, 2009; DeSouza, 2006; Samu & Suaalii-Sauni, 2009; Te Pou o Te Whakaaro Nui, 2007). The challenges I faced while working for a Pacific mental health service were to develop different ways to respond when working with populations from different Pacific islands, and trying to deliver services flexibly and address the diversities in these Pacific populations. Different groups have different needs and at the time I was working in mental health services it was a struggle to be sufficiently flexible to address these needs.

Furthermore, individual health professionals are governed by their own various registration bodies and required to practice under professional codes of practice. For example, nurses are governed by the Nursing Council of New Zealand (NCNZ) and are required to practice within the code of practice (Nursing Council of New Zealand, 2012b). The NCNZ acknowledges cultural needs through Principle Two of the Nursing Council of New Zealand's Code of Conduct (Nursing Council of New Zealand, 2012a) by emphasising "cultural needs and values of health consumers" (p11). The Principle One however states to, "respect the dignity and individuality of health consumers" (p7) which could restrict quality of care for Pacific people who have a collective cultural needs ('Otunuku, 2011). Principle

One and Two have conflicting perspectives, causing tension when individuality of health consumers is applied to collectively oriented Pacific cultures.

I recall an incident from clinical practice where I was contacted by a middle aged Tongan mental health service user who lived with his parents who supported him throughout his life. He requested I arrange supported accommodation for him as he wanted to move out from home and he did not want his parents to know. Principle One would support his individual wishes while Principle Two would be compromised, as his cultural family values would be ignored if parents were not informed. This is one of many complicated scenarios I faced in clinical practice due to conflicting views of cultural needs and the nursing codes of conduct. The Tongan cultural interpretation of mental illness as being possessed by spirits and needing traditional healers was one common theme noted from clinical practice, which also contributed to framing of this research. This Tongan interpretation of mental illness was discussed within the Tongan community and I have also witnessed it growing up in Tonga and in A/NZ. This thesis seeks to better understand Tongan epistemological and ontological constructions of mental illness, as up until now this has been poorly defined. The following section outlines the context of the research and its development, and the evidence that examines issues pertinent to Pacific people and mental health will be addressed later in this Chapter.



## **Introducing the research context**

I grew up in Tonga and was one of three men to start the male nursing profession in Tonga in 1993. My first time leaving Tonga was in 1994 to continue my nursing training in A/NZ. I returned in 1997 and worked at the main hospital in Tonga and most of my time was in the general medical ward where I had nursing leadership roles. It was challenging as my interest was in mental health and I was also a new graduate with expectations from my community and employer, for instance, the Charge Nurse of general medical ward. I migrated in 1999 to A/NZ to pursue my interest in mental health nursing and to join a Pacific mental health service in Auckland.

The New Zealand Mental Health Survey, *Te Rau Hinengaro* (Oakley-Browne et al., 2006), confirmed the existence of different levels of need, reporting that Pacific people who were born in A/NZ have a higher risk of developing mental illness compared to their counterparts who were born in the islands and migrated to A/NZ (Oakley-Browne et al., 2006). This finding was the seed of this research project: I was interested in responding to the question “Why are the risks of developing mental illness higher for Pacific people who were born in A/NZ greater than those who were born in the islands and then migrated to A/NZ?” This was initially the question that I proposed, with the hope that research would provide some answers on how to support diverse Pacific populations in A/NZ with mental health problems.

The New Zealand census 2006 revealed that Pacific people in New Zealand account for 6.9% of the total population. Pacific people are a young and fast growing population, with the Tongan community growing the fastest (Statistics New Zealand, 2006a, 2006b). Tongan

people make up the third largest Pacific group (Statistics New Zealand, 2006b) after Samoans and Cook Islanders. At the time of writing, detailed information from the 2013 census on specific Pacific populations was not available. However, the total Pacific-identifying population had grown to 295,944 or 7.4% of the New Zealand population (Statistics New Zealand, 2013). The number of Tongan people increased by 24% from 2001 to 2006 (Statistics New Zealand 2006). Twenty eight percent of Tongan mothers have four or more children compared with 24% of the total Pacific people and 14% of the total population. Thus, Tongans are one of the fastest growing populations in New Zealand. The median age for the Tongan population is 19 years while for the total Pacific population it is 21 years and for the total national population 36 years. Tongan people born in New Zealand accounted for 56% of the Tongan population and 80% reside in Auckland (Statistics New Zealand, 2006b). Therefore, with the high levels of mental health issues identified in the report by Oakley-Browne, Wells, and Scott (2006), Tongans warrant attention regarding mental health.

This research project involves Tongan people living in A/NZ. Tonga, a Polynesian country comprised of 170 small islands, is divided into three major archipelagos in the South Pacific (Bennardo, 2009). There are multiple layers of diverse social structures in the Pacific islands, which will be discussed below, but diversity occurs in individual cultures as well. For instance, Tongan society has a hierarchical structure categorised into three levels: the King is at the top of this pyramid, followed by the nobility which consists of chiefs in the middle level, with the commoners at the bottom of the pyramid. The three classes each have their own language and it is required that each converse and address these levels appropriately, especially when addressing higher classes like the King/Royalty from the noble's levels, or addressing the King and nobles from the common people's level. Take, for example, the word 'eating', the Tongan translations are *taumafa* for the king, *'ilo* for the nobles, and *kai*

for the commoners (Gifford, 1929; Kaepler, 1971). Inability to perform appropriately results in shame and embarrassment not only on the individual but also to that individual's family and ancestors. Figure 1.1 showed the geographical location of Tonga in the South Pacific and also a map of Tonga.

**Figure 1.1: Map of Tonga**



<http://www.worldatlas.com/webimage/countrys/oceania/to.htm> (29.08.2014)

The formal introduction of Western education and health concepts to Tonga happened with the Christian movement to Tonga marked by the baptism of King George Tupou in 1831 (Wood-Ellem, 1999) and the establishment of the Native Training Institution in 1866, which is now known as Tupou College (P. Latu, 2011). The introduction of Western education systems influenced the Tongan ways of thinking and also the social structure (Kavaliku,

2007). Kavaliku (2007) describes how ‘he left Tonga, as a commoner, at the age of fifteen for further education, and when he returned to Tonga twelve years later with a doctoral degree he became a cabinet minister and was given a new ranking in the noble class’. Kavaliku describes what was involved in making this shift and adapting to the change of lifestyle, “I had to learn whole new vocabularies and linguistic styles, the chiefly language and the language for Kings” (Kavaliku, 2007, p. 8). Careful consideration of these three levels is essential when working with Tongan people, and there needs to be awareness of the customs, practices, and boundaries, so that culturally safe practices are guaranteed, or culturally unsafe practices are at least minimised.

The Tongan monarch, Queen Salote III was known internationally for her humbleness and great leadership, having led a traditional, male dominated culture through difficult times (1918-1965), (Wood-Ellem, 1999). Queen Salote III played a vital role in connecting Tonga with Western models of education and medicine and handed these responsibilities to her son Tupouto‘a, who graduated with a Bachelor of Art and Law, the first Tongan to graduate from a university. Tupouto‘a took over the Education and Health portfolios in the Tongan Government and continued establishing Western systems and structures of education and health in Tonga (Wood-Ellem, 1999). Medical doctors were trained abroad: Sione Tapa was sent to New Zealand, and Tilitili Puloka, Leopino Foliaki, and ‘Opeti Lutui were at the Central Medical School in Suva, Fiji in the 1940s. These people were the leaders of modern medicine in Tonga. Queen Salote III was keen for the Western influences but her heart was with the “Tongan traditions, customs and values” (p. 225) and she also emphasised that these changes should be made “slowly rather than too quickly” (Wood-Ellem, 1999, p. 223).

## **The research population**

The research population for this study is Tongan people in A/NZ. Tonga is the only remaining monarchy in the South Pacific that has not been colonised or under any foreign power (Vaioleti, 2011), and the 2006 census reports that Tonga has a population of 101,991 (Statistics Department, 2008a, 2008b). The monarchy status of Tonga demonstrates traditional Tongan culture and it is an important component to note, as it may influence this research project, especially constructing meaning of mental illness with Tongan ontology and epistemology and also Western influences through colonisation.

Tongan people in this project are perceived as a migrant population to A/NZ yet both Tonga and A/NZ are part of the Polynesian group. The geographical boundaries of Polynesia run from Hawai‘i in the north to A/NZ in the southwest, Easter Island in the southeast, then the boundary goes back to Hawai‘i and Polynesia captures all islands within this triangle (Craig, 2011; Gunson, 1997). Gunson (1997) referred to this triangle as families of Polynesia and discussed them in four different periods, starting from the age of the Gods, legendary tribal ancestors, semi legendary genealogical period and the fourth period is the ability to trace back through the ancestors safely. Collocott (1921) discussed the age of the Gods through the legends of Maui who lives in the underworld and brought fire to the World which highlighted the age of the Gods. Gifford (1924) also documented myths and tales in the Pacific and argued that migration within the Pacific started thousands of years ago and these migrations are told through these myths and tales which discussed the age of the Gods, legendary tribal ancestors and the semi legendary genealogical period.

Tongan people have migrated all over the world, and a large number migrated to A/NZ (Statistics New Zealand, 2006a; Statistics New Zealand and Ministry of Pacific Island Affairs, 2011), Australia, and the United States of America. The recorded migrations of Tongan people according to Gunson's fourth period, where we can safely track our ancestors migration through history to A/NZ started mostly in the 1950s, for economic reasons and job opportunities (Ministry of Social Development, 2008; Taumoefolau, 2012). Tongans migrate to A/NZ to work and some for educational purposes through Queen Salote III's leadership. Some of these Tongans chose A/NZ as home with dreams for better education and life for their children. This led to more migration with reasons of rejoining family members in A/NZ and also holding the vision for better future in A/NZ (Taufatofua, 2011; Taumoefolau, 2012).

### **The development of this research question**

After consultation with my supervisors and with experts in Pacific and mental health regarding my proposed research question around risks of mental of illness for Pacific born and A/NZ born Pacific raised by *Te Rau Hinengaro* study (Oakley-Browne et al., 2006), I gave much thought to the research project and decided that the question needed further refining as the focus on diverse populations was too complex. This issue could be eliminated by focusing on one ethnicity, - in this case, Tongan. The decision to focus on the Tongan community was heavily based on considerations of my own Tongan cultural background with the view that similar cultural backgrounds between the researcher and the researched could generate in depth data. The sensitivity of the subject matter - mental illness, was also considered with the researcher being an insider within the Tongan community. I decided that the sensitivity could be handled carefully within a Tongan cultural framework to guide engagement with Tongan people, and it will be more beneficial for this study to be conducted

by an insider who can view mental illness from both Tongan and Western and biomedical understandings. Further discussion on the researcher as an insider will be discussed in Chapter Four where the research design of this project is described.

It was also highlighted in these consultations and discussions that there is a need to examine the root of the issue; to consider what mental illness means for Tongan people. It is important to validate that the understanding of mental illness means the same thing to both Tongan people and to mental health workers before asking the question about why risks of mental illness are higher for A/NZ born Tongans than for Tongan born people. Attempting to do this highlighted confusion in the Tongan community about the term 'mental illness'. For example, there is no Tongan word or Tongan translation of mental illness; numerous Tongan words are used to explain mental illness. This becomes problematic when discussing diagnoses of mental illnesses like depression, schizophrenia, and so forth. It was not clear whether Tongan people are thinking about the same sets of symptoms, behaviours, and attitudes that define mental illness from a Western and biomedical interpretation.

This confusion raised more thinking around Tongan peoples' perceptions, interpretations, and definitions of mental illness. It is important to clarify the definition of mental illness because the entry criteria for accessing mental health services are based on the identification of the main presenting problems. The high prevalence rates of mental illness in Pacific population and their over-representation in mental health services (Oakley-Browne et al., 2006) raised questions around Pacific people – including the Tongan population which sits within the 'Pacific' umbrella in A/NZ – entering mental health services. Do Tongan people know why and how they entered mental health services? Or are they confused and feel lost in the mental

health system? Do they feel heard or not listened to? Oakley-Browne et al (2006) also found that Pacific people are less likely to access mental health services. That low access rate raised more questions such as: Why do Pacific people do not access mental health service and do they access other services? If yes, what are those services and why Pacific people choose that service?

Furthermore, it is likely that mental health workers have little understanding of Tongan people and their interpretations of mental illness when admitting Tongan people into mental health services. By exploring what Tongan people mean when they talk about mental illness, this study can contribute to knowledge about Tongan perceptions and understandings of mental illness and address the confusion that arises between Pacific peoples and mental health services. The findings will also provide answers on Tongan understandings of mental health services and how these services are perceived by Tongan people.

These questions and assumptions all pointed to the need to track back to the fundamental meaning of what mental illness is for Tongan people. My initial question around why the risks of developing mental illness are higher for Pacific people who were born in A/NZ than for those who were born in the islands and migrated to A/NZ now seemed to cover the surface without knowing what was underneath. This realisation shifted the focus of the research project and I decided that investigating the root of mental illness was a good place to start – just ask Tongan people plainly and in simple form, “What are the meanings of mental illness for Tongan people in A/NZ?”



This study, then, explores the meaning of mental illness for Tongan people in Auckland, home of the largest population of Tongans in A/NZ. Tongan people are classified under the ‘Pacific’ category in A/NZ (Statistics New Zealand and Ministry of Pacific Island Affairs, 2011) although the diversity of Pacific cultures is dynamic and complex because of the many ethnicities within it (Allen & Laycock, 1997; Bathgate & Pulotu-Endemann, 1997; Bridgman, 1997; Ministry of Health, 2005, 2010a; Ministry of Pacific Island Affairs, 2009; Statistics New Zealand, 2006a). The following section discusses key terminologies used in this research project.

## **Key terms**

This section discusses certain key terms which can, at times, be difficult to define as they have multiple meanings, interpretations, and definitions largely determined by organisations, contexts, discipline, researchers, and so forth. These multiple meanings can potentially create confusion so this section therefore clarifies how these terms are used in this study.

### **Mental distress, mental illness, and mental disorder**

My clinical role at the mental health service, meant I was familiar with this term, mental illness. The mental health services I worked for were largely guided by tools such as the *Diagnostic Statistical Manual of Mental Disorders* (DSM) which has an illness deficit focus through identifying symptoms (American Psychiatric Association, 2000; American Psychiatric Association & DSM-5 Task Force, 2013). This form of practice aligned my way of thinking with Western approaches and interpretations of mental illness through an illness and disorder interpretation with focus on the DSM criteria for mental illness. The process of

conducting the research for this study, however, extended my understanding of the term mental illness and I have come to realise that it is associated closely with the term mental disorder, and that both terms suit the Western and biomedical views of illness. The other part of my journey is that I have come to realise that in a Tongan context, the social and spiritual components of framing health transcend these narrow or reductionist ways of constructing mental disorder.

A more overarching term, that appears to be more comprehensive and flexible and able to extend outside the Western and biomedical views of illness, is mental distress which Sharma (2012) defines as

first and foremost, a crisis of the self. This crisis stems from the individual's perceived capacity or incapacity to control his or her life and to adjust to his or her social environment. (p106)

Sharma argues that the onset of mental distress is precipitated when someone is unable to cope socially and their behaviour changes as a consequence. This onset stage can be distinguished as mental distress, whereas mental illness and disorder requires symptoms to be identified, in order to fulfil criteria for a specific mental illness. Therefore, while the term mental illness was used for designing and approaching the research, mental distress and mental illness were used interchangeably for the writing of the thesis, as it suits the diverse presentations and complexities of the subject matter. A study in Canada (Caron et al., 2012) used mental disorders, and psychological distress was added to cover the range of mental illnesses. Seimyr, Welles-Nyström, and Nissen (2013) support distress when they look at maternal mental health as it captures different presentations like stress and ineffective coping mechanisms and others such as Rognmo, Torvik, Ask, Roysamb, and Tambs (2012),

extended mental distress to children of people with alcohol issues which highlights the range of situations that mental distress covers. Barrera, Schulz, Rodriguez, Gonzalez, and Acosta (2013) used the term mental distress with Mexican people and argued that mental illness has a psycho-medical focus where mental distress has a psycho-social focus. Barrera et al. (2013) goes further and discuss supernatural powers, acculturations, abuse, relationships, work and stressors and their relationships to mental distress. The broader definition of mental distress rather than mental disorder and mental illness, and the previous use of mental distress in research made me choose this concept for this study. Mental distress is used throughout the research project to explain both mental disorder and mental illness. The term mental distress covers those aspects outside of the biomedical model definition and criteria like diagnosis of mental disorders like Schizophrenia and Bipolar Affective Disorder. These terms are only used in this thesis when used by participants or in specific quoted literature.

### **Service user**

Service user is used in this research project to refer to those experiencing mental distress and using mental health services. McLaughlin (2009) identifies terms like client, patient, customer, consumer, expert by experience, and service user which are used in social work practice. Service user and consumer, however, are the most commonly used terms in A/NZ and this is reflected in government documents (Mental Health Commission, 1998b, 2012; Ministry of Health, 2007, 2008). The term consumer is rejected in this thesis due to the connotation of choice of service use, when often there is no choice. This research, therefore, uses service user due to its openness rather than focusing on one's need and illness (McLaughlin, 2009), and also its consistency with use in government documents in A/NZ

suggesting that this is the preferable term to define people who use the services for mental health.

## **Pacific peoples**

The Pacific populations of A/NZ migrated from their respective Pacific islands, mostly from the Polynesian triangle, and now make up 6.9 % of the total population of A/NZ (Statistics New Zealand, 2006a). I want to emphasise in this section that the term ‘Pacific peoples’ is used in this thesis to refer to the “whole nation, those living in the homelands and those living in New Zealand” (Ministry of Justice, 2000, p. 9). The Ministry of Justice clarifies that self-determination is a major factor in identifying which nation one wishes to identify with. The Ministry of Pacific Island Affairs (2006, p. 4) lists the ethnicities that comprise the Pacific population in New Zealand thus: “Samoan, Cook Islands, Tongan, Niuean, Fijian and Tokelauan groups, with smaller numbers from Tuvalu, Kiribati, Papua New Guinea, Vanuatu, the Solomon Islands and the small island States of Micronesia”. This Pacific population in A/NZ has at least thirteen different languages (Statistics New Zealand and Ministry of Pacific Island Affairs, 2011) with more than half being born in A/NZ (Statistics New Zealand and Ministry of Pacific Island Affairs, 2011). Samoan is the largest ethnic group comprising 47% of the Pacific people with Tongan people making up 16% (Ministry of Pacific Island Affairs, 2006). This illustrates the diversity amongst Pacific people in A/NZ.

There are times when Pacific people do need to come together for political strength, and a shared cultural identity is useful. Tongan scholar ‘Epeli Hau‘ofa (2008, p. 441) calls for

Pacific people to stand by their indigenous values and beliefs and he states that, “Oceania is vast ... Oceania is us. We are the sea, we are the ocean, we must wake up to the ancient truth”. Hau‘ofa refers to Pacific people as Oceania, and emphasises the depths and vast spaces Pacific people represent which is also their identities. Hau‘ofa proposes Pacific peoples reconsider and reclaim their ancient truths including how Oceania interprets and defines their world, which suggests that they may have been ignored. Māhina (2008) proposes the term *moana* which refers to the ocean, and claims that it is exclusive, indigenous, authentic, and can be less problematic than other terms. D’Acry (2008), Hau‘ofa’s (2008) and Māhina (2008) agreed on the ancient definition of Pacific, *moana*, and this will be addressed further in the Discussion Chapter (Eight) of this thesis, along with the importance of the need to maintain this definition. There is the need to revitalise these ancient truths, and not to overlook these, and define Pacific people by population composition and migrations as highlighted in the A/NZ definition.

The definition of Pacific used in this research is largely guided by the New Zealand Government’s documents through the Ministry of Health, Ministry of Pacific Island Affairs, and Statistics New Zealand, which focus mainly on the largest ethnic Pacific populations in A/NZ from Samoa, Cook Islands, Tonga, Niue, Fiji, Tokelau, and Tuvalu (Ministry of Pacific Island Affairs, 2008). This research project used the A/NZ’s definition of Pacific which is utilised nationally and also informs the New Zealand health system and other government departments; this is a population-driven definition of Pacific people in A/NZ. This definition is inclusive of those who populate A/NZ and can be problematic by excluding those Pacific islanders who do not reside in A/NZ, or smaller Pacific populations which are categorised under ‘others’ in the A/NZ census. Understanding Pacific compositions, locations, identities, and differences can be a key point when working with Pacific people with mental illness.

These understandings can inform practice lead to a change in approach with Pacific groups, and healthcare will be developed and delivered appropriately and safely. In this thesis, therefore, the term ‘Pacific peoples’ is used for all Pacific people in A/NZ and also those in their Pacific homelands. The term ‘Pacific people’ will be used contextually and the context will be defined to clarify where that Pacific population is situated.

## **Structure of the thesis**

This thesis explores the meaning of mental illness to Tongan people in A/NZ. Mental illness can be constructed in many competing ways. It could be considered a product of some health challenges, or it could be constructed a continuum of health and illness. When this continuum is applied to the mental component of health, the continuum then moves from mental health on one end, to illness or distress in the other. Chapter One has begun by introducing the background information about this research project, introducing the research population, Tongans as a distinct ethnic group and the research population. The development of the research question has been outlined and then the key terms that are used in this thesis have been defined.

Chapter Two and Chapter Three review the literature: Chapter Two focuses on defining health and illness, and then focuses on the psychological and mental aspects of health, with a specific focus on mental illness. Chapter Three reviews the literature around mental health and illness specifically amongst Pacific peoples.

Chapter Four discusses the research design and the methodology employed in the research. This includes the aims of the research and the research question, and describes the research design and procedures. The conceptual/cultural framework of *talanoa* is introduced and described. Analyses of the data using a thematic approach is discussed in this chapter and the participants are introduced and how they were included during the data collection phase is explained. The processes of analyses are discussed. Ethical considerations and requirements are addressed. Chapter Four introduces the three themes that emerged from the data, these were *tufunga faka-Tonga* (Tongan constructions of mental distress); *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress), and the *tufunga fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress).

Chapter Five discusses the first major theme, *tufunga faka-Tonga* (Tongan constructions), and its four subthemes – reality (*fa'unga*), directionality (*hu'unga*), temporality (*tā'anga*), and positionality (*tu'unga*).

Chapter Six follows with the second major theme, *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress), and its four subthemes – challenging Tongan beliefs, using of English biopsychosocial language, stress as onset of mental distress, and drugs and alcohol.

Chapter Seven considers the last theme *tufunga fepaki mo e fetaulaki he vaha'a 'o e tufunga faka-paiōsaikosōsiolo mo e tufunga faka-Tonga* (intersections between biopsychosocial and Tongan constructions of mental distress), and its five subthemes – migration, social networks,

services and resources for people and families experiencing mental distress, participants experiences with mental distress and, finally, the Christian faith.

Chapter Eight summarises the findings from the study, considers them in relation to the literature reviewed, and discusses their implications. The findings have a strong Tongan traditional voice and Tongan ways of practice are explored and discussed. The Tongan process of healing is also described in this chapter and it applies to the A/NZ context and the mental health setting.

The final chapter, Chapter Nine, discusses the research process and acknowledges the limitations of this study. Recommendations from the study are presented. A Tongan model, *ūloa*, for working with Tongan people experiencing mental distress and illness is proposed and an argument is presented for how this will contribute to improving the current state of working with Tongan people with mental distress.



# **Chapter Two: Defining Health and Illness and the Role of Culture in Mental Illness**

## **Introduction**

This chapter along with Chapter Three presents a review of the relevant literature for this research project. The research question asks “What is the meaning of mental illness amongst Tongan people in Aotearoa New Zealand (A/NZ)?” The review explores literature associated with Tongan mental health and mental illness, starting with international and global understanding of health, then mental health and mental distress, mental illness and mental disorder. The focus moves in an inward direction to look at Pacific mental health and mental distress, mental illness and mental disorder and then the focus is on Tongan people. Because the study is focused on the Tongan population in A/NZ which is identified as a migrant group, it was deemed appropriate and relevant to include literature about migrant populations in the review. The presentation of this review is structured to move from an overall view of the research, to the research question: what is the meaning of mental illness for Tongan people? The chapter firstly presents health, then mental health, followed by culture and its influences on health and mental health and also on health providers, followed by mental distress, mental illness and mental disorder.

The literature reviewed was sourced largely via online databases such as EBSCOhost, CINAHL, Scopus, PsychINFO, Index New Zealand, JSTOR, and Google Scholar using the word mental\* as the main keyword with other relevant words like Pacific, Tonga, indigenous, migrant, and so forth. There was very little literature on Tongan understandings of mental

illness; this strengthens and highlights the need to research this important area to inform health care practice and policy development.

## **Defining health**

This research project investigated the meaning of mental illness for Tongan people and it is therefore important to trace the roots of mental illness. Mental illness is related to mental health, and both concepts are components of health generally (Fernando, 2010; Rogers & Pilgrim, 2011). Health, therefore, is the root of this discussion and this literature review starts with an exploration of health, followed by aspects of mental health and illness, starting with the international definitions moving towards Tongan meanings.

In 1946, the World Health Organization (WHO) defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1946, p. 100). This definition has been heavily criticised however, including concerns around clarity of the word “complete”, as the requirement for complete health would leave most people defined as unhealthy (Capstick, Norris, Sopoaga, & Tobata, 2009; Huber et al., 2011). This focus on complete health, including social well-being, could be said to shift the focus to medicalised health due to dominant influence of biomedical science and may be a danger when the “nature of a problem is seen to be medical, its cause is said to be medical, and a medical solution is looked for, rather than any other type of solution” (Boddington & Räisänen, 2009, p. 54). As social well-being is often overlooked in service provision, the WHO definition therefore raises questions about the direct relationship

between poor mental health and high levels of social needs and therefore the service boundaries of health, illness, disease and wellbeing. The Mental Health Commission (2011) reported 80% of people with long term mental health problems are unemployed – the highest of any disabled group. Poor housing is common (Office of the Deputy Prime Minister, 2004; Peace, Kell, Pere, Marshall, & Ballantyne, 2002; Peterson, 2007), as well as high levels of threats and actual violence in mental health communities (Mental Health Commission, 2011).

The questions on boundaries of health are not only important to define health but will also identify what we refer to as illness and disease. The notion of illness and disease from the WHO definition can be quite unclear and Hofmann (2001 ) highlights the complexities of disease explaining its different concepts and extensions:

Disease concepts do not always have the same extension. Sometimes the concept refers to theories of disease, while in other instances the ascription of disease is the issue, and sometimes they are intermingled. Correspondingly, a wide variety of terms is applied in the debate, e.g. such as “concept of disease”, “disease concepts”, “disease entities”, “disease identity”, “disease status”, “disease condition”, “disease category”, “disease event”, “disease process”. The relationship between them is not always clear. (p. 218)

Health is a complex concept that extends to defining disease leaving complicated and muddled concepts, health and disease, which need to be untangled and identified. Disease is addressed later in this review but here I return to the focus of this section, to consider the definition of health in general. In relation to their work with rural Canadians, Thomlinson, McDonagh, Crooks, and Lees (2004) broaden the definition of health to include spirituality, explaining being healthy as:

a holistic relationship between the physical, mental, social and spiritual aspects of one's life; a balance that included 'the big picture'. Being able to do what they wanted to do, to cope, to enjoy themselves, to not be bored and to feel they were productive citizens was important. (p. 261)

The inclusion of the spiritual aspects expands the definition of health and Thomlinson et al. (2004) highlight *ability* as a key theme in the capacity concept of health. This is supported by Makoul, Clayman, Lynch, and Thompson's (2009) work in the United States of America on the definition of health from which four elements of health appear: physical, psychosocial, capacity, and control. The physical aspect includes the body and biomedical; the psychosocial refers to the mental, emotional, spiritual, and social aspects; capacity refers to ability and living an active life; and control refers to impulse and self-control (Makoul et al., 2009). For Schmidt and Frohling (2000), the concepts of capacity and control emphasise the relationship between one's level of "functions and well-being" (Schmidt & Frohling, 2000, p. 236). Schmidt and Frohling describe individuals' health in terms of their responsibility to the society rather than focusing on the absence of disease. This shift to responsibility to society starts to resonate with indigenous interpretations of health. Definitions that are more holistic resonate with the beliefs of indigenous peoples. For example, the Aboriginal people in Australia associate health with functions and duty to the community, and define health as:

not just the physical well-being of an individual but is the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well-being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life. (Boddington & Räisänen, 2009, p. 57)

Boddington and Räisänen extended health to a communal level with a focus in the community and a circular motion between life and death. The variations on the definitions and redefinitions of health from the WHO definition in 1946, through time and other cultures have been extensive and broad. The differences in interpretations of health are reflected in the wide range from the WHO individual focus on health to a collective focus from indigenous Aboriginal people. Across the Tasman Sea from Australia are the indigenous Māori people A/NZ.

### ***Langimālie* (clear and peaceful sky) Pacific health**

As Gunson (1993) noted earlier, A/NZ is the geographical cornerstone of Polynesia is the south and their indigenous people are Māori. The concept of health for indigenous Māori people is demonstrated through Te Whare Tapa Whā, depicted as a house with four sides that sits firmly upon the land (whenua). The whare (house) is held in place by four (wha) poles representing Te Taha Wairua (the Spiritual Dimension), Te Taha Hinengaro (the Mental Dimension), Te Taha Tinana (the Physical Dimension), and Te Taha Whānau (the Family and Social Dimension) (Durie & Kingi, 1997). The different dimensions of Te Whare Tapa Whā are consistent with the Aboriginal view, and also extend to the interpretations of health in the Pacific, with the themes of collective, community-oriented work within social structures and functions.

Cook Island health researchers Laing and Mitaera explain that the Cook Island word for health, is *ora'aga* referring to “all things that affect a person’s life, be it physical, spiritual, emotional or in regard to relationships and the environment” (Laing & Mitaera, 1994, p. 208). The Cook Island definition is developed from what affects a person’s life and their

relationship with the environment, which suggests that illness happens when one's relationship with the environment is compromised physically, spiritually, or emotionally. The extension of health to social relationships and the environment sits well with the Māori and the Aboriginal perceptions of health. The health component of relationship with the environment highlights the close relationship between these people and the natural environment and these are considered important in terms of health. The Cook Island people are counted in A/NZ as Cook Island Māori due to their common ancestors and heritage with Māori people (Statistics New Zealand, 2008), which again confirms the closeness between the people of Polynesia, and this is also evidenced in their views of health.

Moving across the Pacific Ocean, Samoan words for health are *soifua* (life/to live) and *maloloina* (rest/health/to recover from illness), which highlight a life lived in peace and recovery from illness. Peace within the society is consistent with the Cook Island's interpretation of health. Siosiane Bloomfield, a retired Tongan nurse and former Principal of the Queen Salote School of Nursing in Tonga, researched traditional healers and their practices in Tonga. Bloomfield (2002) discusses the Tongan translation of health as *mo'ui lelei* (good life). Taken alone, this literal translation of *mo'ui lelei* as good life or good health is aligned with the WHO definitions of health rather than Tongan social interpretations. However, Bloomfield adds that Tongan people strongly align health with social aspects and mostly with the spiritual aspect; that "life is threefold, as the Tongans would say, *sino*, *'atamai mo e laumālie* (body, brain and spirit)" (Bloomfield, 2002, p. 33). Bloomfield emphasises that good health exists when all duties to families, land, and society are fulfilled. She adds the importance of duties to society related to health. These duties are required in different social levels of the society, family, extended family, village and country. Thus,

social relationships and also the relationship with the land are important in defining health in the Tongan context.

Māhina (2002a) supports Bloomfield's threefold interpretation including physical for body, mental for brain, with a focus on 'social tendencies' rather than spirit. Māhina emphasises the term '*mālie*' as in 'harmony' and 'beauty' and its relation to health:

as in *langimālie*, the ancient Tongan collectivist, holistic and human-environment sense of good health, is applied as a common suffix to all forms of social activity ... *faingamālie* (opportunity), *tu'umālie* (wealth), *kaungāmālie* (well-attended), *napangapangamālie* (well balanced), *lotomālie* (middle point) and *faivamālie* (good work of art). These mutually-inclusive, symbiotic situations are established, specifically when a state of harmony and beauty is reached and opposed relationships between chaos and order, in nature mind and society. (Māhina, 2002a, p. 305)

Māhina extends his definition of health into the relationship between humans and the environment, using *langimālie* – which, literally translated, means 'clear sky' – for good health. Thus, a healthy environment equates to a healthy community and individuals. Within the environment, Bloomfield discussed cultural activities where illnesses are caused when social relationships are disrupted. These activities include illnesses to the unborn child when the pregnant mother drinks from the wrong end of the coconut, stealing, or making sarcastic remarks about another child. Illness, from a Tongan perspective, is "a break-down in the social relationships between inferior human beings and superior human beings or between human and supernaturals" (Bloomfield, 2002, p. 34). Bloomfield argues that health, therefore, is being free from ill feelings from all relationships.

Bloomfield's (2002) definition of threefold components of health is consistent with the Cook Island definition of three aspects of life, and her translation of *mo'ui lelei* also relates well with the Samoan *soifua maloloina*. The Cook Island and Tongan components of health have similarities in that both clearly identify two aspects, physical/body and spiritual, but the third component is different. Whereas the Cook Island's definition identifies emotions, the Tongan definition identifies with the body organ associated with thinking, the brain. It is, therefore, clear in the Pacific definition, that there is a physical component, which is associated with the body, a spiritual component, and then a third component which is associated with the brain, emotions, and social tendencies (Capstick et al., 2009). These elements of the third component of health – relating to thinking, attitudes, and behaviour – then, are key factors in terms of what constitutes mental health (Fernando, 2010; Pilgrim, Rogers, & Pescosolido, 2011) and these elements are discussed further in Chapter Nine with the proposed Tongan model of *ūloa* suggesting a model to address mental health when working with Tongan people. The following section focuses on reviewing understandings of mental health starting from international studies to a focus on Tongan people.

### ***'Atamai mo e fakakaukau* (mind and thinking) – Defining mental health**

Mental health is a complex concept to define as it is intertwined with cultural and social values (Rogge, 2011; Szasz, 1971); agreeing on a definition of mental health can, therefore, become very 'messy' due its multiple cultural layers and diverse nature. Herman (2011), for example, defines mental health as “a set of positive attributes...positive emotion (affect) such as feelings of happiness, a personality trait that includes the psychological resources of self-



esteem and mastery, and as resilience, or the capacity to cope with adversity” (p. 406). Herman’s conceptualisation of mental health, which focuses on the positive, highlights ‘happiness’ which does not feature for other writers addressing mental health and illness as discussed below (Fernando, 2010; Pilgrim et al., 2011; Rogers & Pilgrim, 2011). Ultimately, mental health can be defined when determinants of mental illness are identified and those symptoms are highlighted and accepted as defining mental illness. Therefore people may experience mental health, despite having a diagnosis of a mental illness. Myers, McCollam, and Woodham (2005, p. 18) state that mental health is “the emotional and spiritual resilience which allows us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own, and others’ dignity and worth”.

Fernando (2010) claims that the word ‘well-being’ captures more of what mental health is about and can be used to better understand mental health in countries with more traditional concepts of mental health. This connects with the proposed contribution by Huber et al. (2011, p. 236) who write that “a strengthened capability to adapt and to manage yourself often improves subjective well-being and may result in a positive interaction between mind and body”. Huber et al. (2011) emphasise the individual’s capability to adapt and manage self to capture the well-being that Fernando (2010) suggests. This well-being is demonstrated through the optimistic relationship between the mind and the body.

With indigenous Aboriginal and Māori populations and also Pacific interpretations of health, mental health was highlighted as the component of health. The interactions between the mind and the body and the connection to well-being discussed by Fernando (2010) relate to the Tongan perceptions of health generally presented in Bloomfield’s (2002) definition with its mental health component, and also Māhina’s (2002a) contribution around reconnecting

individuals to nature, referring to good health as *langimālie* (clear and peaceful sky) with a mental health component as in *'atamai* (mind) and *fakakaukau* (thinking). Māhina's views highlight the organ associated with thinking, the brain, which arguably has some biomedical influences due to its focus on the pathophysiology of the brain. The perception of mental health in Tonga shows a variation from the collective relationships (Bloomfield, 2002) to the individual brain (Māhina, 2002a). It is therefore important to examine Tongans' own interpretations of mental illness and how culture plays an integral role in defining mental health, illness and mental distress. The literature reviewed shows some disparity with more literature found on mental distress, mental disorder and mental illness compared to mental health. This reflects how mental illness and disorder are more substantiated terms with associated research and evidence, whereas mental health does not yet have this legacy. This imbalance demonstrates the problem focus of our health systems where there is more focus on mental distress, mental disorder and mental illness with little attention on mental health. The review also found the different interpretations of these health issues in different cultures and its interpretation in Tonga is yet to be found.

### ***'Ulungāanga – Culture***

Culture affects all aspects of life including health and well-being. Blackburn (2008, p. 86) defines culture as “the way of life of a people, including their attitudes, values, beliefs, arts, sciences, modes of perception, and habits of thought and activity”. Culture encompasses with how they live their life (Mitias & Al-Jasmi, 2004) and also changes through time, from generation to generation (Sengall, Lonner, & Berry, 1998). Pacific researchers Macpherson and Macpherson (1990) discuss this view, showing how culture influences how people

perceive things like health and health practices, and how they observe and respond to these practices. Elizabeth Wood-Ellem's (1999) biography of Queen Salote III of Tonga – a very well respected leader of the only remaining monarchy in the Pacific – notes that Queen Salote III suggested that culture evolves with time, and proposed that Tonga needed to move with these changes.

In psychiatry, culture is a “commonly used label for a particular social group” (Loewenthal, 2007, p. 5). Loewenthal suggested that using the notion of ‘culture’ in psychiatry and psychology relates to social groups, and ethnicity. Fernando (2010) and Loewenthal (2007) note that culture is a variable that plays a vital role as it is associated with ways of living, behaviours, and attitudes. Fernando discusses how attitudes and behaviours form as a recognised entity within any one group of people. The American Psychiatric Association and DSM-5 Task Force (2013), who publish the classifications of mental disorders, acknowledge the importance of culture in mental health assessments, diagnoses and management, suggest that “culture includes language, religion, and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems” (American Psychiatric Association & DSM-5 Task Force, 2013, p. 749), and that culture is open and continuously changing over time due to exposures to other cultures and concepts. The American Psychiatric Association and DSM-5 Task Force (2013) also discuss two cultural construct groups, firstly, race, which divides people into geographical boundaries due to their biological traits and common features, and secondly, ethnicity, which explains and distinguishes a group of people of community. As addressed earlier, Polynesia is the race for this research project and Tonga is the ethnicity. However, it is important to note that ‘race’ is contested as it is conferred on a group which some people do not accept (Gross & Livingston, 2002; Solorzano, 1997).

Tongan people are included in the 'Pacific peoples' category in New Zealand statistics (Statistics New Zealand, 2006a). Different groups of Pacific people have criticised this agglomeration as it potentially dilutes the distinct ethnic cultures of the Pacific into one 'Pacific culture'. It is vital to clarify the term 'Pacific', therefore, and also who the term Pacific people refers to in this project. It is important to note that the Pacific Ocean covers more than two thirds of the surface of the world (D'Arcy, 2008) with many islands scattered throughout this ocean – and that people from these islands are widely referred to as Pacific Islanders/peoples. With race, Polynesia is one racial group within the Pacific Ocean and as discussed earlier, Polynesia covers the triangle that runs from Hawai'i to A/NZ and Easter Island (Gunson 1993, 1997). There are also two other racial groups within the Pacific Ocean - the Melanesian and Micronesian cultures (Gunson, 1993), which again confirms the complexity and dynamic nature of the Pacific and where Pacific boundaries lie, considering the size of the Pacific Ocean.

Wepa (2009) discussed culture in forms of practices as

our way of living, the way we brush our teeth, the way we bury our people, the way we express ourselves through art, religion, eating habits, rituals, humour, science, law and sport; the way we celebrate occasions, all these we carry out consciously and unconsciously. (p. 31)

Wepa (2009) highlights, for Māori, how culture relates to how people live every day and those everyday actions become habits that are performed consciously and unconsciously. These actions define normal and abnormal behaviours and attitudes in societies, which then contribute to identifying and defining, who is mentally healthy and also who is mentally un-

well. The expression of culture is affected directly by where a person is born, cultural heritage, parental culture, and the environment including the experience of migration and acculturation or the adoption of, and adaptation to, the new culture (American Psychiatric Association & DSM-5 Task Force, 2013; Bhavsar & Bhugra, 2009; Sharma, 2012).

The distinct ethnic cultural practices between the people of different areas of the Pacific can be illustrated using an example described by Su'a William Sio, the Member of Parliament for the South Auckland Mangere electorate. Sio spoke at a leadership workshop for Pacific people (Manukau Institute of Technology, 2009) about an incident where people from Tonga, Fiji, and Samoa greeted their leaders: Tongans crawled on the floor to reach their leader, their King; the Fijians walked on their knees to their leader; and the Samoans walked to their leader and shook his hand. This example shows that while values like respect are consistent throughout the Pacific (Foliaki, Fakakovikaetau, Waqatakirewa, & Pearce, 2004; Macpherson & Macpherson, 1990; Vaka, Stewart, Foliaki, & Tu'itahi, 2009), there are great differences in practicing these values. These different cultural ways of living and practice contribute to differing definitions of ethnic culture. In Tongan, culture is translated by Churchward (1959, p. 618) as *sivilaise* which is a Tonganisation of the word civilised; clearly this interpretation can mislead people and fails to capture the meaning of culture. This Tonganisation would be fair if it was associated with concepts of culture and contribute as an addition Tongan language. Culture and civilisation are two different concepts and using the term 'civilisation' to define culture starts complicating the meaning of culture in the Tongan context.

Churchward was a linguist who worked with several Pacific languages on grammar and dictionaries (Schultz, 2001), and Tonga was one of the countries where he worked with in terms of their language (Bennardo, 2009). Churchward was ordered by the then Minister of

Education, Tupouto‘a, in 1946 to work on Tongan grammar, and the development of the *Tongan Dictionary* was assisted by a Tongan man, Feleti Vī (formerly Ve‘ehala, a noble title holder) (Wood-Ellem, 1999). Māhina (1992) explains that *tala e fonua* is the Tongan interpretation of culture where language (*tala*) and land (*fonua*), which also refers to people, encompasses important concepts of culture. Taking the definitions of culture discussed earlier in this section, with its behavioural orientation and evolving characteristics through time, I argue that the closest Tongan word for culture is *‘ulungāanga* as it is a combination of *‘ulu* (head) and *anga* (behaviour). *‘Ulungāanga* can be used to explain peoples’ ways of thinking and behaviour and how they interact within the society with people and also their surroundings. Ethnic culture can be called *‘ulungāanga fakafonua* and if ethnicity is identified in the Tongan context, it can be called *‘ulungāanga faka-Tonga*.

Macpherson and Macpherson (1990) argue that culture can be grouped into two types: the material elements or man-made resources, and non-material elements which are more natural like language, values, customs, and skills. The material and non-material types of culture influence the individual’s values and behaviours (Singelis & Brown, 1995). Singelis and Brown (1995) support Macpherson and Macpherson (1990) and add that “culture is both conditioning and conditioned. Through its institutions, rituals, socialisation practices, and patterning of interactions, culture provides the guidance and rewards that systematically shape individual social cognition” (p 356). Singelis and Brown (1995) highlight that culture is constructed; physically by its members and also psychologically through perceiving of material and non-material elements of culture. This, then, suggests that mental distress and mental illness can be physically and psychologically constructed differently in different cultures. These discussions of culture highlight the importance of asking, what is the meaning of mental illness for Tongan people in A/NZ, as it involves two cultures, where the Tongan

culture is located inside A/NZ culture, and literature identifies that mental illness is constructed differently in cultures. The previous discussions on health generally and the mental health component of health raised cultural differences in terms of interpreting mental health and illness. The mental health component relies on how people think, behave and live their life which fits well with an individual's culture or *'ulungāanga*. Mental illness will then refer to the other end of mental health with impaired thinking and behaviour which will again be influenced by culture. When addressing mental illness, it is important to acknowledge culture and its contribution to health. The following section discusses the way culture has been formally recognised in nursing practice and its importance for both nurses and service users.

### **Cultural safety in nursing**

The importance of culture is incorporated into health care and addressed in nursing practice guidelines (Nursing Council of New Zealand, 2012a, 2012b). The notion of cultural safety is vital when working with people experiencing mental illnesses and disorders. Irihapeti Ramsden pioneered the cultural safety path for nurses in A/NZ, highlighting how the constraints of the individualistic and linear Nightingale nursing model replaced the complex and holistic Polynesian model of health (Ramsden, 1990). Ramsden argued that identities of Māori nurses were not managed carefully through nursing training, and she described the training as an assault on the Māori nurses' identity. Ramsden argues that securing the nurses' own identities allows them to care for people in a culturally safe manner. Richardson (2010) emphasises the relationship between cultural safety and practice in nursing. Nurses, therefore, need training and support to use cultural tools, and Richardson (2010) also supports

Ramsden's prior proposal to return to a holistic and collective focus to replace the reductionist and individual focus of nursing. Cultural safety not only empowers nurses through addressing their own cultural needs but also increases their ability to attend to service users' cultural needs. Ramsden (1990) also highlights the importance of cultural safety in terms of Pacific people in A/NZ, due to their increasing populations and different interpretations of health and illness. Wepa (2009) supports Ramsden (1990) describing cultural safety as:

a way of being with another person, which encourages and celebrates difference. It is not about seeing others as different from you; rather you are different from others. It is also about you accepting others' difference and acknowledging your own background and culture. (p. 91)

Wepa's emphasis on looking within ourselves and acknowledging our differences from others, again supports the importance of asking the question, what is the meaning of mental illness for Tongan people? Another approach to assessing effective work in diverse communities is cultural competence. Whilst cultural safety focuses on the practitioner's approach and their openness to be guided, cultural competence offers practitioners knowledge related to particular ethnic groups. Cultural safety is favoured here as it provides practitioners with a way of working with any diversity, rather than to have limited specific cultural knowledge about diverse groups. Cultural competence is often distilled into a set of essential knowledge that can be stereotyping. More recent developments of cultural competence have seen an extension in the approach. Loftin, Hartin, Branson, and Reyes (2013) stated that cultural competence is where health care providers are able to address different cultural groups through culturally appropriate care through cultural self efficacy, cultural awareness, cultural knowledge and cultural competence. Walker and Sonn (2010) supports Loftin et al. (2013) by identifying twelve steps when working with Aboriginal people in mental health,



that include rights and safety through awareness and interventions to evaluation, research and ethical practice and responsibility. Leotta (2013) highlighted that cultural competence is a culturally competent tool when working with particular social groups and this tool is not fixed but changes according to context and time. These more recent changes to cultural competence have extended the approach toward cultural safety, and therefore cultural safety was chosen as the focus for this thesis.

The current pooling of people from the Pacific as a homogenous group fails to acknowledge ethnic and cultural differences, and it is, therefore, difficult to 1) encourage acknowledgement of diversity within the group, 2) recognise different cultural needs of each ethnicity and 3) develop adequate responses to work well with different ethnicities under the defined Pacific category in A/NZ. The development of culturally safe approaches that reflect the different cultural and ethnic groups have been problematic considering the complexities and diversities of Pacific people in A/NZ. Cultural safety acts as a form of mediation of conflicts between two cultures, rather than one imposing on the other but does not guarantee that culture is fully acknowledged and addressed at all times. This problem translates to health and mental distress.

Mental distress can overlap between the material resources and non-material elements of culture with society deciding when one behaves outside the norms of non-material elements like values and customs and society; as such, society constructs a mental disorder for the individual. The following section discusses the constructions of mental illness, mental disorder, and mental distress.

## ***Vale, puke faka-‘atamai, mahaki‘ia faka-‘atamai* – mental distress, mental illness and mental disorder**

The previous section focused on culture and cultural safety with the reason why cultural safety was considered over cultural competence. Culture informs to people’s behaviour and relates to mental health and illness. This section will discuss the literature on mental distress, mental illness and mental disorder.

Clarifying the meaning of mental illness is important as mental illnesses are collections of symptoms that arise from particular beliefs, thoughts, and behaviours (Perry & Pescosolido, 2011) shaped by culture, context, time, gender, social class, and other factors (Fernando, 2010). Mental illnesses are seen as “cultural norms proscribing attributes, traits or conditions regarded as shameful or in some way deviant” (Scambler, 2011, p. 218). Therefore, symptoms of mental illness are open to interpretation and these create conflict when one definition is forced on another. Because assessment tools and processes are determined by a particular view of mental illness, the interpretation of mental illness may cause ambiguity, tension, and conflict and recovery may be slowed. Fernando (2010) and Szasz (1971) argue that mental illness is a part of culture, with Szasz noting, for example, that cultures have norms of behaviour against which individuals’ behaviour is compared. Szasz provides the example of witches and witchcraft, in former times; those who behaved outside of the norm were described as possessed. In the light of scientific understandings of health and illness, however, ‘possession’ shifted from being explained as witchcraft to being explained as mental illness (Szasz, 1971). Read (2004) writes that the progression into medicine and

mental illness were made in the nineteenth century when a physiological cause for one form of mental illness was found. This was the brain damage in ‘dementia paralytica’ which also reflects the evidence base focus of medicine. The definition of illness also tends to be different from culture to culture (Burnham, 1980; Macpherson & Macpherson, 1990), so that the translation of illness could be misinterpreted between cultures. Furthermore, the addition of specialised areas like mental, spiritual, social and physical dimensions may complicate these misinterpretations (Fernando, 2010) due to their relationships with illness in different cultures.

Szasz (1971) stresses the importance of defining mental illness, and knowing what it is before proceeding to manage it. Rogers and Pilgrim (2011) support Szasz and explore the sociological perspectives of mental health and illness. Szasz (1971) explains how society determines illness and changes diagnosis when it is socially unacceptable or vice versa. He stated that the science movement took over religious ideology, replacing theology with medicine (Szasz, 1971). The movement to science took the ‘illness’ from religious and sociological disturbances like possession and witchcraft to biological disturbances focusing on the brain.

Goffman (1970) extends these changes and highlights how they were reflected in labels and the naming of the institutions that looked after these patients. For example, the development of the names of the institutions progressed from ‘madhouse’, to ‘asylum’, to ‘mental hospital’ to today’s ‘psychiatric institution’. These institutions were used when a person behaves outside of social norms and shows deviant behaviours (Gove, 1970). Goffman (1970) suggests that this shift was due to the powerful influences of science through shifting the illness from madhouse through asylum to mental hospital, suggesting mental illness as the

most valid frame that suits this illness. This pathway clearly ignored indigenous knowledge and interpretations of mental illness which exist in the Pacific and elsewhere. The Pacific literature is reviewed later in the next chapter.

Bentall (2004) discusses sanity, mental illness and madness stating that “the boundaries between sanity and madness are indistinct and permeable...it seems reasonable to assume, as a general principle, that abnormal behaviours and experiences exist on continua with normal behaviours and experiences” (p. 115). Bentall (2011) also notes that emotional and thought processes are important in psychosis and that there are “strong associations between psychosis and different kinds of social adversity” (p. 326). Studies on migrant populations, such as the Afro-Caribbean population in the United Kingdom, have found that these populations have a higher incidence of psychosis than the general population (Bentall, 2011). Bentall attributes the higher incidence of mental illnesses in migrant populations to constructions of mental illness. The relationship between migration and mental illness is likely to be significant in this research as it has been shown that Pacific people have higher incidences of mental illnesses in A/NZ than the general population. This supports the notion that the culture of Pacific people will have a part to play in constructing mental illness differently. The literature about migrant populations is reviewed later in the next chapter.

Rogers and Pilgrim (2011) discuss how mental illnesses are now more visible in comparison to decades ago, and yet “the boundary between normal and abnormal functioning had become increasingly permeable or fuzzy in a number of ways” (p. 267) where one person’s diagnosis of mental illness can be another’s job description or way of life: for example, soldiers and boxers are paid for imposing violent activities on others. Despite the complexities of mental

illness, there is a need for some guidance for assessment and treatment of distress, whatever the cause may be. One response to this call for guidance was the production of the Diagnostic Statistical Manual of Mental Disorders (American Psychiatric Association, 2000).

### **The Diagnostic Statistical Manual of Mental Disorders (DSM)**

The Diagnostic Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) published by the American Psychiatric Association, is a “classification of mental disorder that was developed for use in clinical, educational and research settings” (American Psychiatric Association, 2000, p. xxxii). It is used as a standard tool in diagnosing people with mental illness and is implemented worldwide throughout mental health services, including in New Zealand and in the Pacific. DSM IV defines mental disorders and identifying criteria under each diagnosis. The categories for diagnosing mental disorders are derived from Western and biomedical definitions (American Psychiatric Association, 2000) following the work of Kraepelin who was one of the influential people in modern psychiatry (DeVries, Müller, Möller, & Saugstad, 2008; Palm & Möller, 2011). The DSM IV is the fourth edition of the DSM manual, produced as an attempt to classify mental disorders that were ignored in the WHO International Classifications of Diseases (ICD) earlier versions (Möller, 2009). The fifth edition of the DSM was published in 2013.

It is either the ICD or the DSM that is used as a standard diagnostic tool in mental health services. Marshall, Spitzer, and Liebowitz (1999) discuss the evolution of mental disorder from the first edition of the DSM through to the fourth edition, and yet further research is needed to clarify current classifications of mental disorders and the growing list of symptoms

in the DSM V that was released in May 2013 (American Psychiatric Association & DSM-5 Task Force, 2013; Kaplow, Layne, Pynoos, Judith A. Cohen, & Lieberman, 2012). These classifications are operational based and disregard the causes or aetiology of the disorder and:

because of resource constraints, professional dispute, and public concern, the major criterion for attracting a formal diagnosis is not their classifiability according to the DSM-IV-TR, but rather increasingly, that of ‘social risk’, defined in terms of risk to oneself and/or others and embodying obvious social control functions.

(Warelow & Holmes, 2011, p. 384)

Young (2010) reviewed the DSM IV and the proposed amendments for the upcoming DSM V noting that there are some “aspects of the DSM-IV that merit improvement, and there are others that have had no or minor adjustments where major ones or even removal are better options” (Young, 2010, p. 321).

Critique of DSM IV suggests that there are gaps that are important not to ignore in classifications of mental disorders and their criteria. Mental illness is when a person crosses from mentally healthy or wellness to some form of mental distress. Mental disorders are defined by DSM IV as a set of symptoms and criteria for each diagnosis. Mental disorders, therefore, are restricted to only those symptoms identified by DSM IV, leaving some gaps within the mental distress area. For the purpose of the discussion, we can assume that there is a continuum from mental health/wellness to mental distress, determined when one moves across this continuum. Nevertheless, discussions about mental illness in this research refer to the DSM IV mental disorders classifications for its documented defined categories because it is a usual tool used in clinical practice, education, and research and that the critiques that apply to the DSM largely apply to any classification system. It is essential to note that despite

the implementation of mental illness and mental disorder, both terms do not fit the complexities of mental disturbances that mental distress captures. Möller (2009) critiques the DSM and the ICD for the short time frame of their changing of classifications, and how that creates confusion between mental health professionals and the community. This confusion can change diagnosis of long term conditions due to change of classifications and criteria of disorders, and this confusion can also extend to changes in medication (Möller. 2009). Mental distress fits the holistic definitions of mentally un-well which can record the initial point of distress up to the most severe end, and also not confined into the DSM and ICD criteria of mental disorders.

## **Summary**

This chapter reviewed the definitions of health from international levels to Pacific peoples and followed by the mental health component of health. Culture was reviewed and its influences on health and its mental component. The implementations of cultural safety in nursing practices in A/NZ were discussed. Mental illness and mental distress were reviewed and the DSM definitions of mental disorders. The literature suggests that people experience mental health in culturally different ways which reflects how mental illness was (or is) constructed in different cultural contexts. Cultural safety is an approach for health professionals to ensure they are aware of their own culture, and also that of the people they work with.

# **Chapter Three: Mental health, Pacific Island people, Tongans, and Migration**

## **Introduction**

The literature reviewed in the previous chapter identified that mental illness, mental disorder and mental distress are defined and interpreted differently in different societies, cultures, contexts, and over time (Foliaki, 1999; Goffman, 1970; Puloka, 1998; Szasz, 1971; Vaka et al., 2009). This study specifically focuses on one ethnicity, Tongan, for the following reasons. Firstly, focusing on one population minimises the complexity involved in studying diverse groups, while staying focused on the Pacific population. Secondly, it provides the opportunity to explore the meanings of mental illness by using Tongan frameworks using Tongan language. The researcher's own cultural background and Tongan ethnicity contributed to this decision, being an insider with knowledge of the study population, particularly in terms of knowing the landscape of the people and the language. The researcher's insider status – including its potential limitations for the research – is discussed further in Chapter Four in the study design. However, as 'Tongan' remains under the umbrella definition of 'Pacific peoples' in Aotearoa New Zealand (A/NZ), this chapter begins with a discussion about the state of Pacific people's mental health generally in A/NZ, followed by migrant populations, and then moves the focus more specifically to the Tongan population.



## **Pacific mental health and mental distress**

It has been argued that imposing Western and biomedical interpretations of illness on indigenous peoples has increased the prevalence of mental illness and has created chaos in terms of major and far-reaching disruptions, within indigenous communities (Poltorak, 2012; Tamasese, Peteru, Waldegrave, & Bush, 2005; Vaka et al., 2009). Certainly in A/NZ – where indigenous populations from the Pacific are all categorised together as Pacific peoples – the Pacific population tends to lead in inequalities (Statistics New Zealand and Ministry of Pacific Island Affairs, 2011). Tamasese, Peteru, Waldegrave, and Bush (2005) outline this chaos in Samoan society where disruptions and breaches of sacred relationships result in mental distress. Relationships are highly valued in Samoan society and it is important to keep relationships healthy to avoid disruption and chaos. These values and focus on relationships are also relevant to Samoan people when they migrate to A/NZ. While there is a need to fulfil social obligations in Samoa, there are also requirements and responsibilities to comply with in A/NZ, and these pressures may accumulate and contribute to mental distress (Tamasese et al., 2005). *Te Rau Hinengaro* survey identified that there were significant inequalities in Pacific mental health when compared to the general population of A/NZ supports Tamasese et al., 2005 (Oakley-Browne et al., 2006).

Oakley-Browne et al. (2006) conducted *Te Rau Hinengaro*, the New Zealand mental health survey in which Pacific Island populations were intentionally oversampled to ensure sufficient Pacific participants to provide reliable and valid findings for Pacific people. It is important to note that *Te Rau Hinengaro* was a community survey and, as is usual for community surveys, the data did not include psychosis. Statistical information about the prevalence of mental illness in certain groups in A/NZ, including access rates to mental

health services, suicide rates, and the correlation between mental illness and place of birth for Pacific people were provided in the survey results. Pacific peoples were found to have a higher prevalence of mental illness at 25% compared to the 20% of the general population and were also found to be the group with the highest level of suicidal ideation, attempts, and plans. Accessing mental health services was identified as an issue, and it was found that only 25% of Pacific people accessed mental health services compared with 58% of the general population within a twelve months period.

The other significant finding from *Te Rau Hinengaro* was the influence of the environment, and specifically place of birth and migration. Children born in the Pacific who migrated to New Zealand at the age of 18 years or over were reported to have a lower risk of developing mental illness than Pacific children who were born and raised in New Zealand. This finding raises a number of interesting questions about the cause of increased rates of mental illness in Pacific communities, in terms of understanding access to, and outcomes of, health interventions. Kokaua et al., (2009) raise the possibility of more accessibility to alcohol and other drugs in New Zealand with the experience of pressures of adjustment and acculturation, but emphasise that this needs further investigation. Studies on Pacific peoples' mental illness have focused on rates, acuity, and prevalence (Ape-Esera, Nosa, & Goodyear-Smith, 2009; Foliaki, Kokaua, Schaaf, & Tukuitonga, 2006; Oakley-Browne et al., 2006; Simpson, Brinded, Fairley, Laidlaw, & Malcolm, 2003). There is a lack of research to date, however, that questions and seeks to identify what mental illness means to Pacific people; literature discusses Pacific theories of mental illness but with little involvement from the Pacific community to clarify meaning. This lack of research hinders the ability to address Pacific peoples' experiences of mental illness effectively. Further to this, as indicated in the literature, Pacific people in A/NZ are often grouped together, whereas in the Pacific it is

acknowledged that people are from different places and cultures, and whilst there may be similarities, there are also differences in beliefs, traditions, and practices.

The highest levels of health inequalities are found in groups that have poor determinants of health and poor outcomes, such as the highest rates of suicide or prison populations (Fazel & Danesh, 2002; Grann, Danesh, & Fazel, 2008). In a report prepared for the incoming Minister of Pacific Island Affairs in 2008, an ethnic breakdown of the Pacific prison population noted that Samoans account for almost half of Pacific people in prison (47.2 %), Cook Island Māori were 21.6%, Tongans 16.2 %, Niueans 8.3 %, and Fijians 2.9 % (Ministry of Pacific Island Affairs, 2008, p. 10). The prison population have been found to experience depression, antisocial behaviour and suicidal behaviours (Fazel & Danesh, 2002; Grann et al., 2008). Furthermore with the prison population, there are also associations between suicidality and mental distress (Jeon et al., 2010; Searles, Valley, Hedegaard, & Betz, 2013; Tee, Brown, & Carpenter, 2012). People with personality disorders and substance abuse are most commonly seen in prison, where suicidal intent is also high (Fazel & Danesh, 2002; Grann et al., 2008). This demonstrates that there are a significant number of the Tongan population in prison with associated risks of developing mental distress and suicidality.

The *Youth 2000* (Mila-Schaaf, Robinson, Schaaf, Denny, & Watson, 2008) project highlighted a number of issues for Pacific youth including high levels of unemployment and poor health, and that accessing healthcare was a major issue. They found that cost is a major factor contributing to poor access to healthcare and some people generally have low expectations of accessing health services and just “don’t want to make a fuss” (Mila-Schaaf et al., 2008, p. 32). Oakley-Browne et al. (2006) also found poor access for Pacific people, and that Pacific people were found to have the highest incidence of suicidality. Higher rates

of depression and suicide are a factor for migrants, and Tiatia's (2003) work on suicide with Samoan people in A/NZ found that loss of culture contributes to suicidal behaviours (Tiatia, 2012). Tiatia attempted to untangle this health issue and examined it through an ethnic lens, Samoan, where she used "*fa'asamoa* (Samoan way)" (Tiatia, 2012, p. 3), and other Samoan concepts, stating that "New Zealand-born Samoans' beliefs, values, and practices cannot be understood or made fit into a Western mental illness framework" (Tiatia, 2007, p. 95). As Tiatia highlighted, Pacific concepts cannot be understood through a Western lens, it is important, therefore, to apply Tongan concepts and use a Tongan lens when investigating the meanings of mental illness for Tongan people.

Regarding Tiatia's proposal to use an ethnic cultural framework, there is a need to address diversity within the Pacific people, and acknowledge ethnicities and have an ethnicity focused framework. However, despite the need to address diversities appropriately, as recently as 2011 the Ministry of Pacific Island Affairs (MPIA) collaborated with Statistics New Zealand to produce a report on the health of Pacific people as a single, homogenous population with little attention to ethnic diversity (Statistics New Zealand and Ministry of Pacific Island Affairs, 2011). The report notes that the estimated life expectancy rates for Pacific people are lower than the general population of A/NZ, Pacific children are more likely to have hospital admissions (related to poor housing), and that Pacific young people are approximately twice as likely to have mental illness and attempt suicide compared to the general population of A/NZ (Statistics New Zealand and Ministry of Pacific Island Affairs, 2011).

The Ministry of Health *'Ala Mo'ui* document (2010), which discusses strategic plans and highlights priorities and guidelines for Pacific health from 2010 to 2014, also focuses on the general Pacific population with little guidance on ethnic differences and practices (Ministry of Health, 2010a). *'Ala Mo'ui* identifies six priorities areas related to workforce, service delivery, resources and determinants of health, and none of these areas address ethnic diversity. These documents provide evidence that despite these earlier works of Tiatia (2003, 2007), Mila-Schaaf et al. (2008), and Oakley-Brown et al. (2006) recommendations and proposals for appropriate ethnic approaches that reflect the diversity of the Pacific population in A/NZ are still not implemented at government level.

The quantitative nature of *Te Rau Hinengaro* highlights the differences between the Pacific populations and the general population of A/NZ, but does not explain or explore these differences. Several researchers have found that there is a lack of understanding and knowledge amongst Pacific peoples about mental health services (Bathgate & Pulotu-Endemann, 1997) as well as a lack of knowledge about mental illnesses (Bridgman, 1997; Foliaki, 1997). These findings have been incorporated into New Zealand health policies through the Mental Health Commission and the Ministry of Health documents (Mental Health Commission, 1998a; Ministry of Health, 1994, 1997, 2005) in order to identify how to better provide services that people may access.

This current study was prompted by one significant finding in *Te Rau Hinengaro* about Pacific peoples in A/NZ: that Pacific people born in A/NZ are at higher risk of developing mental illness than those born in the islands who then migrated to A/NZ. The initial research question was designed to consider the reasons for the higher risks of mental illness for New

Zealand born Pacific people compared to people who migrated to A/NZ from the Pacific islands. However, as explained in Chapter One, consultation with supervisors and the Tongan community suggested a step back to ask a question that related specifically to people from Tonga, particularly about how mental illness is viewed within this community. As elsewhere in the world, Tonga is influenced by biomedical perspectives that hover over, or are intertwined with, previously existing understandings (Poltorak, 2012). Tongan people have their own culturally influenced interpretations of mental health and illness, and this is the focus of this research project.

It is likely that there is uncertainty in the acceptance of other explanations of mental illness, and it is a long process for the Pacific community to learn and understand these new interpretations and definitions. Acceptance of new definitions by the Pacific community is not always achieved; for instance, some Pacific practitioners trained and educated under the Western and biomedical system hold on to their original Pacific interpretations and definitions, adding them to their learnt Western and biomedical interpretations and definitions (Vaka et al., 2009). The definition of mental illness is, therefore, contextual, influenced by social factors, and different sets of knowledge are interwoven rather than one set of knowledge replacing another. This reinforces the notion that societies define their own norms and values that people should comply with to be regarded as 'normal'. Practices outside these defined norms and values are interpreted as abnormal and referred to as behaving inappropriately and having some form of mental illness or mental distress.

In terms of what is already known about Pacific interpretations of illness, Samoan people believe that there are two types of illness, *ma'i Samoa* (Samoan illnesses) and *ma'i pālangi*

(illness introduced to Samoa by foreigners) (Macpherson & Macpherson, 1990). This Samoan interpretation of intrinsic and extrinsic sources of illness where there are external and internal causes of illness, is echoed throughout the Pacific, and is one consistent cultural belief amongst Pacific nations. In a study of Samoan people experiencing mental illness, all focus groups suggested that mental illness is a result of breaking cultural norms and values and these can go for generations but can be managed through Samoan ways of healing (Tamasese et al., 2005). Tamasese et al. (2005) explains that Samoans have their interpretation of mental illness and also Samoan ways of healing to attend to it. This is shown in the Tongan interpretation of illness discussed in the following section. Tongan people also refer to these two systems in terms of medicines; they are, *faito 'o faka-Tonga* (Tongan traditional medicine) and *faito 'o faka-Pālangi* (Western medicine).

*Faito 'o faka-Tonga* is the treatment of Tongan illnesses often related to the world of spirits, whereas *faito 'o faka-Pālangi* is the treatment of Western diseases such as heart disease, diabetes, high blood pressure and cancer.

(Toafa, Moata'ane, & Guthrie, 1999, p. 160)

This belief is also relevant in the Cook Islands; Laing and Mitaera (1994) explain treatment in the Cook Islands context, and that decisions must be made within families about the combination of traditional and Western medicine used to treat illness. It is a family decision when choosing between indigenous traditional treatment and Western medicine to restore wellness. These family decisions require discussions, consultation with known experts, and the family then decides between indigenous and Western medication.

In Tongan society mental illness is most associated with the world of spirits. Possession by the spirits is called *āvanga* (Puloka, 1999). When people appear to be possessed by the

spirits, Tongan people call on the two systems of medicine, *faito 'o faka-Tonga* and *faito 'o faka-Pālangi*, and this presents a challenge, as making the choice of pathway may prolong access to treatment, even in A/NZ (Vaka et al., 2009). The Tongan way is viewed as more appropriate when working with Tongan people (Fotu & Tafa, 2009) as the Tongan approach addresses the ethnic cultural needs together with the clinical symptoms. There have been attempts in A/NZ to address the mental health needs for Pacific people. Pacific mental health services have been established and Pacific frameworks and models are also in place to inform people who are working with Pacific people.

### **Mental health services and Pacific models of health**

The increasing rates of mental illness in Pacific communities in A/NZ (Allen & Laycock, 1997; Bridgman, 1997; Oakley-Browne et al., 2006; Vaka et al., 2009) is of concern and raises specific questions about the appropriateness of service provision, methods of service delivery, and models of care when working with Pacific people (Lui, 2007). The current health system, designed within the Western and biomedical framework, (Bathgate & Pulotu-Endemann, 1997; Bridgman, 1997; Fotu & Tafa, 2009; King, 2002; Ministry of Health, 1994, 1997, 2005, 2010a), shows little evidence of incorporating and utilising Pacific indigenous knowledge. Recent introductions of Pacific models, concepts, and frameworks such as the *Fonofale model* (Te Pou o Te Whakaaro Nui, 2010), *Pōpao model* (Fotu & Tafa, 2009), *Seitapu* framework (Te Pou o Te Whakaaro Nui, 2007), and the concept of negotiated space (*vā*) (Mila-Schaaf & Hudson, 2009a, 2009b; Samu & Suaalii-Sauni, 2009) have begun to provide alternatives.



The *Fonofale* model is a metaphor which uses the components of a Samoan *fale* (house) to explain the dimensions of health in a Pacific person. These dimensions are culture, family, mental, spiritual, physical and others (Te Pou o Te Whakaaro Nui, 2010). Fotu and Tafa (2009) discuss the *Pōpao* model using the image of an outrigger canoe (*pōpao*) to explain a strength based focus with Pacific perspectives in a recovery phase of mental illness for mental health service users. The development of the *Pōpao* model resulted from a collaboration of Pacific mental health providers and workers with Pacific mental health service users, and uses the outrigger canoe (*pōpao*) components to explain that culture and clinical components are inseparable when caring for a Pacific person. These components are connected through mental health providers and deliveries and these services should be based on the mental health service user's strengths (Fotu & Tafa, 2009). The *Seitapu* framework suggests that a competent worker for Pacific people would be able to maintain a balance at the meeting point of clinical and cultural theories and practices. This framework uses an image of a flower with four petals representing clinical theory, clinical practice, cultural theory, and cultural practice – where clinical and culture run diagonally – surrounding the competent worker in the middle. The clinical diagonal line has clinical theories on one end informing clinical practice in the other end, and the other diagonal line has cultural theories informing cultural practices. The competent worker is positioned in the middle of these four components and able to practice safely, clinically and culturally (Te Pou o Te Whakaaro Nui, 2007). These frameworks emphasise the incorporation of culture into caring for mental illness.

The concept of negotiated space (*vā*) emphasises the importance of relationships in Pacific contexts (Mila-Schaaf & Hudson, 2009b). These approaches aim to inform health providers about the way that Pacific people view health. These approaches are recent developments but

there seems to be continuous issues in their implementation and Samu & Suaalii-Sauni (2009) discuss that there should be some flexibility when working with Pacific populations due to the diverse ethnicities, to address these issues. These models of health need to connect with mental health services in A/NZ effectively to guide services in working with Pacific people (Suaalii-Sauni et al., 2009). This current project addresses the lack of ethnic specific approaches in mental health service delivery. It takes the issue back into an ethnic context to consider existing Tongan perspectives and also proposes an approach (developed in Chapter Eight) to connect Tongan people to services, and includes service delivery strategies appropriate for working with Tongan people.

Despite the higher prevalence rate of mental disorders in Pacific populations, and the role that mental health services play, there remains a lack of evidence about either how well the services meet the needs of Pacific peoples or the reasons for the high rates of mental illness in Pacific populations. While *Te Rau Hinengaro* (Oakley-Browne et al., 2006) identified a number of significant findings about prevalence rates, access to mental health services, high suicide rates, and place of birth and growing up for Pacific people, the reasons behind these significant findings are yet to be explored. Next, the literature around migrant populations is reviewed in relation to mental health as this appears to be a key factor. Similarities and patterns which may be applicable to Pacific mental health and mental distress are discussed.

### **Mental health and mental distress within immigrant populations**

Migration has been found to be a major stressful life event and a contributor to the development or exacerbation of mental illness influencing treatment, rates, and outcomes of

mental illness (Bridgman, 1997; Foliaki, 1999; Haasen, Demiralay, & Reimer, 2008; Kokaua, Schaaf, Wells, & Foliaki, 2009; Lui, 2007; Oakley-Browne et al., 2006; Potter & Phillips, 2006; Vaka et al., 2009). Kelly (2005), for example, discusses how moving to a new environment where individuals have difficulty in establishing social networks is a contributor to mental illness. Individuals have to learn about the new environment and this involves learning about local communities, social structures, economy, political systems, health systems, language, and so forth. These processes of learning require time and resources which can be stressful. Migrant groups, especially economic migrants, are found to be at the lower socio-economic levels, and low socio-economic status is also known to be a contributing factor in presentations of mental illness at a younger age as well as an indicator for lengthy periods of treatment (Kelly, 2005).

Mila-Schaaf (2010) discusses second generation Pacific people's struggle for acceptance within A/NZ society and also their own Pacific community. This struggle highlights and emphasises how identity influences and impacts on mental health. Moving within two cultures and the interface of these two cultures raised some significant issues of acculturation. Haasen, Demiralay, and Reimer (2008) highlight the relationship between acculturation, mental distress, and mental disorder for Russian and Iranian migrants in Germany. Haasen, et al. (2008, p 10) define acculturation as a "process of...adjustment to values and norms of the new society and possibly the loss of values and norms of the society of origin". Berry (1980) cited in (Haasen et al., 2008) defines different forms of acculturation, which include integration, assimilation, segregation, and marginalisation. Integration occurs when norms and values of the new society become merged and intertwined with the norms and values of the society of origin. Assimilation is associated with neglecting the norms and values of the society of origin, whilst adapting and adopting norms and values of the new

society. Segregation occurs when the norms and values of the new society are ignored or rejected and migrants hold on to the norms and values of their society of origin. Lastly, marginalisation results when the values and norms of both the new and the society of origin are ignored.

Haasen, et al., (2008) highlight that each of these forms of acculturation is related to different stressors and also they vary in terms of duration. While Hassen et al. (2008) focused on Iranian and Russian migrants to Germany, these types of acculturation are experienced in migration to any new culture but are subject to the different contexts. Djuretic, Crawford, and Weaver (2007) discuss the migration of people from Yugoslavia to the United Kingdom (UK) and the psychological challenges they face starting from immigration requirements, to ways of living and coping with the UK way of life. In A/NZ the Chinese migrant population explain their challenges with acceptance by society due to their low level of English comprehension and the way it affects employment opportunities where lack of employment is a determinant of mental illness (Abbott, Wong, M., Au, & Wilson, 1999). Mladovsky (2009) discusses these levels of acculturation with migrant populations in Europe in relation to mental distress and highlights the importance of addressing inequalities at policy level. Mladovsky explains how England and Netherlands have more priorities for mental health in comparison to Italy who prioritise sexual and reproductive health. Mladovsky proposes that more research is needed to confirm different needs of migrants and suggests addressing requirements through policy.

While Haasen, et al., (2008) and the other authors focused on migration between countries, El Sendiony, Abou-El-Azaem, and Luza (1977) looked at the relationship between mental

illness and changes of culture in Egypt and found that rates of mental illness increased when people moved from rural to urban areas. Overall, the increase in mental illness may be related to the disruption in the existing social structure that was caused by this movement. This disruption of social structure applied to Tongan migrants to A/NZ where the Tongan social structure shifts a hierarchical system (monarch) to a democracy system in A/NZ. Letting go of one's original knowledge and replacing it with foreign knowledge is not a simple process and can take a long time period of adjustment. It is a complex process as it requires more than just giving up one and adopting another idea. This process is complex and challenging and the change can potentially change the identity of individuals through adopting new ideas and lifestyles.

People of Pacific and Tongan origin who migrate to New Zealand fall into different acculturation categories depending on each individual family's values and beliefs combined with levels of exposure to, and acceptance of, new knowledges (Foliaki, 1997). The relationship between Tongan culture and A/NZ culture conflicts in many ways: Tongan society can be collective and circular while A/NZ society has a more individual and linear focus (see Chapter Eight). The Tongan communities in A/NZ are sometimes formed into groups like churches and villages from Tonga. People live all over Auckland but they go to the church where the people in their village from Tonga worship in New Zealand, even if this means travelling long distances. This can potentially create tension and difficulties for Tongan people to adapt to, and adopt A/NZ culture.

More than half of the Pacific population in New Zealand were born in New Zealand (Statistics New Zealand, 2006a). Kokaua et al. (2009) found that New Zealand born Pacific

populations had higher risks of diagnosis of mental disorders than those born in the islands. The terms ‘New Zealand born’ and ‘second generation’ refer to children of migrants; the latter term is employed internationally and the former is more familiar in the A/NZ context (Mila-Schaaf, 2010). Confusingly, a newer term ‘first generation’ is also used to discuss children of migrants but the term second generation will be used throughout this project to refer to children of migrants.

A study of second generation British-Barbadians who were born and raised in Britain provides an example of the social and psychological struggle for acceptance experienced by the second generation migrant population when returning home to the land of their forebears and ancestors. The research highlights their struggle for social acceptance when they returned to Barbados, the birthplace of their parents, as these second generation migrants were being perceived by the local people as mad (Potter & Phillips, 2006). The authors describe how cultural interpretations contribute to mental illness. Activities like walking in the sun and sunbathing on the beach were interpreted as being out of the ordinary and abnormal in Barbados and translated as odd behaviour or some form of mental illness. The local Barbadians usual behaviour is to walk in the shade and avoid the sun, going to the beach for gathering food, fishing, or swimming. Functional speed and operating tasks and activities were also identified as indicator behaviours; local Barbadians operate at a slow and calm rate while their British-born counterparts tended to speed things up. When local people observed their young British-born relatives and friends behaving differently from the local norms, the interpretation was that those who were British-born were displaying abnormal thinking and so the young people were labelled as being mentally unwell.

Some of these issues are experienced elsewhere by migrant populations and can be extended to the Pacific population as well, especially issues of identity among the second generation Pacific people in A/NZ. Mila-Schaaf (2010) writes about how second generation Pacific people in A/NZ struggle with negotiating how they belong in their respective communities. One participant in her research said

Here I am proud Samoan and I tell you what, when I go back to Samoa. I know how you feel when you go to Tonga, or you know, to your roots back in Samoa. They don't see you as a Samoan. They see you as something quite different. Now like I said, I always grew up being called: "You're not Samoan are you?" ... They can pick up the Kiwi accent in Samoan. So, in New Zealand, I am extremely proud of my Samoan-ness. And back in Samoa? Yeah, I am proud of being Samoan. But also, they make it quite clear that I'm also something else. I'm Samoan and a New Zealander.

(Mila-Schaaf, 2010, p. 224)

As with the Barbados example above, Mila-Schaaf also mentions and expands on the differences in the speed of life in different environments, especially movement from rural to urban areas and also from the Pacific to A/NZ.

When I go to Tonga, and I do so quite regularly, I come to appreciate what Tonga is about. When I go to the village I think "wow things are really simple here". Then I go to *Nuku'alofa* [the capital of Tonga] and think "wow things are a bit faster here" and then you hear of people coming from the village straight to Auckland even to Mangere – you can only imagine what these people are thinking; that life around them is extremely fast! You can see why all these problems are rising so rapidly.

(Mila-Schaaf, 2010, p. 67)

Mila-Schaaf challenged Stillman, McKenzie, and Gibson (2009) who argued that migration from Tonga to A/NZ has economic gains and improves mental health. Stillman, McKenzie, and Gibson (2009) used income and employment as indicators of mental health which is different from Tongan researchers such as Māhina and Bloomfield whose definitions include intergration of social and spiritual relationships into mental health (Bloomfield, 2002; Māhina, 2002a).

The discussion began with issues of mental health and illness, followed by a focus on Pacific people and migrant populations. The review now focuses more specifically on Tongan people and the Tongan population in A/NZ, including the literature related to the mental health and mental disorders of Tongan people. The term mental distress will be used as well to cover those aspects outside definitions of mental disorder and their criteria presented in DSM IV. The DSM IV covers diagnosis of mental disorders like Schizophrenia and Bipolar Affective Disorder and risks missing out mental distress like *lolo mai* (Lasalo, 1999) which are not identified by the DSM IV.

***Vale, puke faka-‘atamai, mahaki‘ia faka-‘atamai amongst Tongan people (Mental health and mental distress amongst Tongan people)***

In traditional Tongan society it is/was believed that mental illness is associated with evil spirits, with healing as an attempt to get rid of the spirit through the use of powerful smelling leaves that “are said to *namu tēvolo*, smell like a ghost or spirit; consequently they have the power of scaring off ghosts” (Collocott, 1923, p. 138). A potential tension is created



in assessments and treatment when Western and biomedical definitions of mental illness are imposed on Pacific communities' traditional definitions and interpretations. The current mental health system assesses Tongan people through a Western and biomedical lens, and treatment is based on these assessments. This again highlights the importance of exploring the meaning of mental illness for Tongan people as a starting point to ensuring that the care is based on accurate and relevant information.

This research project poses the question: what is the meaning of mental illness for Tongan people in New Zealand? The Tongan population is increasing rapidly (Statistics New Zealand, 2006b) and the World Health Organisation (WHO) predicts that mental illness will be world's second major cause of disability by year 2020, next to heart disease (World Health Organization, 2001). The question raised by this research project is long overdue as rates of mental illness have been increasing (Oakley-Browne et al., 2006; Vaka et al., 2009) and management of mental illness has largely focused on designing appropriate Pacific cultural tools to inform health services about working effectively with Pacific people (Crawley, Pulotu-Endemann, & Stanley-Findlay, 1995; Fotu & Tafa, 2009; Ministry of Health, 2010a; Samu & Suaalii-Sauni, 2009; Te Pou o Te Whakaaro Nui, 2007). These suggest that health services are working with Pacific people using culturally appropriate tools but fail to question their levels of understanding and interpretation of the illness. This failure needs to address to clarify illness and more importantly, to address this question at the ethnic level to address the diversity of Pacific peoples. This is why this project explores the meaning of mental illness for Tongan people in A/NZ.

Dr Mapa Puloka, a renowned Tongan mental health clinician based in Tonga and the driving force for mental health in our Tongan community, first started to uncover Tongan concepts related to mental illness (Puloka, 1998, 1999). Puloka states that Tongan people interpret mental illness from cultural perspectives rather than Western biomedical perspectives. If an individual experiences mental illness and manifests some active psychotic symptoms such as hearing voices, visual hallucinations, fixed false beliefs as delusions and paranoia, many Tongans attribute this to a Tongan illness known as *‘āvanga*

which is couched in culture specific idioms. It has mystical phenomena with a pathological manifestation that is characterised by dissociation. *‘Āvanga* in its popular Tongan conceptualisation means an acute short duration sickness caused (or believed to be caused) by a spook. (Puloka, 1999, p. 268)

Puloka (1999) proposes a model of *‘āvanga* which is determined by psychosocial and ecological factors where one is being psychologically moved from one geographical area, usually home, to another, a place of peace like the bush or the beach. Puloka dissects the word *‘āvanga* into three components, *‘āvea*, *‘ave*, and *‘anga*. Puloka defines *‘āvea* as spirited away, *‘ave* as carried away, and *‘anga* refers to place, fitness, and suitability. He refers to *‘āvanga* as a form of horizontal abduction where one is abducted through being spirited (*‘āvea*) or carried (*‘ave*) away to a new place (*‘anga*) of peace. Toafa, Moata'ane, and Guthrie (1999) support Puloka in the Tongan cultural interpretation whereby mental illness can be a “spirit related illness (*mahaki faka-tēvolo* or *fakamahaki*)” (p. 161), in which mental illness is related to dead peoples’ spirits who are associated with these abductions. It is important to note the complexity of describing mental illness in Tonga, as noted by Toafa, Moata'ane, and Guthrie (2009) who support Puloka’s cultural interpretations, and extend the translation of mental illness in Tongan words, *‘āvanga*, *mahaki faka-tēvolo* and *fakamahaki*. These terms

refer to the notion that the afflicted person has been possessed by a spirit, or *mala* which means cursed, or that s/he has broken a *tapu* (or taboo) and is suffering the consequences of having broken that *tapu*. This is not unlike the Māori understandings of *mana*, *tapu*, and *noa* (Durie, 2007; Shirres, 1992), that refer to things that are sacred and regarded as cultural norms and practices which passed through generations.

Foliaki cited in Bathgate and Pulotu-Endemann, (1997) extended the Tongan explanation of mental illness to include attitudes and behaviour, psychotic and/or eccentric behaviours – sometimes referred to as *fakasesele* which literally means stupid, fool, idiot, silly – and *angaangaua* meaning two characters or personalities with *anga* as the Tongan word for behaviour and *ua* meaning two (Bathgate & Pulotu-Endemann, 1997). In summary then, Puloka (1999) provided the explanation for the horizontal movements across geographical areas through spiritual and physical abductions, while Foliaki introduced the Tongan terminology for explaining those behaviours.

Puloka's background as a medical doctor is reflected in his work where his interpretations of mental illness from a Tongan traditional perspective are based on the DSM IV criteria and guidelines. For example, his Tongan translation for Bipolar Affective Disorder is '*āvanga fēmaleleaki* (Puloka, 1999, p. 274). '*Āvanga* is related to possession by a spirit and *fēmaleleaki* literally means running forward and backward abruptly, unsteady, or back and forth. This captures the DSM IV criteria for Bipolar Affective Disorder (BPAD), to have one depressive episode and one a manic episode or mix of episodes (American Psychiatric Association, 2000). Schizophrenia is translated as '*āvanga motu'a* or old '*āvanga*, referring to its development, as to give a diagnosis symptoms must be present for a period of six

months. Puloka explained the nature of mental disorders in the Tongan language, and adapted it to fit the Western biomedical explanation and criteria defined in DSM IV.

Mafi, who practiced as a general practitioner in Tonga, reports that people present with mental disorders only when it “affects their ability to carry out the ordinary duties of life, or it produces physical symptoms which induce fear of serious physical disease” (Mafi, 1999, p. 196). Lasalo (1999) agrees with Mafi and writes that Tongan people struggle to express mental illness and often present with physical somatic complaints. Lasalo, who was a medical doctor and worked regularly at the outpatient department in Tonga’s main hospital, *Vaiola* Hospital, discusses an illness that Tongan people called *lolo mai*, which is associated with feelings of numbness, loss of energy and concentration, and abdominal pain with difficulty breathing. These symptoms are consistent with the criteria for depression and anxiety and Lasalo confesses that he has

never met a Tongan who would outwardly say, ‘I am anxious or I am depressed (*mafasia*)’, ... a European handles a stress – he intellectualises it and says to himself, ‘I am depressed’. A Tongan on the other hand tends to internalise the concept and is dealt with as a somatic (physical) feeling and says ‘I have a pain in the chest’ rather than ‘I am so depressed my heartaches. (Lasalo, 1999, p. 260)

Going back to Puloka’s work, Māhina extended it from psychological and ecological into sociological and anthropological perspectives combining attitudes, behaviours, and relationships (*vā*) (Māhina, 2002a, 2008). Māhina argues that maintaining good behaviours and attitudes maintains good *vā* within the Tongan society; disruption of *vā* on any level – individual, family, community, and so forth – will create disharmony and chaos and

contribute to triggering and causing mental illness (Māhina, 2002b, 2008; Māhina, Māhina, & Māhina, 2007; Poltorak, 2007).

Māhina also looked at the Tongan concept of *vale* or ignorance, and how *vale* and *sesele* (silly/eccentric) are used in the Tongan context – both in Tonga and outside of Tonga – and their relation to mental illness. The terms *vale* and *sesele* are used interchangeably for mental illness. The word *vale* is also used for young children's inexperience, as '*tamasi'i vale*' (inexperienced/innocent boy), at times often excused as '*kei vale*' which means 'still a child', unskilled and uneducated (Māhina, 2008). This interpretation extends to education where the individual collects information, as in '*ilo* (knowledge production) and *poto* (knowledge application). In education, *vale* refers to a person who is unskilled and inexperienced (Māhina, 2008). *Vale* therefore refers to inexperience and inability to cope which can be related to the nature and symptoms of mental illness.

The words *vale* and *sesele* are also regular terms in the art of Tongan poetic writings. These words are used in numerous occasions in the *hiva kakala* (love songs) genre as *heliaki* (metaphors) explaining the poet's love sick heart in a metaphoric sense. For instance, '*Isa! teu vale 'ia loufātai* says "Alas! I am mentally obsessed for a *fatai* leaf" (personal conversation with Māhina, 2010). *Vale* and *sesele* in this poetic expression somehow reveals that the person's feelings and emotions are at a stage of hopelessness, uselessness, and worthlessness when being in love or being denied. This is noted in the work of Queen Salote's songs and poems which are written and translated into English by Tuku'aho, Taumoefolau, Kaepler, and Wood-Ellem (2004):

*Tataki e singa pea u ofo* (Near daylight I awoke),  
*Pea u pehē ko e hā ē* (wondering what was amiss)  
*mate 'ofa fau 'i hoku loto'* (my poor heart was overcome),  
*ne to 'oa 'o hangē ka vale* (overwhelmed as if going crazy)

(p. 156)

Queen Salote composed in *Lotoleveleva*, a place where she took her son, Tuku'aho, whom she lost to an illness. *Vale* is used here as expression of experiencing loss and going through feelings of low mood, disorientation, denial, and crisis. These feelings are consistent with the DSM IV symptoms of mental illness, specifically depression. *Vale* has, therefore, been shown to have a complexity of meanings which are not easily translated and which are heavily associated with behaviours and attitudes. There is no doubt, however, that *vale* refers to what society defines as 'abnormal' behaviours and attitudes, which is consistent with the notion of mental distress, mental illness and mental disorder. With this consistency, it is important to note that *vale* also refers to inexperience and ability to learn and improve skills, become experienced and no longer referred to as *vale*. This research project however, focused on the mental illness-like component of *vale*.

The causes of higher rates of mental illness in particular ethnic groups are complex, and the debates about them relate to ongoing health, economic, and social inequalities experienced by particular populations (Durie, 1998). In addition, increased access to mental health services through justice routes and lower rates of community and in-patient use suggest some problems for Pacific Island people accessing the mental health services in A/NZ (Oakley-Browne et al., 2006). Mental health practitioners increasingly acknowledge the need to understand broad social and philosophical influences on practice to better inform clinical interventions and increase the possibility of improving outcomes for mental health service

users (Crowe & Carlyle, 2007). A significant issue, therefore, for mental health service providers is how to better meet the needs of people who are at risk of being marginalised due to cultural and language differences. A first step in meeting any cultural needs in the area of mental health care is to understand how mental health and illness are defined, understood, and experienced by particular groups, especially by those groups whose world view may differ from the prevailing, usually Western, constructions of health and illness. Another important aspect to consider is the managing of these health issues in these cultural contexts. Poltorak (2012) argues that the efficacy of indigenous healing and treatment have received little attention and is not a priority for investigation due to the dominance of the Western and biomedical movement.

Poltorak is a medical anthropologist who did his fieldwork in Tonga in 1998, stayed for 18 months and has been visiting Tonga regularly with his last documented visit in 2011. During this time he has worked with traditional healers, health workers and patients in Tonga (Poltorak, 2010, 2012). Poltorak discusses the effectiveness of Tongan healers and how Tongan healers attended to illnesses that the hospital system was unable to look after and even those who are “*tali mate*, a state of waiting for or expecting death” (Poltorak, 2012, p. 272). Healers included social reintegration through monitoring of appetites for example, and monitoring how the patient recovers and resumes normal social activities. Traditional healing in Tonga was recognised by the WHO after a WHO Mission Report on Tonga’s mental health completed by Anthony Williams in 1993 (Poltorak, 2012). This resulted in Tonga’s Ministry of Health hosting workshops with traditional healers for care collaboration (Poltorak, 2010). Poltorak highlights the power of healing and believing and also the powerful Christian influences in Tongan life, one of his study participants quotes

the most important thing about healing is one's faith in it. The power of that treatment comes from God. The most important thing about the healing I do is that the power of my treatment does not come from expertise like doctors who go and study and get a degree. The healing I do, I close my eyes, I pray, and God gives me the power and the knowledge to carry out the healing. The most important thing about Tongan healing is that it is divine. That is something that Tongan people still have faith in. I am merely the instrument. God gives me the power to do his work. (Poltorak, 2010, p. 6)

Māhina (2002a) adds to Poltorak the Tongan process of healing where it has three stages, *tofoto 'o*, *faito 'o* and *tukuto 'o* which capture the *sino* (physical), *'atamai* (mind) and *laumālie* (spiritual), the components of health in Tonga (Bloomfield, 2002). The spiritual dimension covers social relationships between/with the living and also the world of the supernatural which is emphasised by Poltorak in his social reintegration. *Tofoto 'o*, *faito 'o* and *tukuto 'o* works on removing the symptoms and enables the patient to move back to their social identity and background. This process of healing will be discussed in further detail in Chapter Eight with the theory of *tā vā* of reality which is based on time and space. *Tā vā* theory of reality assists in explaining Tongan ways of thinking and interpretation, and contributes to Tongan constructions of mental health and illness.

Overall, there is a paucity of literature about Tongan constructions of mental health. The notable exceptions to this would be writing by Puloka (1998, 1999), Foliaki (1997, 1999; 2006), Bloomfield (2002) and Poltorak (2007, 2010, 2012). It is important to note that there is a growing body of scholarship about Tongan knowledge, concepts and constructions, however, to a large degree this is concentrated in the field of education (Kalavite, 2010;



Manu'atu, 2000; Thaman, 2004; Vaioleti, 2011). Also a recurring theme in this literature is an emphasis on holistic approaches to well-being, the inclusion of spirituality and a distinctively Tongan way of conceptualising knowledge (Kalavite, 2010; Manu'atu, 2000; Vaioleti, 2006). In particular, the concept of *vā* (Mila-Schaaf & Hudson, 2009a), and *tā-vā* theory of reality has been theorised in relation to health and wellbeing (Māhina & Potauaine, 2010), as well as specifically mental health (Bloomfield, 2002; Mila-Schaaf & Hudson, 2009b; Poltorak, 2007).

## **Summary**

This chapter has provides a review of the literature related to mental health and illness, distress, and disorders experienced by Pacific people and migrant populations, with a focus on Tongan people. It identified that people experience mental health in culturally different ways. The literature on ethnic Pacific communities highlights the importance of considering collective, circular, and plural approaches when working with Tongan and Pacific people. The biomedical and Western influences and how they dominate the health system are consistently noted in the literature. Pacific models and frameworks have been introduced and implemented in the health system, however, these models overlook diverse ethnic and cultural needs and there are still gaps for individual ethnic groups, between these models and the delivery of mental health services. This highlights that in order to ensure that all mental health issues are addressed safely and not lost in the diverse Pacific setting, there is the need to take ethnicity into account when managing mental health and illness. Fundamental to doing this is the need to explore the meanings of mental illness for these diverse populations

and particularly Tonga, as there is a significant gap on Pacific mental health and healings identified in this review.

## Chapter Four: *Tufunga Fekumi* (Research Design)

### Introduction

Given the Pacific mental health issues raised and discussed in the literature review, and the Oakley-Browne et al. (2006) findings discussed in Chapter Two and Three: Pacific people in Aotearoa New Zealand (A/NZ) experience higher rates of mental illness than the general population, poor access to mental health services, higher risks of developing mental illness in New Zealand born Pacific, and high rates of suicide attempts and self-harm for Pacific people, it is important when conducting research into Pacific mental health to use a Pacific framework to inform the research methods. As Tiatia (2007) pointed out and as discussed in Chapter Three, Pacific concepts cannot be understood through Western and biomedical frameworks. This chapter presents the research design for this project, including the aims of the research, methodology, methods, and detail of how the research was undertaken. I use *tufunga* (construction/design) *fekumi* (research), as design is a form of planning, construction and creation of the research.

The concept of *talanoa* is fully explored including its position as the conceptual framework that informs the research, its use as a method for collecting the data, and the choice for its utilisation is discussed. Ethical issues related to this research are considered and discussed. An explanation of participant selection and their participation in the research is provided. Issues of credibility and validity in this research will be discussed including the researcher's role as an insider, and validity. The approach to data analysis using 'thematic analysis' is also discussed, and an outline of the three themes that emerged from this analysis is presented.

The seven *talanoa* groups are also discussed in this chapter, with an overview of each *talanoa* group.

Researching mental illness can be sensitive and fraught and therefore, requires safe and appropriate methods of investigation. Fundamental to the exploration of complex notions such as the construction of mental health and/or illness, is the need for a culturally sound and acceptable research methodology (Cunningham, 2000; Smith, 1999; D. Wilson & Neville, 2009). The Tongan indigenous models of *talanoa* and *tālanga* were explored and *talanoa* was utilised as a conceptual framework to inform this study and provide a culturally appropriate way to dialogue and gather data from Tongan people (Fonua, 2005; S. Halapua, 2002; W. Halapua, 1997; Otsuka, 2006; Robinson & Robinson, 2005; Vaioleti, 2006; Williams, 2009). A qualitative methodology was considered appropriate for this investigation due to its exploratory nature and ability to examine participants' interpretations of the subject matter in depth (Denzin & Lincoln, 2011; Silverman, 2001). This research, therefore, used a qualitative approach informed by the Tongan cultural framework of *talanoa* to focus on Tongan people and mental health and illness. *Talanoa* and *tālanga* will be addressed in detail later in this chapter.

## **Aims of the research**

The overall aim of this research is:

- ❖ To explore the meaning of mental illness for Tongan people in A/NZ.

The research question is:

- ❖ What is the meaning of mental illness for Tongan people in A/NZ?

## **Research procedures and conceptual/cultural framework**

Mental health service providers who come into contact with people from different cultures are often in a position of learning from the person and their family, to ensure their practice is guided by openness and respect for the person and their social role (Cross & Bloomer, 2010). In Australia, A/NZ, and the United States one group of people who experience mental health in culturally different ways are people who have either migrated from Pacific island countries, or are of Pacific descent (Oakley-Browne et al., 2006; Stillman et al., 2009). Both groups of people could be said to be still very connected to their Pacific culture (Hau'ofa, 2008). Some countries such as A/NZ have specific policy initiatives, such as *Le Va* (Te Pou o Te Whakaaro Nui, 2007), to inform cultural competence for mental health workers in contact with Pacific people. There has also been the development of specialist services where people of particular cultures wish to be treated in order to bring together the potential benefits. *Le Va* produced *Talking therapies for Pasifika people* (Te Pou o Te Whakaaro Nui, 2010) to inform how to work with Pacific people in mental health and addiction services. These guidelines

highlight a concept called *talanoa*, which is familiar to people from Samoa, Tonga, and Fiji. *Talanoa* generally means talking or conversation where *tala* means to tell or told and *noa* means zero or sense of harmony (Te Pou o Te Whakaaro Nui, 2010).

The overall approach selected for this research was qualitative informed by the culturally appropriate Tongan concept of *talanoa*. The Tongan concept of *tālanga*, which refers to formal and structured conversations (Vaka‘uta, 2009), was considered alongside *talanoa*. *Talanoa* was chosen as a conceptual framework because of its openness with no strict agenda and therefore was deemed a more suitable approach (Robinson & Robinson, 2005) than *tālanga* for data collection in this research project. The formal and structured characteristics of *tālanga* make it potentially restrictive and prescriptive and, therefore, less suited to this research project than *talanoa*. *Talanoa* was used in the data collection stages for introducing the researcher and the research project to the participants, and for getting to know the participants and their environment. *Talanoa* ensured strong connections between researcher and participants, built rapport and a trusting relationship, and enabled the gathering of extensive data from the research participants’ *loto* (heart/soul). The following sub-sections provide a more detailed discussion of *tālanga* and *talanoa*.

### ***Tālanga***

*Tālanga* has similar characteristics to *talanoa*, and both concepts refer to talking and conversation. However, *tālanga* is more formal in nature, has an agenda and is more structured. Vaka‘uta (2009) discusses *tālanga* as a contraction of *tā* and *langa*. *Tā* is defined

by Churchward in the Tongan Dictionary as “to hit, strike, beat; also *tāa* ‘i to beat, to chop, to cut or carve” (Churchwood, 1959, p. 436). *Langa* is defined as ‘to raise’ or ‘rise up’. *Langa* also refers ‘to build’ and Vaka‘uta (2009) defines *tālanga* as an idea or issue introduced and also the process of how it is discussed, chopped, cut, carved, and, most importantly, built from to greater meaning. Vaka‘uta also extends his definition to place of conversation in *tālanga* which is consistent with Māhina’s interpretation and both discuss *tālanga* as a combination of *tala* ‘tell’ or ‘told’, and *‘anga* which is a suffix used to explain ‘a place’. Māhina then defines *tālanga* as a place where people exchange words and ideas; for example, in ceremonial *kava* ceremonies where talking chiefs (*matāpule*) converse using the Tongan formal language. Thus, the formal nature and structure of *tālanga* would restrict the exploratory purpose of this research project and *talanoa* was regarded as more suitable.

Vaka‘uta (2009) opted for *tālanga* over *talanoa* and critiqued *talanoa* for its monological nature and lack of structure as in “*talanoa mo e loto* (to converse with one’s heart)” (Vaka‘uta, 2009, p. 130) , where an individual converses within themselves or their own heart. The lack of structure of *talanoa* is said to result in a loss of focus. However, I take the monological nature and lack of structure raised by Vaka‘uta as strengths in this research project. The monological nature of *talanoa* is where the individual can reflect and discuss matters with their own *loto* (heart) before responding in the *talanoa*. The lack of structure allows space for sensitive subject matters, such as mental illness to find its way to the participants and also vice versa - participants accept mental illness as the topic of investigation and conversation. This is a non-threatening approach to introducing such sensitive subjects as mental illness, to indigenous populations like Tongans. Despite the criticisms of *talanoa*, I argue that it is a suitable Tongan framework for this research due to its openness, non-threatening approach, and ability to get to the *loto* (heart), its capability to

reflect with the *loto* (heart) to provide answers from the *loto* (heart), and also its non-commitment to particular structures or sequences, providing spaces for information where data can be generated for analysis.

## ***Talanoa***

As has been discussed previously, Tongan people have their own explanations, meanings, and definitions of mental illness which may differ markedly from the Western views of medically-oriented clinicians. This exploration regarding Tongan mental illness required depth and an approach that enables access to the Tongan *loto* (heart of the issue) to gather data for analysis. The concept of *loto* is one which can be difficult to grasp and translate, to present in English. *Loto* literally means inside, which can be referring to inside our body or our inner beings. Vaka'uta (2009) and Halapua (2002) discuss it as the heart. I propose that it is more than the heart as it is associated with emotions and I am using heart and soul for *loto* in this project but these words do not capture the essence of the *loto*. This illustrates how there have been challenging issues throughout this project due to undertaking work in two languages and an attempt to maintain accuracy when translating between Tongan and English.

*Talanoa* has been used in previous studies (M. Latu, 2009; Toluta'u, 2008) and has been reported to be effective for Tongan and Pacific peoples (Otsuka, 2006; Robinson & Robinson, 2005). The Tongan academic Dr Mo'ale 'Otonuku writes about the circular and collective (discussed further in Chapter Eight) characteristics of *talanoa* which suit Tongan ways of



thinking ('Otunuku, 2011). *Talanoa* aims to keep an open discussion with participants to explore all possible meanings, explanations, and definitions, in this case, related to mental illness.

*Talanoa* is a traditional and conventional way of developing and revisiting knowledge within Pacific cultures, as everything was and is told (Fonua, 2005). Tongan history is passed on orally from generation to generation through *talanoa* (Fonua, 2005), and occurs within groups where stories are constructed to gain consensus about an idea, and to explore meanings and associations of any given topic. Tongan economist and parliamentarian, Sitiveni Halapua (2002, p. 1) who used *talanoa* in reconciling political conflicts in Fiji, discusses *talanoa* as face-to-face conversation and explains how the *tala* component “embodies our understanding of the inner feeling and experience of who we are, what we want, and what we do as members of a shared community”. Halapua, in an interview with Fonua (cited in Fonua 2005), explains *noa* as meaning “zero or without concealment”. Māhina (2008) explains *noa* further as the mathematical zero, or the point where the x and y axes meet. That is, *noa* represents the point where agreement is usually achieved and a sense of balance and harmony is established. Arriving at *noa* can be difficult and requires the discussion and negotiation of multiple perspectives. Social roles and status, as well as family roles, play a part in how and by whom the *talanoa* is led, and who agrees to participate. The leader of the *talanoa* balances the inclusivity of participants with developing consensus about the issue within the group, while achieving depth in the discussion.

Although the core meaning of *talanoa* is talking, its practice is dependent on factors such as social status, customs and rituals, language, personality, and professionalism ('Otunuku, 2011). These factors largely determine the topic of the conversation and the depths to which

it will go. For example, a group of Tongan people working in health areas can *talanoa* in depth around health issues using health language and terminologies and these *talanoa* will be inappropriate in a community context with people who do not work in the health professions.

*Talanoa* brings stories from the heart, and is a friendly and informal approach. However, formal settings and gatherings like *fono* (village and/or family meetings), family wedding proposals, funerals, and informal settings like *kava* social clubs, catching up with friends, and gossiping all use the process of *talanoa* to communicate as well (Fonua, 2005; S. Halapua, 2002; Otsuka, 2006; Robinson & Robinson, 2005). *Talanoa* aims to facilitate inclusivity by making participants feel comfortable and able to contribute, which is achieved by the process of *talanoa* managing the barriers within the Tongan hierarchy, power is diffused and people see each other less in their roles or positions of power and more as equals (Jensen, Johansson-Fua, Hafoka-Blake, & 'Ilolahia, 2012; Marcus, 1980). In the context of research, participants are accepted as having not only diverse views but diverse ways of contributing to the processes of data gathering which means they can *talanoa* freely and share information.

*Talanoa* discussions can be wide-ranging with no boundaries when talking about a chosen subject. There are no restrictions on contributing from any perspective and participants are free to choose how they wish to *talanoa* about the subject; for example, they can consider the big picture, or focus on a part of the subject, or related histories, legends, functions, utilisations, and applications. A subject can be explored through multiple levels and layers due to the freedom that *talanoa* provides and it is acceptable to have various levels of involvement.

*Talanoa* is usually constructed through stories around the subject matter. For example, if the subject matter is ‘coconut’ then the *talanoa* is built around how everyone knows and describes the coconut, its history, uses, parts, trunk, leaves, and fruit. When Pacific people use *talanoa* it is to (re)connect with the subject matter using phrases such as: *I/We have, I/We know, I/We saw, I/We hear ...* which draw the subject matter to themselves and constructs knowledge about the subject matter from their experiences and knowledge (‘Otunuku, 2011). In the construction of knowledge about the subject matter through *talanoa*, most stories have similarities which, when shared by *talanoa* participants, lead them to present their experiences in terms of life, culture, professionalism, and other ways of knowing. To use the example above, some may contribute on the position of the coconut tree within the forest amongst other trees, vegetables, fruit, or as it relates to the land and people and how they relate to one another. Some people in the *talanoa* will choose to dissect the subject matter and observe it, critically analyse and contribute to the content and structure of the coconut; for example, one can dissect the coconut fruit and *talanoa* about the parts of the coconut fruit – coconut husk, shell, flesh, and fluid – providing some historical background, associated legends, utilisations, and experiences. These *talanoa* may include functions and contributions of a particular part or parts of the coconut fruit to the coconut fruit as a whole, the coconut tree, the land, and the people. These *talanoa* somehow cover the subject matter in a descriptive and circular manner; observing the whole and its components, its physical and geographical location, status from different angles, studying its shape, nature, and characteristics. These contributions are told using stories from life experiences, and observations. All these components of the subject are examined through *talanoa* via stories from participants.

Participants may also wish to observe *talanoa* without making verbal contributions and offer non-verbal cues throughout the *talanoa*. These non-verbal cues, like nodding and body language, encourage speakers to keep on talking until they arrive at a *māfana* (warm) and *mālie* (harmonious/well done) state (Manu'atu, 2000). Gunson (1993, p. 149) records how a Pacific “listener knew what the speaker meant by perhaps the rise of an eyebrow, an expression of the face, a tilt of the head, or a description moulded with fingers”. These non-verbal expressions lead the *talanoa* to *māfana* (warmth) and *mālie* (harmony/well done). The *māfana* (warmth) and *mālie* (harmony/well done) rest in the *loto* (soul/heart), and non-verbal cues shine light and guide the way to the *loto* through *talanoa*.

When arriving at the *loto*, the essence and true opinions about the subject are revealed. Halapua (2002) describes *loto* as the essence of the heart where true opinions rest and so it is necessary to reach the heart when it comes to questions around experiences, attitudes, views, meanings, definitions, and beliefs as we need depth to get accurate perspectives. The essence of the heart explains true opinions but I also note my earlier proposal regarding the challenges of presenting *loto* in English due to the difficulties of direct translation. Halapua (2002) acknowledges that trying to get to the *loto* is time consuming, but argues that it is important to get there as it is more valuable to get a small input from the *loto* in comparison to lots of superficial information from the surface which could be inaccurate and ineffective (Fonua, 2005).

The role of the researcher using *talanoa* is to facilitate the telling and collection of stories, and to extract the required information and deconstruct it into themes linked to the research question, and to then re/construct knowledge about the subject with information collected

from the *talanoa*. A good relationship between the researcher and the researched is required to provide a solid platform and safe environment for *talanoa*, which is necessary when asking a community to construct knowledge especially about sensitive subjects such as mental illness and distress. The establishment of good relationships starts when the researcher and participants first meet and includes introductions, presentations, verbal, and non-verbal communications. Like the Māori *mihimihi* as a way of introduction, Pacific people add family genealogies to their introductions: this includes grandparents, parents, and *kāinga* (extended family) when appropriate. The inclusion of genealogies emphasises the connection to the land, landscape, society, *kāinga*, and people, and also demonstrates the relationships and interconnections within the group. Once the connection is established, rapport and trust follow, and 'ofa (love) is felt in the atmosphere which, in turn, creates an atmosphere of *māfana* (warmth) where everyone can communicate freely and exchange information, experiences, and knowledge and fresh data will flow straight from the *loto*. So *talanoa* enables participation in the way that the participant wishes, sets the connections within the group which promotes good relations, delves deep to uncover rich data, and builds consensus within the group around a topic. The discussion may be very broad, at times related and at times unrelated to the topic, but all is viewed as a necessary process to build knowledge.

*Talanoa* was used in Tonga by Tongan researchers to investigate Tongan women's experience of domestic violence (Jensen et al., 2012). Domestic violence is a sensitive topic and *talanoa* was very effective in terms of getting in to the participants' *loto* and to collect in depth data. In that study, different levels of abuse were reported and *talanoa* allowed these women to share right from their *loto*. One participant shared how she was used subjected to abuse in her relationship with her husband and this was supported by her parents, who locked her in the room with her husband to fulfil her sexual duties (Jensen et al., 2012). That level of

sharing sensitive information from what has been happening in her *fale* (house), on the *fala* (mat) in her locked room reflects the depth *talanoa* provides in research, as violence and sex are not topics that can be openly discussed in the Tongan society. This *talanoa* demonstrates how Jensen et al (2012) were able to get to this participant's *loto* and able to gather this important information for their research. This example clearly shows that *talanoa* can be a powerful and appropriate tool for working with sensitive issues for Tongan participants in research.

Vaioleti (2011) discusses the power of *talanoa* through relationships of *talanoa* participants. He emphasised the strength of *talanoa* through its ability to instruct, narrate, tell stories and have able to “create an ideal sense of being for a Tongan which is one who is balanced spiritual social being who is at harmony with self, family, the environment and his/her God/s” (p. 14). However, Vaioleti argues that *talanoa* can only be effective and powerful when there is good relationship between the teller and listener. Vaioleti highlights the significance of *talanoa* in relationships and also a sense of being a Tongan within any society.

*Talanoa* teaches Pacific people about society and its landscape, with its many layers, structures, dynamics, and boundaries and, therefore, about connection with the land, society, *kāinga* (extended family) and, most importantly, about identity (Fonua, 2005). *Talanoa* is used throughout the Pacific as a research approach (McFall-McCaffery, 2010; Otsuka, 2006), a teaching approach (Kalavite, 2010), and when seeking solutions to complex social issues (Ministry of Social Development, 2012). *Talanoa* has also been employed in research to explore many areas including health (McGrath & Ka'ili, 2010), and business (Prescott & Hooper, 2009). Halapua (2002) urges Pacific people to use *talanoa* to draw from our very

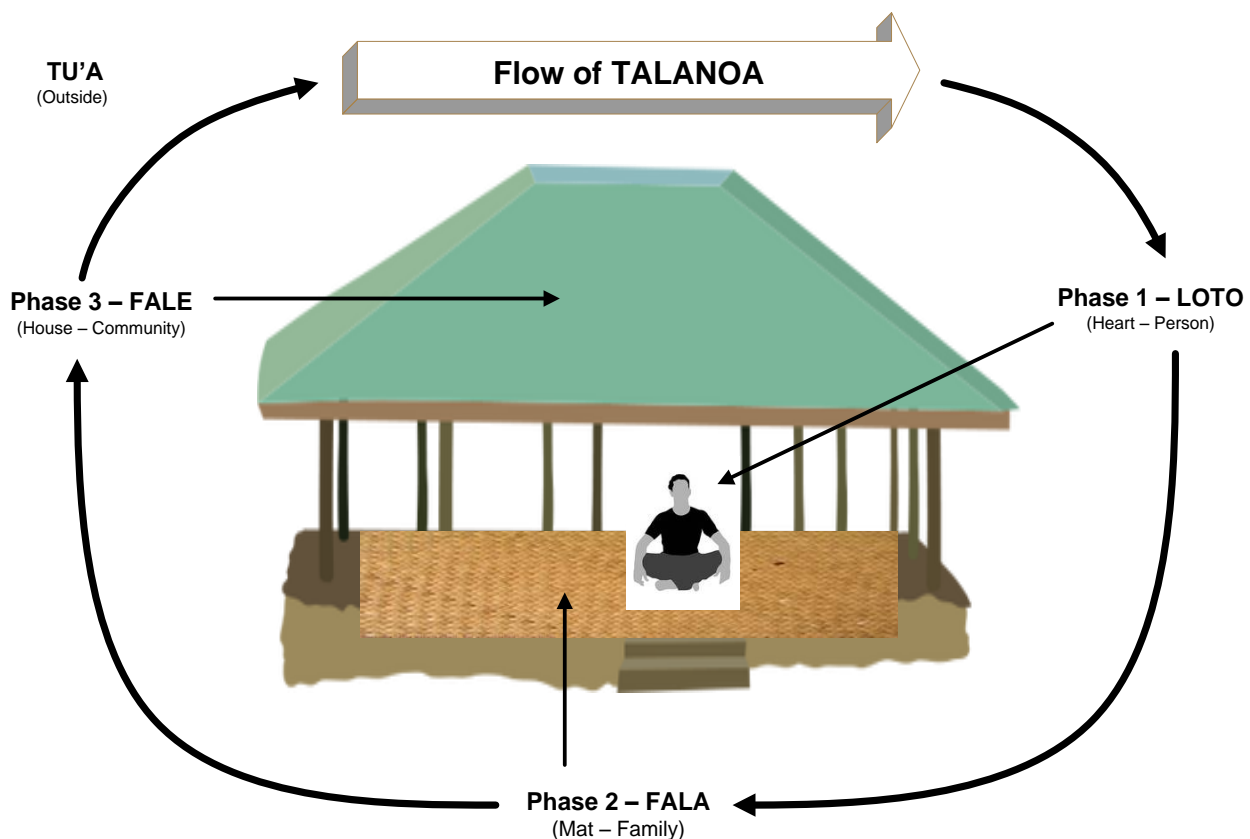
own cultural way of doing things, rather than using foreign tools to try to solve our Pacific issues (S. Halapua, 2002).

The use of *talanoa* in this research was with groups allowing participants to tell their stories. Storytelling can also be seen as a form of *talanoa* and Myers and Macnaghten (1999) discuss how it can be used from a single or a group perspective to tell about an experience or topic. A number of narrative studies using storytelling have been undertaken with migrant populations and diverse ethnic communities who, as participants, have the choice to converse in English or their first language. For example, narrative focus groups were used with a migrant Filipino population in the United States to explore the role of Filipino American grandparent caregivers, and this approach was found to be an effective way of collecting data with a marginalised ethnic group (Kataoka- Yahiro, Ceria, & Yoder, 2004). In Southern Malawi, the Namitambo also contributed to narrative focus groups in a study exploring perceptions of a health issue where the researchers noted a high level of contributions from the focus group members (Tolhurst et al., 2008). In New Zealand, focus groups were employed in a study examining elderly Pacific caregivers of young people with disability (Foliaki, Nosa, Birkenhead, Kanongata'a, & Faamoe, 2009). This research concluded that focus groups were a valid method of data collection and key issues were identified through a process that allowed people to contribute meaningfully. These focus groups were known as *talanoa* groups.

*Talanoa* was also employed in this project as a framework for conceptualising mental illness. As Vaka'uta (2009) criticised *talanoa* as being monologue with no second party to converse with, where he argues that conversations require more than one person to exchange words and

ideas. I built from Vaka'uta's work taking the stance that *talanoa* starts within the individual on that monologue level where one converses with one's soul (*loto*) determining what should be expressed verbally. Once a decision is made by the individual, an opinion is expressed in the verbal form of *talanoa*. *Talanoa* has different phases which I present as a conceptual framework. The first phase starts from the *loto* and progresses to the second phase where one verbally expresses *talanoa*. *Talanoa* in that second phase is conducted on the *fala* (mat), representing a Tongan cultural space. The final phase ensures that the *fala* is protected within a Tongan cultural structure; the *fale* (house) represents this cultural structure. Chapter Eight discusses these phases in greater detail and explains how they were used in this research project. Figure 4.1 shows these phases and an example is given following Figure 4.1 to demonstrate their application in this study.

**Figure 4.1** *Talanoa*





*Fale* means house but also refers to families and extended families. *Fala* is the Tongan mat that is used within the Tongan *fale* for people to sit upon and *talanoa*. The phases of *talanoa* start from the personal level in the *loto*, (soul/heart), where one consults with their *loto* before expressing their opinion to the *fala* (mat). The *fala* is the space where the individual rests and is positioned inside the Tongan *fale* (house). The *loto*, *fala*, and *fale* need to be in the right space and time, and the *talanoa* flows freely through these spaces. *Tu'a* (outside) of the *fale* is not an effective place for *talanoa*. Any conversation outside (*tu'a*) of the house (*fale*) is not considered to have any significant value and is not taken seriously. This is why it is vital to emphasise that in order to *talanoa* effectively with a Tongan person, there is a need to get into their *fale*, sit on their *fala*, and *talanoa* to their *loto*. The circular and collective characteristics of *talanoa* ('Otunuku, 2011) encompass the *fale*, *fala*, and *loto*, producing quality results from Tongan people, as the data are given from the *loto*.

## **The participants**

An Intermediary Person (IP) worked in partnership with the researcher and the participants to act as the contact person for both. This was to alleviate cultural pressures from both parties, but especially for the participants. Because the Tongan community is small with a high chance of both parties knowing each other and Tongan people at times finding it difficult to say 'no' to authority figures, it was anticipated that the participants might feel obliged to participate if the researcher invited them to be involved in the study. In this instance, as I was undertaking this level of study as well as working in the health system, some members of the Tongan community may have seen me as a superior/authority figure, and this I wished to

avoid. I identified potential groups for the study and the IP approached and invited individuals to participate. I discussed the study in great depth with the IP so that he could answer questions from potential participants. The IP discussed the study in depth and answered questions from the group members and confirmed participation in the *talanoa*.

The IP reinforced ethical commitments like confidentiality, the choice to participate or not, and the right to withdraw from the research at any time until the start of the *talanoa*. Confidentiality and ethical issues around the research were discussed with the IP and a ‘Confidentiality Agreement’ was signed by the IP (see Appendix II). The IP also conferred with the participants about possible venues where they would feel most comfortable and then informed myself about the number of participants for each *talanoa*, and the venue and time.

The participants in this research project are members of the Tongan community in Auckland. The study had seven groups and a range of Tongan people were interviewed. The groups were: community leaders, women, men, youth, mental health service users, families with mental health service users, and families without mental health service users. The number of participants in each group varied from 5-12 participants and they are also referred to in this thesis as *talanoa* groups.

The rationale for selecting this number and groups of participants was to explore the views and perceptions of Tongan people in the Auckland region on mental illness, and aimed to capture data from all age groups in the Tongan community excluding those 18 years old and younger. Gender appropriate groups were provided to allow depth in the sharing of

information and in consideration of the sensitive nature of the subject matter, mental illness. It was important to access a diverse range of community members ranging from community leaders to youth and also families who were able to provide a wide range of perspectives on mental illness.

**Figure 4.2 Participants: *Talanoa* groups**

<b><i>Talanoa</i> Groups</b>	<b>Participants</b>
<b>1. Service users</b>	Tomasi (Male), Masi (Male), Venusi (Male), Soni (Male), ‘Esau (Male), Tevita (Male), Moana (Female), Taiana (Female), Nina (Female), Liana (Female), Sekona (Male), Sulieti (Female)
<b>2. Men</b>	Soane, ‘Ili, Vuna, Soape, Hale, Saimone, Samu, Soketi, Moleni
<b>3. Youth</b>	Samantha (Female), Toakase (Female), Nomani (Male), ‘Inoke (Male), Joshua (Male), Frank (Male), Naioka (Female)
<b>4. Women</b>	Tangikina, Losa, ‘Eleni, Pele, Lisa, Siu, Palu, Mele, Seini, Moa, Sina, Mona
<b>5. Community leaders</b>	Mosese (Male), Kefi (Female), Ane (Female), ‘Asinate (Female), Vili (Male), Simi (Male), Lina (Female), Mathew (Male), Pita (Male)
<b>6. Families without mental health service users</b>	Lemeki (Male), Leilani (Female), Melenaite (Female), ‘Anau (Female), Lita (Female), Lomio (Male), Vikilani (Male), Saia (Male)
<b>7. Families with mental health service users</b>	‘Epoki (Male), ‘Emosi (Male), Pua (Female), Toa (Female), Siale (Female)

For confidentiality reasons and discussion purposes all participants were given pseudonyms. The *talanoa* groups are presented in Figure 4.2 starting with the first *talanoa* group, the service users, which was held at a health provider, followed by the other *talanoa* groups accordingly with the last *talanoa* group, families with mental health service users at the bottom of the table.

## Data Collection

The *talanoa* sessions were mostly conducted in Tongan cultural settings like churches, family homes, and *kava* places as proposed by the participants, and all complied with Tongan protocols like *lotu* (prayer), so as to acknowledge Tongan spiritual cultural values. Rounds of introductions were undertaken and the *talanoa* were conducted in Tongan, English, or a mixture of both depending on the participants' choice of language.

The seven *talanoa* groups were different; some got straight to the discussion of mental illness and others, like the men's *talanoa* group, wanted to clarify the research question first before getting on to *talanoa* about mental illness. The families with mental health service users' *talanoa* started with questions about the Information Sheet (Appendix III); after the participant's questions were addressed, the *talanoa* proceeded to the meanings of mental illness. The service users and the youth *talanoa* groups began to *talanoa* about mental illness immediately after the introduction.

Facilitating the *talanoa* sessions was different for each group and my role was to ensure that the *talanoa* was not going too far from the subject matter. The open nature of *talanoa* took the discussion to different levels and my role as a facilitator was to direct it back to the meanings of mental illness through asking open questions that connected their current comments with mental illness. This facilitation needed careful consideration to avoid restricting the *talanoa* to only mental illness, and still having freedom in terms of the free flowing of topics to maintain the authenticity of *talanoa*. The focus of my facilitation was to ensure that the *talanoa* had linkages to mental illness in any form and level. For example, there were times where participants would share a story, then they would name an individual in the story, and the *talanoa* strayed to that individual's background – such as roles and responsibilities – and risked taking it further from the subject matter. My role was to listen through all of these and ensure that the *talanoa* came back to the initial story. Some participants returned to the subject matter after going on a tangent for a while, and sometimes other participants redirected the *talanoa* back to the subject matter when they felt that the *talanoa* was moving away from the subject matter. In cases where I felt that the *talanoa* was going too far from the subject matter, I redirected the *talanoa* back through asking questions or making comments relating to meanings of mental illness. The open nature of *talanoa* meant that some data were not directly related to the subject matter and the research project but were very important in maintaining the process of the *talanoa* so that the participants shared from their *loto*. When the *talanoa* kept going off track and no new information was presented, the session was ended. The *talanoa* sessions were recorded on an audio recording system and I took some written notes during the *talanoa*. I wrote notes after the *talanoa* summing up the findings. The tapes were transcribed later and analysed before translating to English for presentation.

## **Ethical issues**

Ethical approval was gained from Massey University Human Ethics Committee in 2009 (Appendix I). There were some ethical issues around potential coercion as discussed previously, language and level of reading, consent processes, confidentiality, audio recordings, *me 'a 'ofa* (gift for the participant's participation), and safety of participants. These required particular consideration and careful handling in this research: these were mainly related to the research population, and the nature of the subject matter, mental illness, and are discussed in detail in the following sections.

### **Language and level of reading**

Both Tongan and English languages were used to give participants freedom of expression without the need to translate into a prescribed language for the purpose of the research. This required translation of materials like the Information Sheet (Appendix III) and Consent Form (Appendix IV) from English to Tongan. The translation was completed by myself and validated by two people, a Tongan health professional and a Tongan translator. This same translation process was carried out for the data analysis. It was difficult at times to translate Tongan concepts into English however, this was done carefully after discussions with Tongan elders to validate these translations.

The *talanoa* in the seven *talanoa* groups flowed freely and the participants had the freedom to use Tongan terminology without struggling to translate and express their ideas in English, and vice versa. This was very important as attempting to translate Tongan terminology into English risks compromising the accuracy of the original material. The speaker or teller tends, therefore, to explain and define the terminology and the meanings will depend on the interpretation of the listener. This illustrates the importance of listening to both verbal and non-verbal cues and interpreting it accurately. This is an example where this research can distinguish an insider researcher listener, to an outsider researcher listener. The insider in the *talanoa* will have the ability to know and listen to the structure and content of the *fale* (house) which symbolise family, the location of the *fala* (mat), while they are listening to their participant sharing *talanoa* from their *loto* (heart/soul).

Difficulties associated with expressing genuine Tongan concepts in the English language, also act as a barrier and can hinder the flow of information. The researcher's ability to collect data both in Tongan and English allowed participants to freely express their views about the subject matter. This freedom of expression allowed the *talanoa* participants to engage deeply with the subject matter. The participants drew from their experiences and knowledge and, through *talanoa*, engagement and rapport were established forming a platform for sharing information. This platform can be represented by the *fala* (mat) inside the *fale* (house). Their own views, perceptions, interpretations, and meanings of the subject matter, mental illness, were shared.

## Consent processes

The main issue relating to consent was that of written versus oral consent. Written consent to participate in research studies is considered best practice to provide a level of protection for participants and researchers. However, oral consent was preferable for Tongan people. Tongan history has been passed down orally, written information and practices are new to the Tongan community and it was thought that requiring written consent may discourage participation. Tongans are highly literate and Poltorak (2012) explains that they are nearly 100% literate and also the highest number of PhDs per capita in the world, yet they still prefer, trust, and are more comfortable with the oral process. Verbal communication gives more information to Tongan participants and allows them to ask questions. Consent was, therefore, offered in different forms ranging from written individual, written group consent, to individual oral and group oral consent. All participants provided oral consent, individual and group, and these were taped. Participants introduced themselves and gave oral consent and the group consent was given by a group representative. For example, the men's group gave a group oral consent via their group leader and individual participants introduced themselves. The process in this research was that the IP first approached the potential participants and sought agreement to participate. The researcher explained the research project again before the *talanoa* started and participants were reminded of the right to withdraw with no need to give any reasons. Written consent was offered and available to participants, but this was not used by any participants. At the beginning of the recording of each *talanoa*, oral consent was requested and given by every participant along with agreement to record the session. All participants provided consent. This is another example of how mainstream/Western practices need to be adapted for different cultures.



## ***Me'a'ofa***

*Me'a'ofa* is the Tongan equivalent of *koha*, a gift for participation in the research. The ethical issue for consideration is that gifts for research participants may sometimes influence the findings in terms of the amount of gift. In this case, participants were acknowledged for their contribution to the research project through a small *me'a'ofa* of \$10.00 petrol voucher as a token of appreciation for their participation in the study.

## **Confidentiality**

The explanation to participants by both the IP and the researcher about the study also covered confidentiality. Participants were assured that no names would be disclosed in the project and that their anonymity would be protected by using pseudonyms. This was very important and participants shared comfortably, knowing their identities were protected and giving them freedom to openly discuss their views about mental illness. Knowing about this level of protection allowed the participants to offer critical views of Tongan culture and the health system.

In relating to *talanoa*, participants were comfortable knowing what they shared from their *loto* (heart/soul) will not be discussed along with their identities. This protection of participants' identities is very important as sharing information from the metaphorical *fale* (house), which represents family, and the *fala* (mat), which refers to the context of the family and the position of the individual inside the family, are very private and it took courage for

Tongan participants to disclose sensitive information from these places. It is very challenging to get a Tongan family to share inside information from their family. The challenges multiply when one attempts at going deeper than the *fale* (house) and the *fala* (mat) into someone's *loto* (heart/soul). Going into the *loto* (heart/soul) is one thing and encouraging information from the *loto* (heart/soul) is another thing, where the latter can be more challenging than the former. However, confidentiality can assist getting information from the *loto* (heart/soul) as it protects the participant's identity and the participant.

### **Audio recordings**

The importance of using audio recordings to capture the information shared in the *talanoa* groups was explained to the participants. The audio equipment was noted to be a distraction at times and participants felt like they had to move closer and speak to the recorder. The recording of the *talanoa* itself seemed uncharacteristic and unnatural and some participants were slow to get into the *talanoa* because of the presence of the recorder. However, as the *talanoa* proceeded, the recorder appeared to become invisible and all participants became involved in the *talanoa*. At no time did any of the participants ask for the recorder to be switched off. Some discussions continued beyond the end of the recording and notes were taken.

## **Safety of participants**

Because of the nature of this research topic, special consideration was given to the safety of participants. In the case where a participant was stressed or might become unwell, the researcher would be able to provide reassurance, attending to mental health needs and arranging access to appropriate services if needed. There were changes of mood throughout some *talanoa* groups and some tears at times, but these tears were shed when participants shared sensitive issues that were very important to them, these were voices from their *loto*. At other times, there was humour and laughter, and these were associated with sharing sensitive issues as well, sometimes in these situations it is easier to break out in humour and participants laugh at incidents they can relate to. Specific care was taken with participants who are users of mental health services and also their families in terms of their mental health in relation to issues discussed in the *talanoa* groups. However, none of the participants expressed stress or became distressed and so no intervention was required.

## **Terms of credibility**

This section discusses the research process and the researcher's roles as an insider to support the credibility of the research.

## The researcher's role as an insider and an outsider

There has been on-going argument throughout the research community about the position of the researcher and the researched in terms of being an insider or outsider (Breen, 2007; Dwyer & Buckle, 2009; Rabe, 2003). Insider status refers to the researcher sharing the same

identity, language, and experiential base with study participants...this insider role status frequently allows researcher more rapid and more complete acceptance by their participants...participants are typically more open with the researchers so that there may be a great depth to the data gathered. (Dwyer & Buckle, p. 58)

The insider, then, can potentially access in-depth data, but the role can also be detrimental due to a potential lack of objectivity and the close attachment between the researcher and the participants (Rabe, 2003). It is difficult to grasp the concept of insider/outsider in research as they are not linear and static in nature but have more of a fluid character (Breen, 2007). For example, the researcher will often start as an outsider and work inwardly to be an insider throughout the research project. This was reflected in the research through *talanoa* when I had to move from different roles such as listening to facilitating, to leading the *talanoa* back to the research question when the *talanoa* went astray.

My role as researcher in this project was as an insider, as a member of the A/NZ Tongan community. I acknowledge that being an insider could be considered to be a limitation of this study but the nature of the data generated indicates that my insider status was influential in accessing depth. I was born to Tongan parents and grew up in Tonga then migrated to A/NZ. This heritage allows me not only to understand the Tongan way of living but also to live it as

well. In relation to the research, I understood Tongan structures and how my role fluctuates and adapts to different contexts. For example, my role as a lecturer and researcher gives me the opportunity to teach others, to speak, and to lead, but when I am in my Tongan community, I am the boy who listens and follows instructions from my Tongan elders. It is important to move swiftly and smoothly between these roles as failing to do so can cause damage to relationships, with the possibility of generating poor data. Such damage could extend to the research participants not participating in the project. It is therefore beneficial to clarify my position and how I entered this project. Although, I entered as a researcher, it was important to show the Tongan community/participants that I know my place in the Tongan society and to lower myself to that level. This was demonstrated through verbal and non-verbal expressions; for example, sitting near the *kava* bowl in the men's *talanoa* group. The ranking of the Tongan *kava* circle increases as you move away from the *kava* bowl. The one sitting at the *kava* bowl is the one serving the others (Biersack, 1991; Collocott, 1927).

The non-agenda, facilitating, listening, and storytelling components of *talanoa* suit the role fluctuations well, as it does not direct and lead people with superior and dominant characters. *Talanoa* gave me the opportunity to enter in my researcher's role and, at the same time, to be able to *talanoa* using humble Tongan words which demonstrates to participants that I am aware that I am still young and considered immature in the Tongan culture when elders are present. Approaching Tongan elders was different from youth as most of the youth grew up in A/NZ. When participants realised that I know my place when coming to the Tongan community, participants felt comfortable enough to tell their stories. Their *talanoa* became *māfana* (warm) and then travelled to the *loto* (heart/soul) where the rich stories and deep understandings reside (Fonua, 2005; S. Halapua, 2002).

Tonga has a long oral history and this was a major consideration for gathering data in this project. Wilson (2008) suggests entering research such as this in a culturally appropriate way, where the role of a storyteller is more fitting than adopting the role of a researcher. Linda Tuhiwai Smith's work in decolonising research methodologies to suit indigenous populations emphasises the power of storytelling in indigenous populations. Smith explains that histories were passed from generation to generation orally and they were passed through stories: "stories contribute to a collective story in which everyone has a place" (Smith, 1999, p. 144). Storytelling is more compatible with the oral history practices of Tonga than the term 'research' which represents a Western concept and is often perceived to be associated with authority and power that may not benefit Tongan people. Storytelling aligned with my approach in this research and identified me as a knowledge seeker who is willing to listen and learn from participants. Aspects of identity in qualitative research play a key role and require adaptation depending on the relationships with participants and the levels and types of interactions (Holloway & Freshwater, 2007).

Identity was carefully considered in this research by the researcher and the structuring of each *talanoa* group was handled carefully when engaging with each *fale* (house). Each *fale* (house) contained their own *fala* (mats) and these *fala* (mats) were positioned differently in these seven *fale*. I entered each *fale* (house) differently according to the cultural context and protocols. The participants were aware that the researcher was an insider in the Tongan community from a research angle, but to be part of the *talanoa* the researcher has to be inside the *fale* and also sitting on the metaphorical *fala*. It is vital for the researcher to position himself accurately on the *fala* in the *fale* as deviations can cause major disruptions in the

process of research. In the Tongan context, it was best to position myself as a storyteller and learner, positioned so as not to adopt a higher status position or as a person of expertise. This strategy worked well within the *talanoa* groups and the result was positive relationships where the participants' contributions were valued. The learning for the researcher was twofold in understanding more about the research process and the topic. As an insider researcher, there is a great risk involved in terms of my credibility in my community if I do not report accurately and truthfully.

### **Trustworthiness and authenticity**

Holloway and Freshwater (2007, p. 145) argue that validation techniques may be appropriate in quantitative research but do not apply to qualitative studies where testing of validity rests with the voices of the participants, "the authentic voices of the participants can be heard and that the findings present their life world or reality". However, for this study, the authentic voices of the Tongan people were heard through using *talanoa*. *Talanoa* provided a context where participants talked openly and the researcher also had opportunities to confirm participants' viewpoints, and thus providing validity to the findings. Authenticity was tested in this research through ongoing *talanoa* ('Otunuku, 2011; McGrath & Ka'ili, 2010; Vaioleti, 2006) with an academic and expert on Tongan culture. These *talanoa* involved analysing of data and translation of data into English language.

Where generalisability is an important component of assessing credibility of quantitative research projects, and generalisability refers to the results of the study and how they apply to

the wider population that is represented by the study population (Walliman, 2006), transferability is considered in qualitative research and transferability focused “on the participants who are knowledgeable about the topic under study to build a sample that is specific to the needs of the study” (Chilisa p169). The research covered a section of the Tongan community in Auckland and deliberately selected a wide range of participants – men, women, youth, services users of mental health services, families without services users of mental health services, families with services users of mental health services, and community leaders – this study sample population provides an appropriate qualitative study population for Tongan people in Auckland. This is an appropriate sample as a main objective in qualitative studies main objectives is to gain in depth data and the seven *talanoa* groups are sufficient as they provide a range of perspectives (C. Marshall & Rossman, 2011; Mason, 2002; Silverman, 2001) from the Tongan community, covering gender, age, families, experiences of mental illness, leaders and youth. More importantly for this project, generalisability is not an issue in qualitative studies (Walliman, 2006; Wolcott, 2001).

### **Data analysis: thematic analysis**

In this section the process of data analysis is presented. The analysis was thematic with inductive generation of themes identified in the data. Also in this section is a description of the process undertaken to complete the thematic analysis. In addition to the generation of themes, another stage of analysis was undertaken in recognition of the distinct and different content of each *talanoa* group. At the end of this section, the *talanoa* groups are presented diagrammatically as an introduction to the findings.



## **Working with the data**

The data was audio recorded and transcribed in full by the researcher. As will be discussed in more detail later, the *talanoa* groups were conducted in Tongan, or in Tongan and English and were transcribed as they were spoken. A consequent stage of the process was to translate the spoken Tongan into English and in the findings chapters, data are presented in both Tongan and English where Tongan was spoken. The translation of the data was then discussed with a Tongan translator and Tongan supervisor. Throughout this process, the main themes were identified in the data and the data was separated into data sets that were then discussed with supervisors and refined. The next section describes the process of thematic analysis.

## **Process of thematic analysis**

Thematic analysis is used to describe patterns across qualitative data and was selected for its ability to fit with the *talanoa* approach and to accommodate the generation of the themes from the data (Braun and Clarke, 2006). Upon reading the data it was identified that each *talanoa* told a different story. The analysis across the *talanoa* identified a number of patterns both from each different *talanoa* but also within the *talanoa* themselves. What became apparent was that the *talanoa* had generated data that would mainly fit into five main categories. The initial coding identified five major themes: Tongan constructions, Western and biomedical constructions, resources and outcomes constructions, interface or meeting point constructions, and the rest of the data were allocated to the fifth theme which was named ‘anything else’ for the purpose of the analysis. This accounted for the majority of the

data with very little data discarded. The only data that was discarded was not concerned with the topic of the research. This initial coding generated the themes in the following way. The data identified as Tongan constructions tended to be discussed in Tongan, used Tongan concepts and challenged biomedical constructions. The biomedical constructions tended to use English words, and challenged the Tongan constructions. Resources and outcomes were identified where participants discussed access to services and the outcomes of interventions and these related to Tongan and biomedical constructions. Interface constructions drew on data where Tongan and biomedical constructions were intertwined and tended to be discussed in Tongan and English. The fifth category was used to store data that did not immediately fit in the other categories but was of interest with a view to utilising it at a later stage of analysis. Upon refining the coding system, these five categories were collapsed into three categories shown in Figure 4.3.

**Figure 4.3 Themes**

<b>Theme</b>	<b>Name</b>
1	<i>Tufunga faka-Tonga</i> (Tongan constructions of mental distress)
2	<i>Tufunga faka-paiōsaikosōsiolo</i> (biopsychosocial constructions of mental distress)
3	<i>Tufunga fepaki mo e fetaulaki he vaha'a 'o e tufunga paiōsaikosōsiolo mo e tufunga faka-Tonga</i> (intersections between biopsychosocial and Tongan constructions of mental distress)

The *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress) theme and the *tufunga fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress) theme relate to some themes from the literature reviewed, but also present new knowledge about how Tongan people make sense of mental illness, as Tongans living in A/NZ. The majority of the *tufunga faka-Tonga* (Tongan constructions of mental distress) theme offers additional knowledge to what was discussed previously in the literature. The analysis followed a conventional qualitative thematic analysis (Braun and Clarke, 2006), where the themes were identified, defined and further refined. In reading and coding the data, the researcher was informed by the relevant literature along with the participants' contributions, in order to build and inform theory. Consequently, it was possible to inductively generate theory that adequately reflected the community's perspectives, consistent with the *talanoa* approach. Thematic analysis has been used widely in qualitative research and has been found useful in constructing meanings (Braun & Clarke, 2006). Fu and Parahoo (2008) used Miles and Huberman's (1994) technique of labelling, coding, categorising, and theme development to explore perceptions of depression among Taiwanese people much like was undertaken in this study. This study used Miles and Huberman's technique to develop the themes around meanings of mental illness for Tongan people. Importantly there is a similarity between Miles and Huberman's technique and *talanoa* in terms of identifying themes and building from those themes (Fu & Parahoo, 2008).

A second stage of analysis was utilised in recognition of the different perspectives from each *talanoa* group. While it was evident that there was not total consensus within the *talanoa* group as the discussion identified that the participants had diverse perspectives, one aspect of the *talanoa* is to come to a consensus. This stage of the analysis identified what that consensus position was for each group, discussed below.

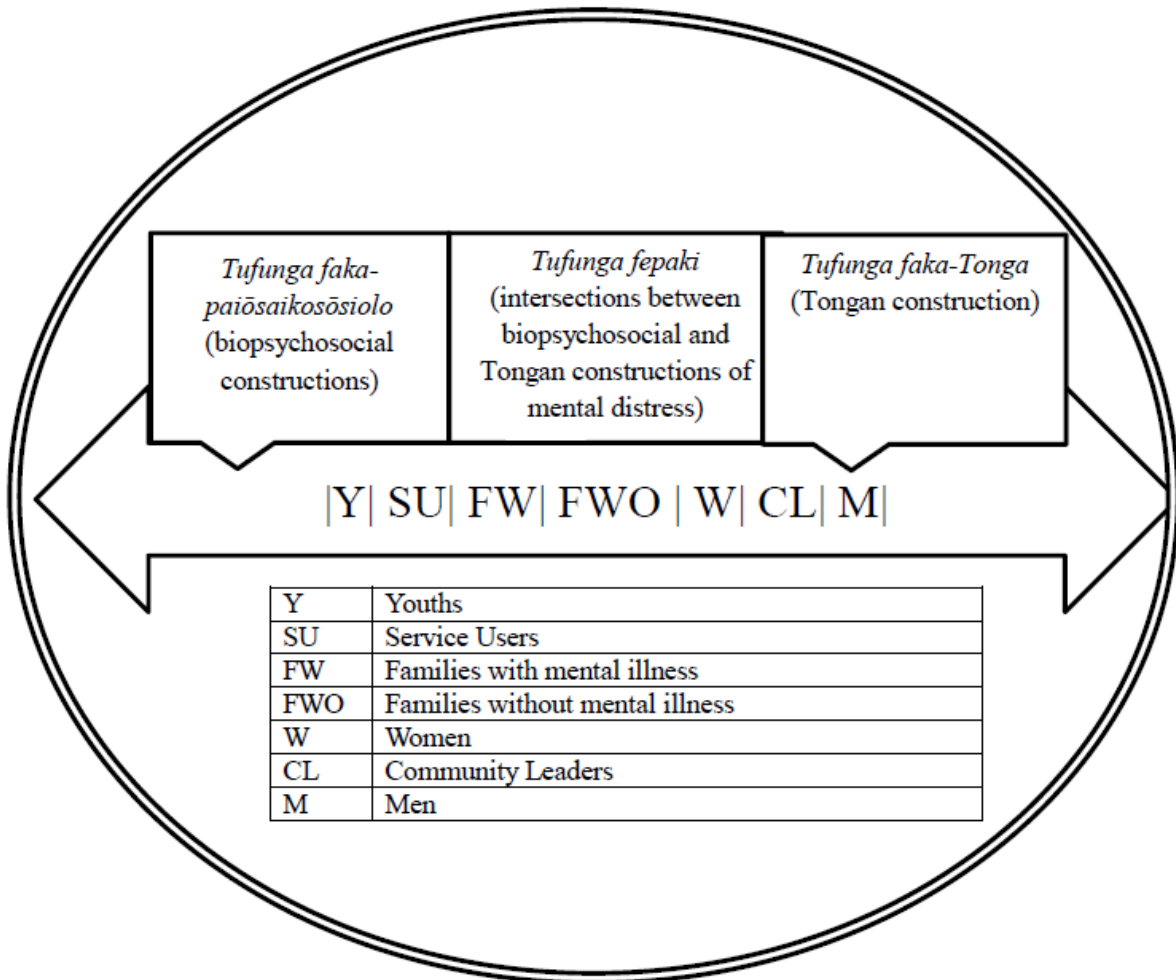
## Introduction to the findings

Thematic analysis identified three main themes arising from the data: *tufunga faka-Tonga* (Tongan constructions); *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress), and the *tufunga fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress). The findings reveal that interpreting, defining, and constructing mental illness are influenced by many variables such as context, migration, time, age, and gender. The findings also show that definitions change as individuals make adaptations as they move through space and time, with the extent of change depending on the level of acceptance of the individual of their new circumstances. The *tufunga faka-Tonga* was the strongest collective voice (theme) from the participants, followed by the *tufunga faka-paiōsaikosōsiolo* theme. These two themes were the two pillars at each end of the continuum, while the third theme, *tufunga fepaki*, was located between them in the middle, where the other two themes met. It was evident that participants changed their interpretations, perceptions, definitions, and constructions of mental illness through migration as they are exposed to new and often foreign knowledge. Changes in people's views about mental illness did not occur instantly, but over time as they were exposed to new knowledge and ideas, depending on how this new knowledge was interpreted and accepted; in other words participants moved along a temporal continuum. These changes were reflected in this research as different groups shifted along this temporal continuum. The findings, therefore, are presented in a continuum but the ongoing changes of views about mental illness through time and space suggests that this continuum may be a snapshot of a diameter of a moving circle of perceptions of mental illness, with *tufunga faka-Tonga* (Tongan constructions of mental distress) and *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental

distress) in both ends. This complex idea is challenging to present and I am using a diameter of a circle to demonstrate this, as the Tongan perceptions of mental illness revolves continuously in a circle between *tufunga faka-Tonga* (Tongan constructions of mental distress) and *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress). This continuum demonstrates what and how participants viewed mental illness at the time of this research project.

In this temporal continuum, the men's group was the strongest group at the *tufunga faka-Tonga* (Tongan constructions of mental distress) end, followed by the community leaders, women, families without mental health service users, families with mental health service users, service users, and the youth group standing strong at the *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress) end. Figure 4.4 shows the continuum of findings and where each *talanoa* group was positioned according to *tufunga faka-Tonga* and *tufunga faka-paiōsaikosōsiolo*. The discussion now shifts to a brief consideration of the data gathered from each group and how they relate to each theme, starting from the *tufunga faka-Tonga*.

**Figure 4.4**                      **The seven *talanoa* groups**



***Talanoa* participants**

This section introduces the participants and the seven *talanoa* groups as described in Figure 4.2 and provides a summary of the main themes identified from each group. The first *talanoa* was with the service users’ group. This group consisted of mental health service users most of whom have used services for a number of years. This group of Tongan mental health service

users came together and shared their experiences, including how they can support one another with mental illness.

### **Service users' *talanoa* group**

In this group there were twelve participants consisting of seven services users and five community support workers. There were seven men and five women aged from their twenties to their fifties. The majority of this group were born in New Zealand or migrated to New Zealand at a very young age, rather than migrating to New Zealand as an adult aged eighteen years old or older. The service users were transported to the venue for the *talanoa*, and this led to some slight delays. The *talanoa* lasted for one hour and it was conducted in both English and Tongan.

The main message from this group highlighted that mental illness is mainly a social and environmental problem. This group also constructed mental illness from a Western and biomedical paradigm (*tufunga faka-paiōsaikosōsiolo*) using diagnoses such as schizophrenia, bipolar affective disorder, and so forth. There were discussions about their experiences and journey with mental illness as individuals, families, and communities, including how they were perceived by others. These ideas and other related contributions supported the *tufunga fepaki* (conflict and interface between Western/ biomedical definitions and Tongan concepts) theme. The *tufunga faka-Tonga* theme was discussed but was strongly opposed, challenged, and disregarded by the younger participants. The older participants acknowledged the *tufunga faka-Tonga* (Tongan constructions) but reported they were more accepting of the *tufunga*

*faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress), in terms of using the mental health services and treatment for better outcomes.

### **Men's *talanoa* group**

The second *talanoa* was with the men's group and it was held at one of the local places in Auckland where *kava* gatherings are usually held. *Kava* has been a significant cultural symbol in the Tongan culture, which represents land and people and also a suitable place for collecting information from Tongan men (Biersack, 1991; Collocott, 1927). Marcus (1980) explains the *talanoa* in the *kava* sessions and how people contribute freely even in the presence of nobles and people from higher ranks. The cultural significance of *kava* and also the ability to *talanoa* freely and not be restricted by the Tongan hierarchical structure, and the deep discussions of topics by men (Bott, 1981) were reasons for choosing it for this *talanoa* group. Vaioleti (2011) states that the complexities and dynamics of *talanoa* at the *kava* also test the cultural competency of the researcher, which was also an area I was comfortable with, in growing up around the *kava* circle and also heavily involved in Tongan *kava* duties.

There were nine participants in total, including a mental health professional, ex-school teacher and principal, Tongan music composer, talking chief, social worker, church minister, unemployed participants, and community members. The age distribution was from the twenties to sixties. The *talanoa* started three hours behind scheduled time due to participants arriving late. However, this had the advantage of the participants arriving one by one and the researcher was able to greet and welcome each of them as they arrived. This created a one to one connection between the researcher and each participant. Rapport was established effectively between the individuals within the group as the participants got to introduce



themselves and get to know each other before the formal *talanoa* started. The result was that when the *talanoa* started formally, participants felt comfortable with each other and they got straight into the sensitive subject matter. The men's group was conducted mostly in the Tongan language, with the occasional use of English to clarify some ideas that were primarily Western and/or biomedical in nature. The main message this group provided was around traditional Tongan concepts and understandings of mental illness. The Tongan terminologies used to describe mental illness were discussed beginning with the introduction and establishment of Western and biomedical ideas in the Tongan community. The new knowledge of psychiatry was discussed and how this new knowledge displaced the old traditional Tongan culture, language, religion and ways of knowing. The men's group strongly positioned themselves within the *tufunga faka-Tonga* and explained the theme with a great deal of depth utilising supporting stories around causes, signs, symptoms, treatment, and managing mental illness in the Tongan ways.

The formal part of the *talanoa* lasted about ninety minutes. However, when the conversation went off track and began to focus outside the subject matter, the formal *talanoa* group ended and the audio recording device was turned off. The group was informed that the *talanoa* for the research process had ended and the standard Tongan cultural process for closure was needed to complete proceedings. The appropriate way of ending the *talanoa* around the *kava* circle has its own cultural traditional formalities and procedures. This requires the researcher to stay and share *kava* with the participants until the *kava* prepared for the night is finished. It was important to fulfil this cultural procedure as a way of respecting the participants and their culture, rather than just collecting the data and then leaving. The whole process lasted about nine hours that night.

### **Youth *talanoa* group**

The youth group was held at a church hall in the evening. The IP arranged the youth *talanoa* group through a Tongan youth activity agency. The venue and time were decided by the participants and this information was passed to the researcher by the IP. There were ten potential participants and three were excluded as they were under eighteen years old (as agreed through the ethics approval), so the *talanoa* had seven participants. More than half of this group were born and grew up in New Zealand, and this makes English their primary language of communication. The *talanoa* was conducted in both English and Tongan. The definition of youth varies within cultures and this was reflected in this group as the youth leaders were over thirty years old and four participants ranged from eighteen to their late twenties. This group had about an hour of *talanoa*.

The main ideas from this group were associated with mental illness around unstable social relationships, the onset of mental distress starting when relationships break down which brings social fragmentation, stress, feeling loss of hope, worthlessness, and mental illness identified in psychiatric diagnoses. The messages from the youth group were around relationships – and especially love relationships, girlfriend and boyfriend – looking at mental illness as chemical imbalances and needing medical treatment to control symptoms, some spiritual interpretations around the Christian faith, with some disagreement around the Tongan constructions of mental illness. This was the group that most strongly connected mental illness with the *tufunga faka- tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress) opposing the *tufunga faka-Tonga*.

### **Women's *talanoa* group**

There were twelve Tongan women gathered in the community hall late morning for this *talanoa*. These women were all born in Tonga, and had migrated as adults. These participants felt more confident and comfortable expressing themselves in the Tongan language than in English. The women are mothers and grandmothers and all were involved in a women's support group for older people. They met regularly and they knew each other reasonably well. The majority of the women did not drive and were transported by family members or support workers to their regular meetings. They get together to do activities that range from spiritual, physical, and cultural practises, to preserving their own culture through traditional handicrafts, and also learning about new things. The IP invited the women's group and also raised that the researcher is a Tongan male, the group were happy for me to attend and conduct the *talanoa* despite the difference in gender. They were willing to share their views about mental illness and the *talanoa* group was conducted completely in the Tongan language and lasted about an hour.

The strongest theme from this group suggested that mental illness is a *pālangi* illness and should be treated under the medical system and, therefore, was aligned towards the *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress). These women interpreted mental illness as behaviours and attitudes and how society perceives these, for example, odd behaviours, such as being outside of one's normal disposition. The *tufunga faka-Tonga* was also strongly expressed and was identified and the participants highlighted the need for further exploration of the meanings and roots of our Tongan concepts and terminologies for mental illness.

### **Community leaders' *talanoa* group**

The community leaders' group was held in a Tongan Church hall in the evening. There were nine participants, consisting of five men and four women including church leaders, media, leaders of ground-breaking projects for our Tongan and Pacific communities, education, politics, music, *kava* club presidents, and youth leaders. The group included a range of ages from youth leaders to older church and traditional leaders. These leaders work closely with their communities and are well respected. The range of experiences and skills, and the different types of leaders that attended this group were quite broad, and, thus, provided a variety of perceptions and opinions. Some of these leaders already knew each other before the *talanoa*, but for others it was the first time they met. Some knew each other only by reputation. This was reflected in the *talanoa* as some people were comfortable to share at the start of the *talanoa* group, and some initially assessed the settings and surroundings before contributing to the *talanoa*. It was a slow start and they participated more as the *talanoa* proceeded.

The community leaders' group was conducted in both the English and Tongan languages and it lasted for an hour. There were mixed messages from this group with regard to *tufunga faka-Tonga* and *tufunga faka-paiōsaikosōsiolo*. These constructions were drawn from participants' personal experiences of mental illness and how they were managed. Responses indicated that the services managing mental illness also influenced how participants interpreted mental illness and outcomes which also determined the types of approach they choose. The majority of the group aligned more towards the *tufunga faka-Tonga* due to the effectiveness of traditional healers. It is important to note that the women leaders and the youth leaders strongly positioned themselves towards the *tufunga faka-paiōsaikosōsiolo* of

mental illness, largely influenced by the hospital; system and A/NZ society. This is consistent with the youth and the women's *talanoa* groups.

### **Families without mental health service users' *talanoa* group**

Families without any family members who were service users were the next group. The IP arranged this group through Tongan community networks and the *talanoa* was held at a family home. The eight participants in this group consisted of four men and four women. All of these participants were born in Tonga and migrated to New Zealand as adults. The participants were primarily recruited through church networks. These participants had met each other prior to the *talanoa* and knew each other to some degree. The participants were all fluent Tongan speakers and so the *talanoa* was conducted in the Tongan language with the occasional use of English terminology for clarification when participants found it easier to understand concepts or terms in English and vice versa where they discuss English concepts. The duration of this group was about an hour.

The families without mental illness highlighted social problems related to the environment, home, parenting, drugs and alcohol, social fragmentation, and migration as contributors to the onset of mental illness. The change in environment when moving from rural to urban areas in Tonga and also migrating from Tonga to New Zealand influenced mental states. The majority of the findings from this group aligned with the *tufunga fepaki* with numerous mentions of migration, generation gaps, mental health services and misunderstandings.

### **Families with mental health service users' *talanoa* group**

There were five participants in this group and all of these families had someone in their family with a diagnosis of mental illness using mental health services. This *talanoa* was held at a health service provider, a non-government organisation that provides support for these families. All participants in this group were born in Tonga and spoke the Tongan language fluently. The participants undertook the *talanoa* process in the Tongan language throughout the *talanoa* group and, at times, used English terminologies to demonstrate and support their arguments. In terms of gender, there were three women and two men and this *talanoa* lasted approximately an hour. The strongest collective voice for this group aligned with the *tufunga faka-paiōsaikosōsiolo* theme supporting the biomedical definitions of mental illness and their management of mental illness.

Families with mental health service users constructed their views of mental illness according to their experiences within their families and also with health services generally and mental health services. The service outcomes were shown by these families to be a strong variable in how people determine to interpret and construct mental illness. These responses fall under the *tufunga fepaki* theme.

Miles and Huberman (1994) explained how researchers usually come through challenges when collating research data as the information can be in different formats, including formal and informal, verbal and non-verbal, sensitive and intrusive. There may also be different styles presented in one transcription. The transcribed data were coded and categorised according to themes that emerged from the data and were read alongside the literature. The attempt to categorise data into linear themes was challenging due to multiple meanings of

Tongan concepts and its difficulty to translate into English. There are words that are used in everyday language and practices familiar to Tongan people, and when these words are critically considered, including its origin and meaning, they have different meanings. The word '*atamai*' refers to the brain and the mind in everyday practices, and Māhina (2002a) took a critical look and dissect it into two words, "'*ata* stands for 'image' and '*mai* 'in the direction of'" (p. 303) and he defined '*atamai*' as self-imagining. Puloka (1999) did the same for '*āvanga*', which the everyday use in the Tongan society refers to illness possessed by spirits. Puloka defined '*āvanga*' as '*āve* (taken) and '*anga* (place) where an individual is being taken away to another place. There are concepts in the data which have everyday meaning and can identify with one theme through labelling, coding and categorising. However, when attempting to take a critical look at its meaning, it has another meaning where it can also be related to another different theme. '*Āvanga*' for example, has its possession by spirits under the '*fa'unga*' (reality) subtheme due to participants explaining that it is what happen with Tongan people when they experience mental illness and it is real for Tongan people. After Puloka's definition, '*āvanga*' also has some '*hu'unga*' (directionality) component.

The other issue was the use of colloquial terms to explain mental distress and illness. These colloquial terms become a reality of mental distress and illness but their meaning falls into other themes. An example is using '*mahei*' to explain mental distress and mental illness which the meaning of '*mahei*' is tilted but used in the mental health context to explain the behaviour of a person who is not well positioned to maintain harmony, or mentally health. Labelling, coding and categorising data were challenging but also reflected the richness and depth of the data and also the strength an insider researcher can produce with this sensitive and fragile subject matter.

The data was transcribed and translated into English and documented as *Comments* followed by numbers identifying the *Comments* in the *talanoa*. For instance, the men's *talanoa* had 415 *Comments* starting from the opening statement, *Comments 1*, to the closing statement, *Comments 415*. *Comments* presented in the findings appear with their numbers and *talanoa* group. For example, *Comments 76 (Community leaders)* indicates that this is comment number 76 from the community leaders' *talanoa* group. The findings are presented in this format in Chapter Five, Chapter Six and Chapter Seven.

## **Summary**

This chapter has discussed the design (*tufunga'i*) of this research (*fekumi*), including methodology, the aims of the research, and how it was investigated. The use of *talanoa* both as the conceptual framework and as a method for collecting the data is explained and justified, and an explanation of the relationship between *talanoa* and *tālanga* and why *talanoa* was chosen. *Talanoa* was evaluated and proposed in three stages to demonstrate the Tongan ways of communication and how it travels to the *loto* (heart/soul) through the metaphorical *fale* (house) and *fala* (mat). A description of the selection of participants, how they were approached, and how they participated in the research is presented. The employment of thematic analysis to detect the themes emerging from the study is outlined. The participant groups are described and a summary of the messages and data collected from each of the *talanoa* groups is presented. This research design recognises the importance of implementing culturally appropriate strategies when examining issues that are specific to a cultural group, especially sensitive matters such as mental illness and distress. *Talanoa* was used as the strategy in this design to provide the conceptual framework and also in its



capacity as a technique to collect and analyse the data. The suitability of *talanoa* proves its aptness for this project as it provides in-depth data from the *loto* (heart/soul). The following chapters, Chapter Five, Chapter Six and Chapter Seven will discuss the three major themes in depth.

## Chapter Five: *Tufunga faka-Tonga* (Tongan constructions of mental illness)

### Introduction

This chapter discusses one major theme generated from the research findings, *tufunga faka-Tonga* (Tongan constructions of mental distress), and its four subthemes. The four subthemes are, *fa'unga* (reality), *hu'unga* (directionality), *tā'anga* (temporality) and *tu'unga* (positionality). Findings are illustrated by quotes from the participants presented in Tongan with English translations where they were spoken in Tongan, or in English where they were spoken in English. It should be noted that because some Tongan concepts and terms do not translate easily or exactly into English, the researcher has presented these translations in a form that is faithful to the participants' meaning.

The seven *talanoa* groups had different ways of defining, interpreting, perceiving, and constructing mental distress and mental illness through Tongan ways of understanding. The most common message that was deducted from the seven groups for this theme was that mental distress and mental illness is a Tongan illness. Mental illness was explained by participants as a Tongan illness using Tongan concepts and interpretations. Furthermore, Tongan definitions were characterised by behaviours, presentations, and characteristics according to the nature of the illness. Some of the Tongan terms used were *matiti* (cracked), and *vale* (crazy, stupid, inexperienced, immature) to describe or define behaviours of people with mental illness.

Other Tongan constructions were around the causes of mental illness: for example, *'āvanga* where psychotic behaviours were interpreted as possession by spirits, and *mala* is a curse. There were also explanations for thought processes like *'āvea* where an individual obsessively thinks about something resulting in disorientation in the physical world.

These constructions of the *tufunga faka-Tonga* theme were analysed and divided into four subthemes according to how participants discussed their opinions, perceptions, interpretations, and definitions of mental distress and mental illness. The thematic analysis grouped all the *tufunga faka-Tonga* data and these data were further analysed and four subthemes emerged. The data that discussed mental distress and mental illness as a Tongan illness and have Tongan concepts to support these were grouped together. Participants explained these interpretations as bodies of truths and also the reality of mental distress and mental illness amongst Tongan people.

Another set of data used tangible materials to support this reality of mental distress and mental illness. I referred to this set of data as reality (*fa'unga*). Within this reality (*fa'unga*), there are expectations for Tongan people to live and behave within these boundaries of reality (*fa'unga*). Any movement outside reality (*fa'unga*) are also called *'āvea* (obsessive thinking) and *'āvanga* (possessed by spirits) which are forms of mental distress and mental illness. I called this group directionality (*hu'unga*).

There is also a time component within this reality (*fa'unga*) where people are expected to behave according to an expected pace. *Taimi vave* (related to fast timing) and *taimi vave* (slow timing) were referred to as having mental distress and/or mental illness as people moved at a pace that was too fast or too slow. I named this group of data temporality

(*tā'anga*). The other group of Tongan terms and concepts collected were aligned with positioning and I called that last group positionality (*tu'unga*). There are overlaps in the use of the data across boundaries as the words are used in multiple ways and have multiple meanings, which made it necessary to discuss them in each subtheme. There were times where two or more of these subthemes emerged in one sentence.

**Figure 5.1** *Fa'unga* (reality)

Bodies of truths	Tangible materials
<i>angaangaua</i> (two characters or personalities)	<i>masoli</i> (chip/chipped)
' <i>atamai vaivai</i> (weak brain, weak mind)	<i>matilo</i> (crack)
<i>fakasesele</i> (stupid, fool, idiot, silly)	<i>matiti</i> (crack)
<i>lolo mai</i> (feelings of numbness)	<i>matoli</i> (chip/chipped)
<i>mahaki fakamahaki</i> (spirit related illness)	
<i>mahaki faka-tēvolo</i>	
(spirit related illness)	Using balloon, marble,
<i>mala</i> (curse)	power supply, house
<i>maumau faka- 'atamai</i> (injured/broken brain)	
<i>puke faka- 'atamai</i> (illness of the brain)	
<i>puke fakamahaki</i> (illness, possessed by spirits)	
<i>puke faka-tēvolo</i> (illness, possessed by devil/s)	
<i>sesele</i> (silly, eccentric, superficial)	
<i>te 'ia</i> (curse, physically abused as in slapped, smacked, or	
smashed by a spirit)	
<i>vale</i> (ignorance, inexperience, unskilled, crazy, stupid, mental	
illness)	

Figure 5.1 demonstrates the data that were categorised under *fa'unga* (reality), both using bodies of truths which were explained as reality for Tongan people and how they handle mental distress and illness, and also using of tangible materials.

**Figure 5.2 Bodies of truths with multiple meanings of concepts**

<i>Hu'unga</i> (positionality)	<i>Tā'anga</i> (temporality)	<i>Tu'unga</i> (positionality)
'āvanga (possessed by the spirits)	ālonga (very slow)	fakahihī'anga (sloppy)
'āvea (obsessively thinking)	'atamai tuai (slow brain)	folo (swallowing something)
<i>puke faka-</i> 'āvanga ( illness possessed by the spirits)	<i>fakapo 'uli</i> (darkness)	<i>haafe meti</i> (half mad, half mate)
	<i>meimei taimi vave</i> (nearly fast timing)	<i>mafuli</i> (overturn)
	<i>meimei tei</i> (half day)	<i>mahei</i> (tilt)
	<i>taimi tuai</i> (slow timing)	<i>male 'ei</i> (incline)
	<i>taimi vave</i> (fast timing)	<i>suei</i> (sway)

Figure 5.2 explains the Tongan terms which explains mental distress and illness and also contributing to the *fa'unga* (reality) of mental distress and illness. These terms have multiple meanings which also aligned with other subthemes highlighted in Figure 5.2.

### ***Fa'unga* (Reality)**

Reality is translated into Tongan using three main words: *sino* (body), *me'a* (thing, something) and *mo'oni* (truth, reality). The use of these three words connected together – *sino'i me'a* (visible body/object), *sino'i mo'oni* (body of truth), and *me'a mo'oni* (true thing/truth) – defines the truth or what considers reality within the Tongan society. The concept of *fa'unga* was used as the analytic lens to define reality as it encompasses the creating and/or preserving of *sino* (body), *me'a* (thing, something) and *mo'oni* (truth, real). *Fa'unga* is used when connected to these words – *fa'unga me'a* (creating and/or collection of tangible and intangibles), *fa'unga sino* (creating and/or collection of tangibles), and *fa'unga mo'oni* (bodies of truths and collection of intangibles) – and it is argued that multiple realities identified in the *talanoa* data collected in this research need a Tongan term that reflects this diversity. *Fa'unga* fits this as it defines reality as body/ies of truth/s and something that is tangible and can be seen and felt by people, physically, emotionally, and psychologically. The *fa'unga* of mental illness was largely referred to as *vale* or behaving in a crazy manner or being stupid.

*Vale* was a term that was consistently discussed throughout the seven *talanoa* groups and the most often used term referring to mental illness. *Vale* was discussed in the literature review as associated with negative ideas, and its discussions in the *talanoa* groups were mostly negative and associations with 'crazy' or unusual behaviour. However, Siale from the families of

service users' *talanoa* group explained the behaviour of her son as *vale*, not as in crazy but as inexperienced.

Siale            *Pea 'ela ia 'o ifi, ko e 'osi pe, pea 'alu hake ia 'o tokoto, ka e ava kātoa pe homau fale 'i lalo...ka 'oku 'alu foki 'a e 'atamai 'o hangē ha ki'i tamasi'i vale.*

English        He will sit there and smoke (cigarette), and he came to sleep, leaving all windows and doors open, because his mind returned and now thinking like a *tamasi'i vale* (inexperienced boy).

Body/ies of truth/s are usually abstract or intangible in form: however, as will be seen below, Tongan people prefer to explain intangible abstract concepts using tangible concrete forms. One reality that plays a vital contribution in understanding this construction of mental illness is comparing mental illness to a perfect object that has become ruined and damaged. The nature of this object was explained as circular, smooth with much beauty, or perfect in most of the *talanoa* groups. When this perfect object maintains its perfect form and content, it was compared to a healthy person, and when it was ruined and damaged, losing its form and content, then it was likened to having some form of mental illness. The words that the seven *talanoa* groups used to explain mental illness using the ruined and damaged object were *masoli*, *matilo*, and *matiti* which mean cracked or chipped, used to explain how the object was ruined. 'Inoke (all names provided are pseudonyms), for instance, who is a youth leader from the youth *talanoa* group described mental illness as a circular object using a typical child's playing marble, and discussed how a perfect marble was compared to good health and a cracked marble was explained as having a health problem.

Comments 95 & 97 (Youth).

‘Inoke        *Tau pehē kapau ko e ngāue‘aki e matoli ē, ko e matoli foki ia, ‘a ia kapau ‘e ‘i ai ha fo‘i mapu ‘e fō lelei. Tau pehē ‘oku haohaoa ia, ‘oku sai ia, fo‘i mapu ko e ‘oku matoli, ‘a ia ‘oku ‘i ai e me‘a ia ‘oku fehālaaki mo ia, pe matilo, ‘a ia ko e ‘ai ko e ‘a e matoli. ‘Oku mahino ‘oku ‘i ai e me‘a ‘oku fehālaaki, kapau teu talanoa mo ha taha pehē, ‘e ‘alu‘alu kehe atu pē ‘ene talanoa ‘a‘ana, pea ka lolotonga ‘e tau ‘ai ‘e tautolu e fo‘i me‘a ko ē, ‘oku tu‘u ia ‘o ‘ai e fo‘i me‘a kehe ‘aupito, ‘aupito pe ia.*

English        If we use *matoli*, *matoli* for example, if there was a marble, round and smooth. Then we say it is perfect and it is good, and the marble that is cracked (*matoli*), there is something wrong with it, or chipped (*matilo*) so with *matoli*. It is clear that there is something wrong, and if we talk with someone like that, he will talk differently in his own ways, and if we do something, he will get up and do something totally different.

This interpretation and comparison of mental illness to a marble being chipped or cracked has a negative connotation and, some of the participants considered it an incorrect or insensitive way of describing mental distress. The perfect marble is compared to a healthy person and any damage to that marble, chipped (*matilo*) or cracked (*matoli*) are referred to as mental illness. This analogy transfers the concept of mental illness relating to being chipped (*matiti*, *matilo*) and cracked (*matoli*, *masoli*) marble to explaining the nature of the brain (*‘atamai*, *‘uto*) and how an individual thinks and behaves. These were explained in accordance with how people function in their relationships within the community. *‘Atamai vaivai* literally translates in English to mean ‘weak brain’ and is often used interchangeably with *vaivai e*



'*atamai* (weak brain) and '*atamai tuai* (slow brain), also employed to describe people who experience mental distress and illness.

Pita, a President of a *kava* club, was involved in the community leaders' *talanoa* group and summed up the conversation about different terminologies used by explaining how contexts and relationships influence how an individual or group of people determine what words and what constructions for mental illness are used. He explained that there is an appropriate word for each occasion or gathering and one should change the terminology according to who they are communicating with. There are words that one should use for friends and those who they are most comfortable with, and there are also words to use when meeting new people, and at social functions like public speaking as formal and informal terms.

*Comments 76, 80, & 82 (Community leaders).*

Pita            *Ka 'oku lahi e 'ū lea ia 'oku 'ikai fe'unga lelei mo e lea he kakai. Hangē, kapau te te 'alu 'o lea ha feitu'u 'oku kakai'ia. Te te faka'aonga'i leva 'a e maumau faka'atamai, tatau kotoa pē nautolu, he 'oku nau 'uhinga pe ki he me'a 'e taha, ka 'oku kehekehe hono fakalea he feitu'u 'oku te 'i ai. Ka te fakakata kita mo ha kakai, 'oku te maheni mo ia, 'e 'o hake pē e fakasesele ia, ko 'ete tō pe kita ki ha kakai 'oku ki'i tokolahi ai e kau faifekau, 'e faka'aonga'i leva e 'atamai vaivai.*

English        There are too many words that do not fit well when speaking with people. Like if I were going to do public speaking, I would use *maumau faka'atamai* (broken/injured brain). They are all the same, they all mean one thing, but different wordings depending on where I am. If I am joking with people that I know well, I can use *fakasesele*

(silly/stupid), and when I get to places with lots of people, church ministers, I will use *'atamai vaivai* (weak brain).

Pita explained that the changes in terminology used to define mental illness depend on the environment, context, and relationship between people. *Fakasesele* was highlighted by Pita as one definition of mental illness which literally translates as silly or stupid which is used for people who behave differently as defined by the community, and is a term that has negative connotations. Despite the negativity of the word *fakasesele*, Tongan people sometimes refer to someone who is hyperactive or behaving extremely out of the society's norms and values on occasions as *fakasesele* or *meimei sesele* (nearly *fakasesele*). *Sesele* is described something that is superficial and very thin and can only superficially touch the surface and is indirect in nature (Māhina, 2008). *Fakasesele* is mostly used informally and can not be used on formal occasions due to its negative connotations. However, *'āvanga* (possessed by the spirit) is one word that is applicable in formal settings. Soane suggested *'āvanga* (possessed by the spirit), a term employed by Tongan people, and argued that this is the most fitting term as that person's thinking is drifting and possessed by the evil spirit.

*Comments 153 (Men).*

*Soane*            *Tei, masoli, fakahihī'anga, vale, sesele, hā fua e 'ū me'a ko ē 'oku tau 'ai ki he fa'ahinga pehē, ka ko e lea totonu pe, si'i 'āvea, si'i puke faka'āvanga, hē.*

*English*        Day (as in half day) (*tei*), cracked (*masoli*), sloppy (*fakahihī'anga*), inexperienced, crazy (*vale*), superficial, silly (*sesele*), and those words we use for those people, but the right word is *'āvea* (drifting or wandering thoughts), *puke faka- 'āvanga* (possessed by the spirit), eh.

This interpretation is that mental illness is caused by spirits of dead people who possess and control aspects of a person's life. The participants used these words to describe how mental illness has associations with dead people and their spirits: *'āvanga*, *puke faka-tēvolo* and *fakamahaki* meaning being possessed by dead people's spirits. Another term, *te'ia*, refers to being physically abused as in slapped, smacked, or smashed by a spirit. Soane discussed in the men's group how a person becomes un-well as a result of this possession and how this impacts on their life. There is an accepted belief in Tongan culture that there is an underworld where spirits rest when people die. This place is called *Pulotu*, and Soane described the way that spirits from *Pulotu* physically abuse people through slapping, smacking, smashing, and beating their physical bodies and disrupting their way of thinking.

*Comments 21 & 23 (Men).*

Soane            *Pe ko e taha na'a ne hanga 'o te'ia, tāa'i, 'o puke he fa'ahinga me'a ko e 'oku ui ko e fakamahaki. 'A ia ko e fakamahaki, ko e puke faka-tēvolo pe ia, ko e te'ia, ko e tāa'i mei Pulotu.*

English            Or someone smacked (*te'ia*) him/her, smacked, and suffered with what we called *fakamahaki*, and *fakamahaki* is also *puke faka-tēvolo*, it is *te'ia*, smacked from *Pulotu* (underworld, home of the dead).

Kefi from the community leaders' group shared a story about her aunty who experienced the same *te'ia* and *puke faka-tēvolo*, describing how they were able to see the marks on her body without recalling any form of physical abuse or anything logical to explain them.

*Comments 226 (Community leaders).*

Kefi                *She had hand prints all over her body and weird images he'ene sino.*

English            She had hand prints all over her body and weird images on her body.

‘Ili went into detail about how these marks on the body can be noted physically, are very consistent with someone who has been beaten, bitten, or poked, but with no clear evidence about how the injuries were sustained.

*Comments 56 & 68 (Men).*

*‘Ili           ‘Oku hangē ‘oku te‘eki ai ketau sio tautolu ki ha taha ‘oku ne tā ‘a e tokotaha puke, ka ‘oku makafokafo ia ‘o hangē na’e tā‘aki ha taufale nai he‘etau sio ko e ki hono sino, ‘osi sio tonu au he ngaahi me’a pehee e ... pea hangē ko e taka‘uli, ‘asi ko e u‘u, hangehangē ha u‘u., ‘Oku lahilahi foki mo e me’a pehē hangē ko e totototo e ongo kano‘i mata, pehē na’e tuhu‘i e.*

English       It feels like, we do not see the one who slapped the un-well person, but there are body marks which look like he/she had been beaten with a broom. I have seen this ... like black bruises, and tooth marks, like they have been bitten. There are also bloodshot eyes, looks like their eyes have been poked.

Ane supported Kefi (above) in the community leaders’ group, sharing how she remembered seeing people running, and shouting, and speaking of dead people when she grew up in her village. The people in the village discussed these behaviours as a result of possession by spirits.

*Comments 180 & 182 (Community leaders).*

Ane           *Kou fa‘a sio au he me’a pehe, kakai ‘oku nau lele. Kakai ko e ‘oku nau lele pea nau talatalanoa pea nau lau nautolu ia ki he kakai ‘oku nau ‘osi mate. ‘Oku ‘ikai kenau sio nautolu ki ai ka ‘oku hanga ‘e nautolu*

*ia 'o fakamatala, 'i he taimi fuoloa 'i Tonga. He'ete kei si'i, kou 'osi sio tonu au ia ai.*

English I have seen things like that, people that ran. People that ran and kept on talking, spoke of dead people. They do not see them but they explained it, back, long time ago in Tonga. When I was young, I have seen it.

Some people who were believed to be possessed by dead people's spirits were described as having relationships with dead people. In these relationships, the spirits were treated as real people and as part of the community. In Tongan culture, relationships between the living and the dead are often described in terms of current and ongoing relationships (Bloomfield, 2002). In certain cultures, people describe hearing voices of ancestors or relatives, and so describe a relationship with the voices they hear (Nazroo & Iley, 2011; Pilgrim et al., 2011). Simi from the community leaders' group shared how he knew of someone claiming that he had children with a dead person. This dead person is not a Tongan dead person and was explained as a *pālangi* spirit. *Pālangi* refers to foreigners especially Caucasian (Craig, 2011).

*Comments 257–259 (Community leader).*

Simi *Me'a 'oku 'i ai e fu'u tama 'oku puke faka-tēvolo 'oku ne tala 'oku 'i ai 'a 'ene fānau 'e toko tolu mo e pālangi*

English There is someone who is *puke faka-tēvolo* and he said that he has three children with a *pālangi* (Caucasian/white person)

Researcher *'Io, OK, ko e tēvolo palangi?*

English Yes, OK, *pālangi* spirit?

Simi *Tēvolo pālangi.*

English *Pālangi* spirit.

This quote introduces the notion of dead people’s spirit from another culture, in this case, *pālangi* spirits having a relationship with the Tongan person who is un-well. Tongan people believe that spirits travel to *Pulotu* when people die (Gifford, 1924). *Pulotu* has been the focus of many levels of investigation in Tonga, yet *Pulotu*’s geographical location has not been detected or located, despite numerous research studies and investigations. While legends and myths claim that *Pulotu* is in Tonga (Gifford, 1923), the participants disclosed their belief that spirits travel from Tonga to New Zealand through usual transport, such as aeroplanes. The quote below was taken from the group of families without mental illness, where it was discussed how dead peoples’ spirits from Tonga arrived in New Zealand. There was laughter in this group when the form of transportation was confirmed indicating that participants realised it sounded unreal that these spirits travelled via aeroplane. The researcher questioned the group to clarify that these were dead people from Tonga that travel via aeroplane, and Leilani, (mother), Lomio (father), and Lita responded by confirming that most of these dead people’s spirits travelled from Tonga to New Zealand in the plane.

*Comments 323–330 (Families without mental health service users).*

Researcher *Ha ‘u ai pē mo e fanga tēvolo mei Tonga ia?*

English Some devils came from Tonga as well?

Leilani Ehh (strong verbal confirmation with nodding her head for “yes”).

Lomio *‘Io, ‘oku ha ‘u pe mo ia.*

English Yes, came with them.

Researcher *‘A e fanga tēvolo ko e ‘oku puke ai heni.*

English Those devils that make people un-well here.

Lita *Heka vakapuna mai.*

English Came on the plane.

(Group laughing)

Researcher	<i>Ko e ha 'u pe 'anautolu mei Tonga?</i>
English	They came from Tonga?
Lomio	<i>Meimei ko e me 'a pe ko e ha 'u pe mei Tonga, fakatotolo atu pe ko e ha 'u pe mei Tonga.</i>
English	Most of these came from Tonga, this was found through investigating them, and they came from Tonga.

This *talanoa* segment from the groups of families without mental illness, together with Simi's segments about the *pālangi's* spirit, is included here to show how Tongan people in A/NZ transfer their beliefs and interpretations from Tonga and apply it here in A/NZ. Wherever Tongan people live, the explanation of mental distress is linked to spirit possession and there are associated treatments for this Tongan explanation.

These practices demonstrate the strength of Tongan people's realities around *tēvolo*. Most of the *talanoa* groups knew and discussed the strong and powerful influence of these beliefs and practices. The men's group took it to another level where they discussed Tongan traditional beliefs and how early Christian missionaries in Tonga mixed their beliefs with Tongan cultures and customs. During this time Tongan culture was blended with the Christian faith and this resulted in certain Tongan terms being replaced by the Tonganisation of English terms, such as *tēvolo* for devil replacing the traditional term, *fa'ahi kehe* (other side). The replacement of Tongan words by new Anglicised Tonganisations allowed Tongan people to continue traditional practices with new ways of knowing and speaking. Tonganisation refers to English words that are incorporated into Tongan language and the meaning is incorporated as well using literal translation and pronunciation in the Tongan tongue; for example, *taimi* for time. These new terms became accepted by Tongan society. Participants of the men's *talanoa* group discussed this and noted how new translations of language not only displaced

the Tongan language but also impacted on the culture by changing the meanings of words. ‘Ili asked a question about the Tongan word for *tēvolo* (devil), wanting to know what it was originally before the adoption of the word ‘devil’. Participants responded with Tongan terms that are or were used for devil (*tēvolo*).

*Comments 203–217 (Men).*

- ‘Ili            *Ko e hā ‘etau ngaahi lea Tonga ki he tēvolo? Mahalo ko e fo’i lea faka-pālangi foki e tēvolo ia.*
- English        What are our Tongan words for devil? Maybe *tēvolo* is a *pālangi* word.
- Soane         *Lea pālangi e tēvolo.*
- English        *Tēvolo* is a *pālangi* word.
- Soape         *Temeniō.*
- English        Demons.
- Saimone       *Satulō.*
- English        (Tongan new term for mental illness identified in this research referring to the devil).
- ‘Ili            *Ko e hā e fo’i lea ko e fa‘ahi kehe?*
- English        What is the word *fa‘ahi kehe* (the other side)?
- Vuna          *Fa‘ahi kehe.*
- English        The other side.
- Soane         *Fa‘ahinga ia ‘oku kehe mei māmani. Ko ‘etau fa‘ahi ‘a māama, ōo e ia ‘o fa‘ahi mai he fakapo‘uli, tēvolo ia, ‘a ia ko e fa‘ahi ia ko e, tapu mo Vuna, ko honau kakai ia.*
- English        Those who are different from this world. We are on the same side with the light; they went to the dark side. That is the devil, so that side, with due respect to Vuna, that is his people.



This *talanoa* shows the many responses and how participants came from different angles when ‘Ili asked the question about *tēvolo*. Participants came back with *temeniō* which is itself a Tonganisation of demons, and *satulō* which is a word used for *tēvolo* and regarded as a colloquial term as it is not found in Tongan dictionaries. Many Tongan people know what these terms are about but do not know their origins. ‘Ili asked again about *fa’ahi kehe* and this prompted more *talanoa* with participants agreeing and realising they had overlooked *fa’ahi kehe* (the other side) as other new words had replaced *fa’ahi kehe* in their everyday language and practices. Soane’s reference to Vuna (another participant in the men’s group) as being from the dark side is significant in Tongan society, as Vuna is a talking chief descended from the old lines of Kings who are known as the Ha’a Tu’i Tonga. This line ruled before the introduction of Christianity and was closely associated with Tongan traditional Gods. Vuna clarified the *fa’ahi kehe* and its meaning in association with Christian movement.

*Comments 361 (Men).*

Vuna            *Ko ‘etau ui pe foki ‘e tautolu, ka ‘oku te’eki ‘omai e tēvolo, ko e kakai ia ko e ‘oku mate, pea toki hoko ‘o ma’ali holo, ‘oku tau ui ko e fa’ahi kehe, na’e ‘asi e fu’u fa’ahi kehe ... pea taimi ko e ‘oku ha’u ai ‘a e tēvolo, pea tau mafuli leva ‘o tēvolo, hē, he ko e fa’ahi kehe, ko e tēmenio, ko e pūloa, nifoloa, hē.*

English        We called it that, as the devil did not come then, it is the dead people, they wander around, we call them *fa’ahi kehe* ... then devil came and changed to devil, eh, the *fa’ahi kehe*, demons, masked, long tooth, eh.

While on the dark side and discussing devils, consequences like curses were discussed by Lemeki at the *talanoa* with families without mental health service users. This discussion

around family histories and trying to detect if there were any wrong doings so that they can relate to it and define mental illness as a result of a curse on the family. This was discussed in the literature review in Chapter Three where breaking of cultural norms correlates with mental illness.

*Comments 263 (Families without mental health service users).*

*Lemeki*            *He 'oku fa'a hoko pē foki he taimi e ni 'ihi, 'a e fakafehu 'i, vakai na 'a mou fai ha kovi ... ha mala na 'e fai, makatu'unga ai e fanau 'i mai 'oku pehē ... Ngaahi me'a ia 'oku fakatu'unga ai e palopalema ko e ki he 'atamai ē.*

English            And it happened sometimes – we questioned, check if you did something bad ... some sinful act which is why he/she was born like that ... Those are things that cause problems with the brain, eh.

Participants' experience with mental distress – either directly or indirectly – clearly influenced where they align on the continuum. Experience is very powerful as it allows the individual to feel and actually live the moment. Learning and ways of knowing in Tonga are mostly through visual and on-going practices which are components of experiences. The experiences were of personal experiences of mental illness and/or included working, seeing, or living with someone with mental illness. An example is given to show the importance of the relationship between experience and knowledge creation in general for Tongan people.

The women's *talanoa* group described how Tongan people create and build knowledge through experiences. Melo gave the example of how traditional Tongan knowledge holders journeyed and preserved traditional ways of navigation. Melo explained that Tongan people practiced these skills and they were successful. This success was also discussed in relation to healing where people were treated successfully using Tongan traditional healers and

treatments influenced people's ways of knowing and understanding of concepts. The example given aligns people to the *tufunga faka-Tonga* (Tongan constructions). The positive experiences influence how Tongan people construction mental illness: this, in turn, determines which end of the continuum (see Figure 4.4) they align more with, *tufunga faka-Tonga* (Tongan constructions) or *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions).

*Comments 108 (Women).*

Melo            *'Oku 'osi'osi ta'u 'a e tū'ulu 'a e kakai 'i he lokiako hono ako'i, 'a e anga 'o e tahi, ke lele'i ai e vaka mo e anga mama'o, mo e uta ke fa'o ai. 'Aho ko ē, na'e tangutu pē e motu'a ia 'o sio hake ki he fetu'u, pea pehē, "oua e ō he 'oku mahu'i e tahi, 'e toka e vaka ia", ko e 'ilo ia mei fe?, ... ko e 'aho ni ia, 'oku faifolau ia he kapasa, ko e faifolau ia 'a ono'aho, na'e sio ia ki he fetu'u ko ē he langi, taumu'a a he, pea taumu'a pe ia ki ai pea taufonua, ...na'e fāfā pē ki tahi, neongo 'ene po'uli 'a hono fofonga, pea na'a ne 'ilo ko e potu tahi e 'o Ha'apai, ko e fa'ahinga taukei pehē.*

English        There are many years where people study in classrooms, studying about the ocean, how boats travel and how far and how much luggage each can carry. Back in those days, an elder would just sit and look up to the stars and say, "Do not go as the sea is not good, and the boat will go under". Where this knowledge did came from?....Today, boats use compasses in their journey; back in those days, people looked at the stars in the sky, focused on that, and they did and they reached lands...he reached and felt the ocean as he did not see anything, he felt

and knew that it was a piece of the *Ha'apai* group, that is the level of expertise.

Pita shared with the community leaders his experiences around mental illness and how a young girl was possessed and presented herself in an unusual way which cemented Pita's construction of mental illness – being possessed by the spirits.

*Comments 324 (Community leaders).*

Pita            *Ko hoku matāpule, ko 'eku sio tonu ia ha lea mai ha le'o mei ha ki'i ta'ahine si'isi'i pehē, 'oku fu'u ta'e'efe'unga 'aupito ia, 'oku mo'oni e tēvolo ki a au, pea 'oku ou tui pe au ki he tēvolo, ka kou ma'u 'e au e fo'i mo'oni, 'ikai ke lava, fakafoki mai mei falemahaki 'ikai ke lava ia 'o faito'o e.*

English        My brother in law, this was my first time seeing with my own eyes a voice that comes from a young girl, it was very incompatible, and the devil is very true to me, and I have got that truth, they were not able, returned from hospital as they were not able to treat.

Participants' experiences with mental distress directly and/or indirectly were discussed by participants throughout the research and some of their quotes were overlapping with other themes and subthemes. Experiences of mental distress also determine the treatment options for the participants and the outcomes of these treatments, contribute to constructions of mental illness. Sina discussed a dark spirit, that Tongan people refer to as *tēvolo*, hence calling this illness *puke faka-tēvolo*, as a *puke* (illness), associated with the *tēvolo* (devil). Sina stated where she stands in terms of interpreting mental illness and also stressed that this interpretation requires different management and treatment.

*Comments 13 (Women).*

Sina            *'Io hangē ha tēvolo, pea mo e kakai ia 'oku mate. 'Oku ne fakamatala na'e sio ko e ki ai, ko e 'uhinga ia ko e 'etau pehe ko e, ko e puke faka-tēvolo e, ko e 'uhi ko e kakai ia, nau 'osi mate nautolu, nau mole nautolu mei māmani, 'oku sio ia ki ai 'oku nau feohi kinautolu, hee.*

English        Yes, it is like the devil and dead people. He/she explained that he/she saw them, and that is why we say it is *puke faka-tēvolo*, because they are dead people, and they have gone from this world, and he/she sees them and is having fellowship with them, eh.

There are different forms of Tongan traditional medicine, mostly involving the use of herbs and leaves that are administered orally or as nasal, eye, and ear drops. Soane from the men's group described how treatment was given and there is also a sign that tells straight away that this is the right medication. The sign of receiving the right medicine is usually when one feels stinging in the throat as soon as the medication is taken. The stinging feeling is the reaction that people are looking for to indicate it is the correct medication. Soane described treatment for possession that involved physical beatings but the person was left with no injuries.

*Comment 51 (Men).*

Soane            *'Oku 'i ai e fa'ahinga faito'o 'e taha 'i e 'āvanga ko e tā'aki 'a e loholoho, tā he mata ē, 'a ia ko e tokotaha ko e 'oku puke 'oku tā e, ka e 'osi ange hono tā, 'oku 'ikai 'ilonga ha me'a hono mata, fo'i me'a faikehe ia ē?*

English        There is another treatment for *'āvanga* which is beating with the *loholoho* (part of the coconut tree where the coconut fruits hang onto),

hit the face eh, beating the one who is un-well. After beating him/her, there are no body marks on his/her face; that is weird, eh?

*Comments 15 & 19 (Men).*

Soane        *'A ia ko e nonu, ka taimi ke 'omai hono fanga ki'i fisi, fua kei iiki, ke te mamamama 'o folo. Ko e fifisi atu fau, pea ko hono mamamama e me'a ko ia 'o tulu'i'aki e mata, pe ko e ihu 'o e tokotaha ko e 'oku 'āvanga, ko e mamahi atu, pea ka 'iloange 'e taka, 'oku sai. 'A ia ko e anga ko e sio 'a e matu'a, ko e 'ai e me'a ko e 'oku vevela ange, he ko 'ene tau pe, 'oku teteki e sino 'a e tangata ko ia 'o foki, hangē 'oku tuli 'e ia 'e tēvolo e ... 'A ia ko hono tulu'i atu pe 'o taka, 'oiaue e taha ko ia, sai. 'E faka'eke atu, ko hai, ko hai na'a ne 'ave ko e? Talamai, ko me'a ia na'e ha'u. 'Eke atu pe ko fe tama ko ia, fuoloa e mate 'a masi'i ia ko ia, ko hai na'a ne 'ave ki ai, ko e fo'i sio faka tēvolo, 'a e pe ko e 'oku 'i he tui ko e 'a e kakai Tonga.*

English      So for the *nonu*, when it is to bring its bud, very small fruits, and I chewed and swallowed it. It is very hot, and chewing that part and drop it in the eye or nose of the *āvanga* person, it is so painful, and if it is stinging that person will be better. So the elders viewed it as, when we get something that is very painful, as soon as it touched anyone, their body shuddered with fright, and that is like chasing the devil ... So when treated with healing liquid and the person felt the pain like stinging feeling, the person cried “*oiaue*”. They are well, then questioned, who? Who took you? He/She said it was that person that came. Then asked him/her, where he/she is? The person (who he/she was talking about) had passed away for some time. Who did he/she

take you to? He/She saw the devil, which is what the Tongan people believed in.

Tongan people have medicine for this illness and have early signs of identifying if the medicine is successful; Soane demonstrated this when looking from a Tongan cultural perspective and practice. The following piece from the *talanoa* with families with mental health service users revealed a time that traditional healers and their assistants/team approached a grave to address the concerned dead person's spirit as a treatment for someone. Vikilani emphasised in the *talanoa* that the traditional healer's team has to be at the grave about eight 'o clock in the evening before spirits wander, and they will be able to communicate with the concerned dead person's spirit or the devil before they leave the grave. Vikilani outlined the process at the grave for healing and its effect.

*Comments 48 (Families without mental health service users).*

Vikilani        *Te ma tuli efiāfi e valu ki mala 'e ke ma 'u 'oku kei loto tokua, ee, 'a ia ko e fakapo'uli hifo. 'Oku ma avangi leva e fa'itoka, hū ki ai e fo'i pamu 'o fakatafe e vai ki ai. Ko 'ene fakatafe ko e 'a e vai, pea ko 'ema foki mai ko ia, 'oku sai ange 'a e mahaki ia 'o talamai ko e 'oku ha'u 'o kole fakamolemole 'oku lalave mai e tafa'aki ko e, mahalo ko e tafa'aki ia na 'e mahua atu ai 'a e lou 'akau pe ko e ha, hee.*

English        We will rush to the grave to get there before eight 'o clock in the evening, to get him/her (dead person's spirit) inside. We opened the grave, inserted a pump, and drained the water and leaves inside. When the water and leaves were drained, we returned and found that the unwell person was already well. He/she (dead person's spirit) came and

apologised as it was hurt on his/her side (referring to the dead spirit), maybe that was the side that the water and the leaves came on, eh.

Vikilani spoke of draining water and leaves from inside the grave which hurt the dead person in the grave. After the draining of materials they returned to find the un-well person already recovered, saying that the concerned devil came and apologised and begged for forgiveness. The men's group had the same interpretation, but presented another option from water and leaves, and also discussed treatment in a New Zealand setting, using plastic flowers at the grave, or some soil from the grave and sea water. Soane reported the boiling of plastic flowers in the grave or boiling some soil in sea water which can also chase the devil spirit and cure people with mental illness. Soane started with assessing the presenting problems and exploring what happened followed his process of chasing the devil. *Manutaka* is a pseudonym for a grave in New Zealand that was named in the *talanoa*.

*Comments 197 & 199 (Men).*

Soane        *He 'e toutou 'eke, kohai? Ko me 'a, to e puke mai, 'eke atu, kohai? Ko me 'a, taha tatau, faka 'eke 'eke atu, 'io, ko e motu 'a pe mei motu, ka 'oku tanu 'i Manutaka. Pea omi leva ki Manutaka. 'A ia ko hono 'ai 'e taha, tānaki kātoa ha 'akau pelesitiki, kapau 'oku 'i ai, 'ai 'o haka 'aki ha tahi, pea 'ai 'o hua 'i ai e tahi, ka e 'ave e matala 'i 'akau 'o lī ki tahi. Ko hono tamate 'i 'anga ia 'o e tēvolo, 'i he tui faka- tēvolo... pea kapau 'e 'ikai ma 'u ha me 'a ai, tata 'i ha ki 'i me 'i kekekele, 'o 'ave pe 'o haka, haka 'aki e tahi. Ko e tahi ka 'oku 'ikai ko ha vai ke fakamāsima, 'a ia ko hono tamate 'i ia, pea ko hono to e 'ai 'e taha ko e 'i Tonga, ko e tānaki e lou 'akau, pea 'ai 'o haka, pea 'ave 'o vaku 'i ha ki 'i kekekele, 'o tanu he fa 'itoka ko ia, ke 'oua 'e to e tu 'u 'a e*



*tokotaha ko ia 'o to e 'alu holo. Pea sai 'aupito ai, 'oku mo'oni 'a e fo'i me'a ko ia.*

English Many questions will be asked, who is it? It is this person (Mr *Pule* – pseudonym for clarification purpose), another one becomes un-well again, and questioned again, who is it? It is this person (Mr *Pule*), same person, yes, it was a man (Mr *Pule*) from the island and he is buried in *Manutaka*. So we came to *Manutaka*. So one way of doing it, collect all the plastic flowers, if there are any, boil with sea water, pour the sea water out, and take the flowers and throw it into the ocean. That is how we kill the devil in the devil ways of beliefs ... and if we can't find anything there, collect some soil and boil it, boil with sea water. It is sea water and not water with salt, and that is how we kill it, and one way of doing it in Tonga, is collect leaves, and boil, and dig a hole at the grave, and bury the boiled leaves there so that person won't be able to get up again. He will be good, and this is true.

In the *talanoa* groups, time was acknowledged and discussed in relation to past, present, and future and how mental distress has been interpreted and labelled over time. Soane pointed that mental distress was once called *faka-mahaki* and now scientists call it mental illness. Soane also mentioned Dr Mapa Puloka's work translating mental illness in the Tongan language (Puloka, 1999), and how the treatment of mental illness has changed through time – it used to be based on traditional Tongan knowledge.

*Comments 42 (Men).*

Soane *Pe ko e faka-mahaki, ka ko e lau he taimi ni, e saienisi, 'oku puke faka-atamai.*

English Or *faka-mahaki* (possessed by the devil spirit), but the words now, scientists, it is mental illness.

*Comments 45 (Men).*

Soane *Pea toki vahevahe ki he fa'ahinga 'āvanga, pe ko e hā fua, 'oku hanga 'e he masi'i ia ko Mapa, 'oku fu'u faka-Tonga'i lahi 'aupito e me'a ē, 'enau kehekehe. Ka ko e anga ko e 'a e 'ū me'a na'e 'ai 'aki he finemātu'a mo e me'a ko ē, he taimi ko e 'a e faito'o, ko 'ene puke pē, lele kia me'a, pea ko e kei lele e tokotaha ko e, 'oku talamai he'e tokotaha ia ko e 'oku puke 'oku sai ia, hēe, "‘osi sai au”.*

English Mapa then distributed mental illness into different types of *'āvanga* and so forth and he (Mapa) did a lot of work in translating these (mental illnesses) into Tongan, their different types. But the old ladies treated these in the past. When someone was un-well, they sent someone to the healer (old lady), and when the person is running (to the healer), the un-well person said that s/he is well, eh, "I am already good".

*Akafia* is an illness where someone is experiencing severe pain and discomfort and is unable to manage despite Western and biomedical treatments. *Akafia* is usually treated by removing and cleaning a dead person's (usually family members) remains from tree roots and other materials that may have intruded into the burial sites. *Akafia* is usually revealed in dreams in which one will see the ancestors appearing and asking for help and explaining why they are going through severe pain. Instructions are usually given about the intruding tree root or object. Once this is dealt with, and remains are cleaned and returned, the severe pain eases for the un-well person. *Akafia* does not directly link with mental illness but demonstrates the

strong traditional construction of one form of an illness and how it was managed effectively with a traditional Tongan way of treatment. *Akafia* also supports Bloomfield's (2002) arguments about the relationship between humans and the supernatural, and its relation to wellness and illness (Bloomfield, 2002) which was discussed in Chapter Two.

*Comments 127 &128 (Families without mental health service users).*

*Vikilani*      *Ko e akafia ia ... ko e 'ū hui ko e 'oku tanu, kuo 'alu atu ... ha aka ia 'o uesia ... mo e me'a 'e taha ko e tupenu ... ko e me'a ia 'oku fakatu'utamaki ai he taimi ni e ngaue'aki ko ē e sote nailoni mo e me'a 'oku 'ikai ke 'auha ia, 'oku fakatu'utamaki ia, he ko e taimi ko e 'oku 'osi ai hui mo e me'a, ka e 'alu hifo ia 'o ... 'o piki ia he hui ... 'a ia kuo pau ke 'i ai ha taha ia he fāmili 'e uesia, 'e langa ha feitu'u.*

*English*      *Akafia is...skeletons of the dead that are buried, roots of trees go into them...and the other thing, is clothes...it is very dangerous, nowadays when using shirts with nylon materials and things that are not destructible, very dangerous, because when the skeletons are finished, clothes stick to the bones...so someone in the family will be affected, experiencing pains.*

*Lemeki*      *pea ko 'ene toki faka'ata'ata pe e hui ko ia ... ko 'ene sai ia.*

*English*      *and only become well when the bones are cleared.*

Mosese in the community leaders' *talanoa* discussed how the hospital system had clearly admitted that they were not able to provide any treatment, "*fakafoki mai mei falemahaki 'ikai ke lava ia 'o faito'o e*", "returned from hospital, unable to treat" for a person admitted with *puke faka-tēvolo* (illness possessed by spirits).

*Comments 314 (Community leaders).*

Mosese           ‘Oku ‘i ai hoku ki ‘i kāinga, ko e me‘a ia ‘oku ou tauanga ‘a ai...ko e ki ‘i ta‘ahine, mahalo pē, pe ko e 21 pe me‘a e, ha‘u ‘o ako he ‘Univesiti ‘i [ongo motu Pasifiki ‘e ua], talu ‘ene foki ki Tonga mo e puke, hangē ko e ‘oku faka-tēvolo, mahalo ko e tokoto eni ‘o ta‘u taha ‘o ‘alu ai pe ia ‘o mālolo, ‘a ia ‘oku lahi pe hono tukuaki ‘i ko e, na ‘e fakalou ‘akau ‘i.

English           I have a relative...that is why I am wearing black...a young girl, maybe around 21 years of age, came to study at university in [two Pacific countries] and she had been un-well since getting back to Tonga, like she had been possessed by evil spirits. I think she had been bedridden for about one year, and then she sadly passed away, and most think that she was cursed through voodoo magic.

Mosese’s experience pushed him away from the hospital system due to their failure and his interpretation through a possible cursed form suggests higher chance of moving towards *tufunga faka-Tonga*.

One form of expressing reality is through *heliaki*, this means metaphor or analogy or saying “one thing and meaning another, making reference to a subject by going around it and enhancing it with layers of meanings” (Tuku'aho et al., 2004, p. 31). *Heliaki*, then, is closely related to the concepts of metaphor and using analogies. Tongan people use stories to demonstrate their arguments and *heliaki* is a Tongan concept where views and opinions are expressed in a narrative sense using stories with themes – this is evident in the comments of Lemeki and Toakase, below. The youth *talanoa* group started by explaining the intangible nature of mental illness; something that can not be seen physically, but is identified when the brain does not function well.

*Comments 14 & 16 (Youth).*

Naioka Ah, mental illness to me is something that is not physical, I mean, you can't touch it and or, ah, but to a certain extent can kind of control it ... yeah, I mean you can control it, and stuff, but if you do have like a group of mental illness that can be control, without medicine.

Toakase, a female youth leader, used a *heliaki* to compare the brain to an electric power supply which is overloaded from the use of too many appliances for the supply of electricity.

*Comments 49 (Youth).*

Toakase 'A 'ia 'oku hangē ko e, 'a ia 'oku overload leva e ngaahi me'a ko eni 'i hoto 'atamai. 'A ia 'oku tatau pe eni mo e 'i ai ha fo 'i palaki 'e taha ka te palaki atu ki ai e ngaahi me'a kehekehe ki ai. Pea 'ohovale pe 'oku fo 'i mate fakafokifā pē, hee, 'a ia 'oku fu'u overload leva e 'u me'a ia 'oku palaki ko e ki ai. Tatau pe mahalo mo e ha'u 'a e ngaahi taimi 'oku lahi ai 'a e fakakaukau 'i hoto 'atamai. Pea kuo tu'u fakafokifā 'a 'ete fakakaukau pea tau 'o mental leva e.

English It is like an overload in our brain. It is like a power supply where we apply different appliances to it. All of a sudden, there is a power outage and it turns off, as it is overloaded with all the things that are connected to it. This is the same when there is too much thinking in our brain. Our brain turns off suddenly and we have mental illness.

Lemeki from families without mental health service users' *talanoa* group, also used a metaphor to explain mental illness comparing it to a balloon.

*Comments 350 (Families without mental health service users).*

Lemeki        *Ko e hangē pe ko e ko e puhi ko e fo 'i pula, ko 'ene puhi, puhi, puhi, 'oku 'alu pe 'o pāa 'a e fo 'i pula, pea 'oku natula pehē pe 'a 'etau, 'a e ivi mafai ngāue ko e 'atautolu.*

English        It is like blowing a balloon; we blow, blow, blow and the balloon will explode, and that is the nature of our ability to work.

*Heliaki* is characteristic of *talanoa* where the conversation it can be circular and going around the truths ('Otunuku, 2011) and what Vaiioleti (2011) argued as a tool that determines cultural competencies of one working with Tongan people. In working with Tongan people, Moana claimed in the service users' *talanoa* group that mental illness is not a *pālangi* illness but existed within Polynesian society and was called *fakamahaki*.

*Comments 37 (Service users).*

Moana        Because it's not an illness that comes from the brain, but they come from the, I don't know where they come from. I think they come from the Polynesian people, not the *pālangi* or anything, like a devil spirit comes into your mind and makes your body go *faka-mahaki, faka-mahaki ia*. I think that's the one.

*Fa'unga* (reality) as discussed, are the many realities that Tongan people give to illness, discomfort, unease, and distress, and the definitions and causes used for these. These understandings are determined and reinforced by beliefs and practices and their historical and cultural understandings of mental illness and become the *fa'unga* (reality) of mental distress and mental illness. The *fa'unga* (reality) of mental distress and mental illness also used

tangible materials that are smooth and circular in shape to explain mental distress and mental illness when these tangible materials have been ruined and damaged, referring to it as a weak brain (*'atamai vaivai*). The possession by spirits was also discussed in relation to mental distress and mental illness. Each of these has different ways of creating distress and therefore different associated treatments. These interpretations have many levels of realities and different meanings behind each reality. This theme indicates the spirituality aspects and interpretations of mental distress and mental illness. The spiritual dimension was a reality for mental distress and mental illness for Tongan people and was significant in constructing mental distress and mental illness. The next subtheme, *hu'unga* (directionality), discusses movement and direction within *fa'unga* and also travelling outside *fa'unga* in relation to constructions (*tufunga*) of mental illness.

### ***Hu'unga* (Directionality)**

The second subtheme of *tufunga faka-Tonga* is *hu'unga* (directionality). Participants across all of the groups described life as a *fononga* (journey). This subtheme discusses these journeys in terms of movement and direction and how there are expectations that people move forward within prescribed directions and at certain times. *Hu'unga*, therefore, focuses on movement and direction within *fa'unga*. The *fa'unga* (reality) data identified that there are prescribed movements and directions within *fa'unga* – there are particular expectations to live within a defined reality, and people in the Tongan community are expected to live according to values prescribed by Tonga culture and traditions. When one's direction takes one outside of *fa'unga*, this is seen as a possible early sign of the onset of mental distress and people are interpreted as being un-well. This unwellness is further categorised into two areas: obsessively thinking about something is *'āvea*, and being taken away from *fa'unga* by *fa'ahi*

*kehe* (the other side/being possessed by spirits) is *‘āvanga*. When there is a Tongan funeral, people are expected to wear black and also *ta‘ovala* (mats around the waist) and the size and colour of the *ta‘ovala* demonstrates one’s relationship with the deceased. Failure, to comply with these expectations will be regarded as moving out of reality in a different direction and these are explained as forms of mental distress.

Directionality was contextualised by participants into time components like day and night, and day was regarded as a *fa‘unga* (reality) of mental health, while moving to night and darkness was seen as being outside of *fa‘unga* (reality) of mental health, and referred to as *fa‘unga* (reality) of mental distress and illness. The Tongan word used for behaving in a manner outside of the defined and allocated reality is *hē* (lost/astray). *Hē* (lost/astray) was employed on numerous occasions by participants to describe someone who became un-well.

Anger was also regarded by participants as a sign of the development of mental illness, people act out of the ordinary when they become angry. Anger was interpreted as moving away from reality or daylight, with darkness covering reality so that a person then acts in an unusual way. The mind has a day (light) and night (dark) cycle and reality is the day period. Ane demonstrated how Tongan people discuss behaviours that are visible and acceptable in the light and therefore regarded as good and acceptable within the Tongan communities. It is possible for the mind to change and anger was described as the unreality, and was referred to as *fakapo‘uli*, literally translated as being filled with darkness.

*Comments 130 (Community leaders).*

Ane                      *Pea ‘e lava lava ke liliu hotau ‘atamai, ‘o ‘i ai e ‘ita, hē, ‘a ia te tau class e ‘ita ko e fa‘ahinga ia ‘e taha, cycle ia e taha ‘o e mental e, he ‘oku te ‘ita pea puli, na’e fa’a lea ‘aki, “na’e si’i fakapo‘uli nai e”, ‘a*



*ia 'oku mole nai 'a e, liliu leva 'a e 'ulungāanga ia ko ia he taimi ko ia e*

English It is possible for our minds to change, and become angry, **lost**, and then we classify anger, as one component on the cycle of being mental, as they say when I am angry and things disappear, “was darkness (*fakapo 'uli*) like aye”, which I lost it, behaviour at the moment changed (emphasis added)

The emphasis I have put on '*hē* (lost)' is to highlight how it played a significant role in the data and relates to one's journey within the expected reality of the Tongan community and what they referred to as mentally healthy or represented by the daylight and when someone *hē* (lost) from this daylight, they are referred to as some forms mental distress where Ane talks about lack of self-control, in Ane's comment, darkness.

Vili discussed lack of self-control in the community leaders' *talanoa* group where emotions take over our behaviour and difficult to control ending up laughing uncontrollably and can be read by others as unusual or forms of mental distress.

*Comments 154 (Community leaders).*

Vili *Hangē ko e lau ko ena ko e ki he 'ita, 'oku 'i ai e taimi ia e ni'ihī, fuoloa ko e 'a 'ete 'ā, 'ohovale pē 'oku 'ai mai ha ki'i me'a ia 'oku fakaoli, 'oku te fiu kita ia hono ta'ota'ofi, 'oku te katakata ai pē kita ia.*

English Like that discussion about anger, there are times where we stay awake for a very long time, suddenly, if someone has/says something funny, it is difficult to control laughing and you keep laughing to yourself.

Mosese explained lack of self-control with episodes where people become moody and act unusually were also discussed as being some form of mental distress and mental illness. In these episodes, people are moving out from expected boundaries of Tongan community on accepted moods and actions.

*Comments 101-102(Community leaders).*

Mosese            *'a ia kiate au, kau pe mo ia ia he fakalea 'a'aku he mental e, 'oku 'i ai pe e ki'i moment*

English            for me, it is part of the definition of mental eh (referring to anger), there is a moment

Kefi                *meimei tatau pe mo e being moody*

English            about the same with being moody

Saia explained further that *hu'unga* as moving away from the Tongan community's expectations, such as becoming lost caused by the misuse of drugs and alcohol. Drug and alcohol use were linked with struggling with socio-economic needs, which may lead to the use of drugs and alcohol as coping mechanisms, and that later develop into problematic use.

*Comments 158 (Families without mental health service users).*

Saia                *Ka e hēhē tokotaha holo ko e 'a e tokotaha ko ia, pea 'i he'ene hē ko ia, fu'u fiema'u 'e ia he taha ke kole ha'ane seniti, 'ikai ke to e ngāue, ko e kole atu 'o 'ikai ke tali. Pea 'alu leva ia ki he tafa'aki 'e taha, 'a e ifi mo e me'a.*

English            When someone goes astray and becomes lost, he/she will very much need someone to provide cash, unemployed. When he/she does not receive these, then they turn to smoking and things like that.

Other participants did not focus on unemployment but acknowledged the role of the misuse of drugs and alcohol in relation to mental distress, claiming that smoking leads to use of other related substances like drugs and alcohol. The families without mental health service users *talanoa* discussed Tongan parenting and boundaries and how these boundaries are affected by migration from Tonga as Tongan children in A/NZ are able to challenge these boundaries. Tongan parents in Tonga have clear boundaries of what children are allowed to do and not to do, and physical discipline is applied when children cross these boundaries. In A/NZ, however, such physical discipline is regarded as physical abuse and is illegal, and the participants revealed their fears about children becoming manipulative. The attitudes of children in A/NZ are also affected by other influences such as school, media, television, other cultures, and other broader influences. This suggests that mental health in *hu'unga* (directionality) is also the ability to live within the boundaries or *fa'unga* (reality) and mental distress is considered when someone moves out beyond these boundaries.

*Comments 163-167 (Families without mental health service users).*

Lemekiki      *Ka 'i ai ha taha 'e tō kitu'a, 'oku 'ikai ke 'ilo ki ai 'a e matu'a, kuopau leva ke ki'i kamosi, hee, ko e fa'ahinga tautea ko ia, ko 'etau ha'u kitautolu ki muli ni, 'oku ki'i fā'atā ange leva e laini ia, hee, 'ikai ketau tā, katau lea. Ka 'i he taimi tatau pē, 'oku kei hoko pe e me'a ia 'i Tonga ia, 'o hangē 'oku ki'i ngali si'isi'i ai 'a e uesia ia, katau ha'u kitautolu ki heni .... 'e faingofua ange ai 'enau ō 'o 'ahi'ahi'i holo, 'a e 'u life kehekehe holo ko e 'a Nu'usila ni. He ko e ō ko e ki he ako, 'oku ō ia 'o mix mo e kakai kehekehe, mo e fa'ahinga to'onga mo'ui kehekehe. ..ako'i pe ia he ako, ka tāa'i moutolu, to'o e telefoni 'o tā ki he kau polisi, hee, 'o hangē ai pe ia kuo faka'atā kiate kinautolu kenau 'ahi'ahi'i e me'a kotoa pē, he ko e ifi ia mo e me'a 'oku 'ikai ko ha*

*me'a, ka ko Tonga ia, ko hono hapo'i 'o'ona ia, ko e me'a ia ke malu'i'aki.*

English If someone falls outside (from the boundaries discussed earlier), starts going off track, and the parents do not know about it, there is need to immediately warn them, so those disciplines are applied. When we come overseas, the boundaries are broader, we do not slap but we talk. In the meantime, the same thing (discipline) happened in Tonga, and it seems like the number of people affected (by mental illness) there (in Tonga) is less while we are here ... It is easier for them here in New Zealand to access all kind of things, when they go to school, they mix with different sorts of people and different sorts of life ... They are taught at school, if you are smacked, pick up your phone and call the police, and it seems easier for them to try everything, like smoking and all those, whereas in Tonga, it will be a smack to protect them.

Lemeki goes on to say:

Lemeki *Kapau na'e 'ikai ke tāa'i ko e ia ho'o 'alu hake, na'e 'ikai ke a'u ko e ia ke fakaa'u ho toketā, ka kou tui, na'e ki'i tokoni hono 'akahi ko e 'o lī kitu'a.*

English If you [the researcher] were not smacked when you grew up, you would never have got to do your doctorate study, and I believe that your parents kicking you and throwing you outside helped.

Lemeki's examples explain both the notion of boundaries that Tongan parents have when raising their children and how these boundaries are stretched and blurred when families migrate to A/NZ. In other words, what is regarded as acceptable discipline is interpreted

differently in both contexts, what is acceptable in Tonga as discipline is interpreted in A/NZ as abuse. These different interpretations need careful clarification. Lemeki argued that discipline in Tonga has good effects and produces good outcomes and used the researcher as an example to support his argument, emphasising that the discipline the researcher experienced in Tonga ensured that he stayed on the right path towards gaining a doctorate. Ignoring this, he argued, will result in conflict causing misunderstanding of boundaries both from Tongan and Western perspectives. Lemeki illustrates the expected expectations from the Tongan community where an individual can move in certain directions (*hu'unga*) and become successful, using the doctorate study example, and another movement in a direction outside (*hu'unga*) of the Tongan expected expectations is driven by non-Tongan influences in the A/NZ society.

Another instance of *hu'unga* was noted in the service users' *talanoa* where Tevita highlighted another movement which mental health users desire; that is moving back in the direction of prescribed reality, through recovery, determined by biomedical practices.

*Comments 25 (Service users).*

Tevita            Ah, mental illness to me is being un-well and not being (pause) independent and wellness and therefore kinds of names were mental illnesses that are written down by nurses and doctors for the type of mental illnesses you have, and you have to take medication for mental illness, and some people are on the road to recovery and some can't recover.

Tevita's comment discusses the journey from the mental illness perspective. He highlights that journey can apply to also travelling back from mental illness to mental health. Mental illness associates with being dependent on other people and mentally healthy is travelling

through to independent. He demonstrates how service users are aware of their location in the journey, illustrates their aim to make it to mental health through recovery.

There were significant data discussing movement out from *fa'unga* (reality) through *'āvea* (obsessive thinking) and also *'āvanga* (possession by spirits). The following segments will discuss the data associated with obsession and possession.

### ***'Āvea* – obsessive thinking**

Obsessively thinking about something is referred to as *'āvea*, where the direction of one's thinking becomes different to society's expectations and defined norms and values. This is indicated by the following *Comments*, 32, 36, and 77 from the families without mental health service users' *talanoa*. These comments highlight Tongan people's interpretations of one's mind being obsessively occupied by factors outside of the prescribed reality; that is, the mind and thinking travels to that factor outside of reality, and the mind becomes obsessed with it. Eventually the mind creates its own reality which is perceived by others as behaving unusually and outside normal life, and therefore, the person is un-well mentally.

*Comments 32 (Families without mental health service users).*

Lomio            *Kou mahalo tama ko e hingoa faka-Tonga, ko ha taha ko e 'oku mole  
'ene fakakaukau 'i ha me'a, 'i ha fu'u nofo fuoloa 'ene fakakaukau 'i  
ha me'a, 'oku ui leva ia ko e 'āvea.*

English        I think maybe the Tongan name; it is someone that had lost their  
thought when thinking about something, their thoughts stayed for a  
long time with that thing and they were unable to let go, and that is  
what is called *'āvea*.

*Comments 36 (Families without mental health service users).*

Lomio            *Ka ko e puke ia ko e 'i he hē e 'atamai 'i ha fu'u mo'ua 'ene fakakaukau 'i ha me'a 'oku 'āvea ia, 'alu'alu ai pe 'ene fakakaukau 'a'ana he me'a ko e 'oku nofo ai 'ene fakakaukau 'o hē hē ai pe ai.*

English            But the illness is when the mind is *hē*, it is when the mind is obsessed with something and becomes *'āvea*, that person's thoughts become very lost.

*Comments 77 (Families without mental health service users).*

Lomio            *'A ia 'oku tau pehe, 'oku nau fo 'i fāmili taha pe nautolu ia, ki he, ko e mo'ua 'a e fakakaukau 'i ha fa'ahinga me'a, pea tupunga ai pē 'ene mole, hē ai pe e fakakaukau.*

English            So we can say that they all identify to one family, when thoughts are obsessively occupied with something, it got lost, and their thinking becomes lost through the process.

Lomio's comments demonstrate how a person starts moving outside the communal/family reality and forms their own reality, which is translated by others as the person being *hē* (lost from reality). As *hu'unga* involves place (*fa'unga*), movement and direction, where the individual is being directed to a place outside of the communal reality and they move towards that place. Moving outside the Tongan community's *fa'unga* (reality) of mental health were reported as obsessively thinking about something outside of this *fa'unga* (reality) and referred to *'āvea*, another form of mental distress.

In the women's group *talanoa* Siu discussed the initiation of mental distress, *'atamai vaivai* through *'āvea*, where the whole thinking starts wandering towards an obsessive thought. Sina

supported Siu through their *talanoa* adding on an explanation about *'āvea* and *puke faka-tēvolo*.

*Comments 24 (Women).*

Siu            (*'Atamai vaivai*) *Ka ko e 'uhinga pe ia, ko ha me'a 'oku mo'ua ki ai hono loto, pea toka leva ia he'ene fakakaukau, 'o hanga pe he fo'i fakakaukau ia ko ia, 'o fakahehema'i 'a 'ene fakakaukau 'o ngali hē ai si'ono 'atamai 'o'ona.*

English        (*'Atamai vaivai – weak brain*) But it simply means that the *loto* is occupied by something, and that I am stuck with my thoughts, and those thoughts tend to incline my thoughts and my mind gets lost/goes astray.

*Comments 5 (Women).*

Sina            *Ka 'i ai ha taha ia, 'oku 'i ai ha fa'ahinga to'onga mo'ui kehe ia 'oku ne ma'u, pea 'oku ui ia ko e 'āvea e, mafuli ia mei he'ene mo'ui totonu ko e na'e 'i ai, hangē ko e 'oku 'alu pea vaevale lau noa'ia holo pe. Pea sio ka nofo ia ha feitu'u, 'oku talatalanoa tokotaha pe ia, pea na'e ui ia he taimi ko ia ko e 'āvea. 'O fa'a ui 'e tautolu ia, 'o tau pehē ko e puke faka-tēvolo, ko e 'uhinga ia ko e 'o e puke faka-tēvolo, na'e ui ia he taimi ko e ko e 'āvea.*

English        If someone adopted a different way of life, then it was called *'āvea*, change from the usual way of living, like going around aimlessly and mumbling all over the place. And if he/she stays somewhere, he/she will talk to himself/herself, and it was called in those days *'āvea*. Sometimes we call it *puke faka-tēvolo* (possessed by the devil), which means that *puke faka-tēvolo* in those days was called *'āvea*.



Siu and Sina described how one's *loto* can be obsessed with something and drive them away from reality as in 'āvea. This is also connected to a 'weak brain' as discussed in the previous section, in that the person's level of thinking has been controlled and taken over by their obsession, in other words their brain has not been strong enough to resist becoming obsessed.

In the men's *talanoa* group Vuna argued that obsessive thinking is usually 'āvea and this is not always related to the devil. He shared a story about his granddaughter who claimed that she had seen his dead sister in a dream, and emphasised that imagination can create reality at times through obsessional thinking about something. *Hu'unga* (directionality) then, shows that the person with the imagination embraces a direction that is seen to be outside reality and may, therefore, be treated by the society as having mental illness or forms of mental distress.

*Comments 288 (Men).*

Vuna            *Ko e 'ohovale pē e pō 'e taha vaeua pō, fetukutuku ange ia ki homa loki, kou pehe atu Lina, "ko e hā e me'a 'oku ke ha'u ai?" Fakalongolongo pe ia, tokoto hake ia he tafa'aki ko ia 'o 'ene kui fefine, ma'a hake 'a e 'aho kou pehe atu, "ko e ha e me'a na'a ke ha'u ai 'anepo?" 'Ikai ke talamai 'e ia. Ta ko e kuo 'osi fafana ia ki hoku mali, 'io, 'ilo Moleni 'a 'Ana, tuofefine ko ia 'o'oku, hoko ia 'ia au, mate foki ia heni, a'u ki he pō ko e, 'alu pe foki ia ki hono loki, fuoloa ko e po'uli, 'oku fetukutuku ange, mo hono 'ū kafu. "Lina, ko e hā e me'a 'oku ke ha'u ai?" Tangi leva ia he taimi ko ia, kou 'osi mahalo 'i 'oku ilifia e, 'ikai keu fakakaukau au ki he, kau mahalo pe 'oku ilifia he matapa sio'ata, pē 'oku 'i ai ha taha 'e fakasiosio mai ai, pea ko 'ene*

*ma'a ko e 'a e pongipongi pea 'alu ia ki he ako, peau 'eke ange ki hoku mali, na'e talaatu 'e Lina ko e ha e me'a 'oku ha'u ai? 'Io, talamai 'e ia ko 'ene mohe ma'u pē 'oku ha'u 'a 'Ana ia, 'o ha'u ia 'o fusi ki lalo mei he mohenga, tā 'o 'ai ke tāa'i. Pea a'u ki he pō ko e, 'alu foki 'a Lina ia efiāfi, ha'u au 'o ma'u e fo'i kī 'o loka'i atu e loka e loki, fuoloa e po'uli, kou fanongo atu ki he tuki mo e ui mo e tangi e, pea kuo fai eni kuo iku kē maua mo hoku mali, talamai ke, "tuku mai e ta'ahine".*

English Suddenly one night, by midnight, she brought her things to our room, and I said, "Lina, why are you here?" She was quiet and lay beside her grandmother. When day broke, I asked her, "Why did you come last night?" She did not say anything. She already whispered to my wife the reason why. Yes, Moleni, you know my sister 'Ana – after me? She died here (in New Zealand). The following evening Lina went to her room. Throughout the night, she came with her blankets and everything. I asked her, "Lina, why are you here?" She cried. I suspected that she was scared, and I never thought of...I thought it was something to do with the window, maybe someone was looking through it. In the morning, she went to school, and I asked my wife, "Did Lina tell you why she came to our room?" She replied, "When Lina was sleeping, 'Ana came and pulled her off the bed, trying to smack her." In the evening, Lina went to sleep. I came and locked the room. In the middle of the night, I heard her knocking, crying, and screaming. My wife and I were starting to argue. She said to "let the girl out".

Vuna's argument was that reality can be formed through imagination and obsessively thinking about something. Vuna was trying to explain how, in this instance, imagination created reality for Lina. His story went on – he told us that he kept locking the door and he told Lina that the door was now locked and 'Ana would not be able to enter the room again, therefore it was safe inside her (Lina's) room. Lina then accepted that 'Ana was only in her thinking and the door was unlocked, and she did not go to her grandparents' room in the middle of night again. Vuna suggested that Lina was having 'āvea (obsessive thinking) about 'Ana coming to her room.

During the families without mental health service users' *talanoa*, Lomio provided an account of someone who was obsessively thinking about something, but behaved in a manner which is consistent with someone who is being possessed by the spirits. Rather than seeing this as a manifestation of the spirit world, the behaviour was seen as a result of the obsessive thinking, and was therefore considered differently.

*Comments 30 (Families without mental health service users).*

Lomio            *Mahalo ko 'eku tui 'a'aku ia, na'e mo'ua pē fakakaukau ia ha me'a. Pea hangē 'oku sio ai pe ia ki ha tēvolo 'o 'alu'alu ai pē ia, 'a ia k o e 'ū me'a ko ia 'oku ne fakamatala, ko ia pē 'oku ne 'ilo, pea mahino pē foki ko e me'a ko e 'oku hā mai ki hono 'atamai 'o'ona ia. 'Oku sio ki a hai, na'e ha'u 'o ngaahi ia mo e hā mo e hā.*

English            I believe maybe, the thoughts were just occupied by something. It seems like he is seeing the devil and this keeps going and this is how he explained it. That is what he knows, and it is very clear that is, what

it is on his mind, he saw someone, came to him and possessed him and so forth.

This demonstrates the similarities of behaviours in *'āvea* (obsessive thinking) and also *'āvanga* (possessed by spirits) where both associate with movements outside of the Tongan expectations of *fa'unga* (reality). The following segment will discuss *'āvanga* (possessed by spirits).

### ***'Āvanga* – possessed by the spirits**

*'Āvanga* impacted directionality with the spirits possessing an individual and directing their thoughts out of the society's defined norms and values. These changes of behaviours show movements (*hu'unga*) outside of *fa'unga* (reality) caused by the spirits, and interpreted as mental illness. *'Āvea* is when one's thought are being directed out by obsessively thinking and *'āvanga* is when one's thought are being directed out by possession and controlled by the spirits. Soane from the mens' *talanoa* group discussed the land of the departed or the Underworld, Pulumotu, and the illness is associated with an external influence from Pulumotu. The physical contact from Pulumotu does not leave physical evidence but have marked changes in people's behaviour.

*Comments 9 (Men).*

Soane        *Ko e taimi ko e 'oku fai ai 'a e ūesia pehē ko e 'o e 'atamai, pea 'oku lau leva ia 'e he kakai Tonga, na'e hanga 'e ha taha mei Pulumotu pe mei fa'itoka, 'o te'ia e taha ko ia, tāa'i, tāa'i faka-tēvolo. 'A ia ko e fa'ahinga tā 'oku 'ikai ke 'asi, ketau sio ki ai, ka ko e me'a pē 'oku hoko ki he tama ko ia, 'oku lele pea 'oku tangi, pea ko e hā 'ene ū me'a 'e fai. Taimi 'oku tau ala ai ki he sino e tokotaha ko ia, 'oku*

*fefeka angakehe, 'a ia ko e fute ha ki'i kau'ime'a molū, fiu ha ongo fu'u to'a 'e ua hono puke, 'a ia ko e 'āvanga ia.*

English In times where people are affected mentally, Tongan people would say, that that person has been physically abused by someone from *Pulotu* or the cemetery. This sort of physical abuse does not leave any body marks, all we see is this person, running and crying and his/her behaviour. When we touch his person, his/her body is so tense, and if they shake suddenly, two strong people will not be able to hold him/her down, this is what we call 'āvanga.

Soape supported Soane in the mens' *talanoa* group and highlighted the strength of this interpretation. Soape confirmed that 'āvanga (possessed by the spirits) is an illness associated with devils.

*Comments 386 (Men).*

Soape *Hanga foki he'etau tui, 'o toe fakamālohi'i ange 'a e fo'i fakakaukau ko ia ko e ki he 'āvanga e, tau tui ko e 'omi 'e he tēvolo.*

English Our belief strengthen our thinking that it is 'āvanga (possessed by the spirits), and we believe that they were brought by the devil.

The womens' *talanoa* group discussed 'āvanga (possessed by the spirits) as an illness associated with the devil. This is included in this section as it identifies the different types of 'āvanga, *faka'āvanga fale* (house 'āvanga), 'āvanga motu'a (old 'āvanga), 'āvanga tahi (sea 'āvanga). Melo highlighted how there are different types of 'āvanga (possessed by the spirits) and required skills to be able to identify the differences of 'āvanga (possessed by the

spirits). There are Tongan expertises in this area and Melo presents her idea comparing to the current health system and health professionals.

*Comments 101 & 103 (Womens).*

Melo *Ko e puke faka-tēvolo na'e ui ia ko e 'āvanga...pea na'e kalasi kehekehe e ngaahi faka-'āvanga , pea na'e 'i ai e kalasi na'e ui ko e faka'āvanga fale, 'āvanga motu'a, 'āvanga tahi, ngaahi lea kehekehe, ka 'oku nau hu'u pe ki he me'a 'e taha. Ko e ngata pē 'i he kau taukei mo e maheni ange 'i he anga 'o e mo'ui, te ne lava ke ne tala, hono, ki'i kehekehe, 'o e 'āvanga fale mo e 'āvanga tahi, 'o hangē ko eni ko e faka'ilonga 'o e flu, mo e faka'ilonga 'o e me'a, ki he kau mataotao ange 'i he sivi e sino 'o e tangata, na'e 'i ai pe e kau ako natula pehe ia, na'e 'osi fa'u pehe'i pe kinautolu ia 'i Tonga, 'a e kau specialists pe ia 'a Tonga he mo'ui 'a Tonga, na'a nau hanga pe 'e nautolu 'o define e fo'i lea ko e 'e ua, 'o lava pe ia 'o mahino lelei mai kia kita ko e 'oku 'ikai ke te 'ilo'i... 'O hangē tofu ko e lava ko e 'o fakamakehekehe 'i he kau specialists pālangi 'a e fā'ele 'i mai ko e kuo 'osi uesia pe 'i loto he fa'unga 'o e mo'ui 'a e pēpē hono 'atamai, pea mo e toki hanga 'e ha me'a 'i tu'a 'o ue'i hono 'atamai, tena 'osi fakataha pe ki he maumau 'a e 'atamai.*

English Possessed by the spirits is what we called 'āvanga, and there were different types of 'āvanga, faka'āvanga fale (house 'āvanga), 'āvanga motu'a (old 'āvanga), 'āvanga tahi (sea 'āvanga) and all these terms refer to one thing. Only the experts in health will be able to tell the differences between these 'āvanga, the difference between 'āvanga fale (house 'āvanga) and 'āvanga tahi (sea 'āvanga), like how we

differentiate the symptoms of flu from other illnesses. We have those expertises in Tonga and they were natural and able to explain and clarify two different terms clearly to us who do not understand...It is exactly like how the *pālangi* experts differentiate those who were born with mental illness, then those who were triggered by some external factors, where both will be referred to as '*maumau 'a e 'atamai*' (broken brain).

*Hu'unga* subtheme suggests that mental distress and mental illness are associated with movement from Tongan *fa'unga* (reality) of mental health to another Tongan *fa'unga* (reality) of mental distress and mental illness as a form of journey. Where people move outside of *fa'unga* of mental health, they are regarded as *hē* (lost) and thought to have mental distress. Becoming obsessed, '*āvea* (obsessive thinking) or possessed '*āvanga* (possessed by spirits) were also interpreted as mental distress and mental illness. Tevita discussed these movements of interpretations flow freely outwardly and inwardly and have the ability to move from the *fa'unga* (reality) of mental distress and mental illness to *fa'unga* (reality) of mental health through recovery. The next subtheme is *ta'anga* (temporality), which is the time component of *fa'unga* (reality) and *hu'unga* (directionality).

### ***Tā'anga* (Temporality)**

*Tā'anga* (Temporality) focuses on how Tongan people interpret and define mental illness relating to time (*tā/taimi*). The previous subthemes discussed *fa'unga* (reality), how Tongan people view the sources of mental distress, and how *hu'unga* (directionality) moves within

reality in certain directions to produce obsessional thinking or actions based on possession. *Tā'anga* (temporality) adds in the time factor and considers speed and frequency. There are expectations about the speed at which people function when completing tasks or chores, and even when communicating – accepted as ‘normal’ timing – and these expectations vary between different societies. Tongan people, too, have their own acceptable speed, in terms of *tā/taimi*, per tasks performed. If one functions outside of these *tā/taimi*, then they are referred to as either *taimi tuai* (slow timing) or *taimi vave* (fast timing), and interpreted as behaving abnormally and having a mental illness. *Taimi* also refers to the duration of the illness: episodic, intermittent, acute, or chronic. The interpretations of mental through timelines in the past to present are part of *ta'anga*, and signify historical shifts in the understanding of mental health and illness (Goffman, 1970; Pilgrim et al., 2011; Szasz, 1971).

Ane from the community leaders’ *talanoa* took the discussion further and explained how a person with mental illness is interpreted through the speed of their language and use of speech; she also highlighted Tongan term for this condition as *taimi vave* (fast timing).

*Comments 51(Community leaders).*

Ane                    *Ko e anga 'eku fakakaukau kapau 'e 'i ai ha tokotaha ia, kapau 'e 'asi mai ki heni ha tokotaha ia 'oku fa'alea, pea 'ohovale pē 'oku ne fai 'e ia ha fa'ahinga fōtunga 'oku fakaoli. Ka 'oku 'ikai fe'unga ia mo e ha'ofanga ko ia, te tau ui ia ko e mental illness, pea tau pehē pē tautolu 'i he Tongan terms, tau pehe pe 'e tautolu, meimei taimi vave, he 'oku kehe 'a 'ene fakafōtunga ko e 'a 'ene action ee.*

English                What I am thinking about, if there is someone, if someone comes here who is always talkative, and all of a sudden, he does something funny. This is inappropriate for the setting, we can call that mental illness, and



we can describe it in the Tongan terms as *meimei taimi vave* (nearly fast timing), because the presentation of his actions is different eh.

*Comments 66 (Community leaders).*

Ane *Taimi vave, kaikehe ko e taimi vave foki 'oku tau 'ilo ki ai, umm ālonga, umm, ko e ha term Tonga.*

English *Taimi vave* (fast timing), and *taimi vave* is what we know about, umm, *ālonga* (very slow), it's a Tongan term.

Ane explained that mental illness is known as *taimi vave* (fast timing) when someone behaves faster than normal timing defined by Tongan society. *Ālonga* (very slow) on the other hand also refers to mental illness. Mental health, then, is when people behave and move according to the normal rhythm of time defined by Tongan society. Participants also discussed the duration of episodes of mental illness and how people were affected differently.

Mosese from the community leaders' *talanoa* incorporated the idea of a *fale* (house) and *tā/taimi* (times), explaining that the *fale* represents mental illness and people who may experience mental distress throughout their lives. Maintaining wellness depends on the ability to exit the house and move on, as when a person struggles to exit, that person lives inside the house of mental illness.

*Comments 137 (Community leaders).*

Mosese *'A ia ko e tau fanongo pe tautolu ia mental, ko e tama ia 'oku fakasesele, tapu mo nautolu, ka 'oku 'i ai pe e ki'i momeniti ia, 'oku te 'osi hū atu kita he matapa 'o e mental, mahalo ko nautolu ia, kuo nau 'osi nofo nautolu ia 'i loto fale, kae 'ohovale pe 'oku tau tukituki atu tautolu he matapa ke te hū atu, 'a ia kapau 'e fakatuituia ai pe ha tama*

*ia, pe 'e toutou hoko 'ene mental 'i he scale ko e ki 'olunga, ka toutou hoko pe ia, mahalo 'e 'alu'alu ai pe ia ke kovi e.*

English So when we hear mental, he is *fakasesele*, with due respect to them, but there is a slight moment, that we had entered the door to mental, maybe for them, they are living inside the house, and all of a sudden, we knock on the door to enter, so if someone keeps entering and has a higher scale of mental illness, overtime, he will become worse.

*Comments 82 (Youth).*

'Inoke *Kou fakatokanga 'i 'e au 'i Tonga he taimi 'e ni 'ihi 'a e kau vale, 'ohovale pē 'oku 'i ai e fo 'i taimi ia 'oku sai pe ia, pea 'i ai pe e fo 'i taimi ia, 'oku fakahā 'aki pe 'ene puke 'a'ana ia, 'oku 'alu'alu ai pe ia, pea ka sio ia ha me'a 'oku siosio ai pe ia.*

English I am noticing the *kau vale* (crazy people) in Tonga sometimes. There is a time where they are well, and there is a time when they become un-well. We know when they are un-well, when they are walking around, if they look at something, they will stare at it.

'Inoke from the youth *talanoa* group discussed symptoms of mental distress and illness, like walking around and staring, and these demonstrate experiences of mental distress and illness. This is consistent with entering of the house that Mosese was explaining as mental distress and illness.

Kefi added to the *taimi vave*, *ālonga* and episodic discussion introducing *meimei tei*. *Meimei* means nearly and Churchwood (1959) also defines *tei* as nearly and specifically referring to time. *Tei* is also interpreted as a Tonganisation of 'day' and therefore meaning someone is still in darkness with little light. Kefi's contribution suggests that day signifies light which

represents mental health. Night on the other hand signifies darkness and represents mental illness. *Po'uli* (night) was discussed above in the *fa'unga* (reality) section as the side of the devil with *fakapo'uli* (darkness) referring to anger. In reference to mental illness *meimei tei* refers to someone who does not have the capacity to represent a full day, and is therefore in darkness.

*Comments 68 (Community leaders).*

Kefi            *meimei tei*

English        nearly near (*tei* – nearly as in time) or (nearly daylight)

The duration of mental illness varies and sometimes can be a single incidence lasting only a few days, but some stay on that lost journey through *taimi* to death. As Mosese explains it, during *hu'unga* the mind *hē* (wanders) outside of reality, at times only going astray for two or three days and then returns to reality. But some individuals create their own reality as they are fixated on their chosen pathways and at times this can lead them to death.

*Comments 236 (Community leaders).*

Mosese        *Neongo 'oku tau fa'a pehe, ko e ki'i one off pe, ki'i puke hake pe ia 'aho 2 'aho 3 pea sai, ka 'oku 'i ai e ngaahi keisi ia, 'oku fononga ai pe 'a e tokotaha ia ko ia 'o puke, puke ai pe ia 'o mate.*

English        Even though we usually say, it is only a one off, where someone will only be sick for 2 or 3 days and become well, some of the cases go all the way, and die.

*Ta'anga* (Temporality) has discussed the speed and timing of movements within the *fa'unga* (reality) of mental health and the time expectations through these movements. *Taimi vave* (fast timing) and *taimi tuai* (slow timing) were interpreted as mental distress and mental

illness. *Ta'anga* (Temporality) focuses on time factors like speed, frequency, and episodes of mental distress and mental illness. These data were referred to as *ālonga* (very slow), *'atamai tuai* (slow brain), *fakapo'uli* (darkness), *meimei taimi vave* (nearly fast timing), *meimei tei* (half day), *taimi tuai* (slow timing), and *taimi vave* (fast timing). The final subtheme is *tu'unga* (positionality), which refers to positioning and relates to the positioning of *fa'unga* of mental health where *ta'anga* is located inside beating to the expected timing from the Tongan community.

### ***Tu'unga* (Positionality)**

This subtheme focuses on the positions and locations of *fa'unga* (reality) of mental health. *Hu'unga* (directionality) and *tā'anga* (temporality) are mostly assumed to be inside *fa'unga* (reality) define while *tu'unga* defines location and position. There is a desire for balance and harmony to acquire wellness. Imbalance and disharmony produce *mahei* (tilting) and *suei* (swaying) which are representations of mental illness through a Tongan lens. *Mahei* (tilted), *male'ei* (inclined) and *suei* (swayed) are used throughout this research when referring to those with mental illness. Previously in this chapter intangible notions were explained through the use of tangible objects such as *fale*, marble, balloon, and power supply. Positionality refers to how these tangible objects are being positioned. Ideally, mental health equates to balance and symmetry and mental distress to any disharmony and be related to issues in life that cause any form of trauma.

Pita in the community leaders' group shared how people witness traumatic events like wars that affect them, using *male'ei* to explain how their way of thinking had been shifted and tilted. Ane supported him.

*Comments 171 & 172 (Community leaders).*

Pita            *Pea 'i ai e me'a na'a tau sio mata ai he mo'ui, 'i ai e kautama ia, o he tau, sio ai he me'a pea male'ei 'aupito ai ia.*

English        At times we see something in life, some people went to war, saw something and that tilted them greatly.

Ane            *Male'ei, ko ia.*

English        Inclined, it is so.

Education is highly valued in the Tongan community (Wood-Ellem, 1999) and the academic expectations from the collective Tongan society extend from the nuclear family to extended family, village, and the Tongan community. The collective focus of the Tongan community accumulates these expectations and can become powerful forcing the intangible position of the mind to move from its balanced state. These cause *mahei* (tilting), *male'ei* (inclining), or *suei* (swaying) of the mind and therefore are interpreted as mental illness or forms of mental distress.

The families without mental health service users discussed how education pressures young Tongans to study, saying that some memorise their lessons which is not a good strategy. They reported that the brain is overturned (*mafuli*) when someone struggles to recall what is memorised. This *mafuli* refers to changing behaviours and literally the turning of the brain, as Lemeki explains:

*Comments 393-395 (Families without mental health service users).*

Lemekī      *Ko e ako ma'uloto 'oku kau ia he me'a 'oku ne uesia ia 'a e 'atamai. He te vivili ke ako ma'uloto ka e 'oua na'a te 'alu 'o tu'u mei mu'a 'o lea mai pea ka a'u 'o fehālaaki, te te sio ki he tafe 'a e pupuha, ko e paipa vai atu. 'A ia ko e ngaahi faka'ilonga ia, ko e 'a e stress up ko e 'a e 'atamai e, kuo tu'u leva e fo'i 'atamai ia he fo'i taimi ko ia.*

English      Learning through memorising affected the brain. I forced myself to memorise things and when I went up and stood in the front and spoke, and if I made any mistake, that was when I saw excessive sweating, like a hose of water. That is a sign of a stressful brain, and the brain freezes in that period.

Lomio      *Mafuli ia*

English      Overturn eh.

Lemekī      *Mafuli ia, he kuo ngalo e me'a ia ko e na'e ako ma'uloto, pea ko hono to e tenge atu ko e ke ha'u, kuo mā. Ha'u mo e lele e pupuha, pea 'oku ta'epau na'a tō.*

English      Overturn, as the things that were memorised have been forgotten and when I am forced to come, there's embarrassment. It comes with excessive sweating and looks unsteady with risks of falling.

Hale in the men's *talanoa* group explained that mental illness was like a helicopter having a broken propeller, where it just keeps flying in circles, unstable and unbalanced (*Comments 151*). Toakase mentioned *haafe meti* which is a Tonganisation of "half mad". Another translation of *haafe meti* refers to *meti* as in "mate" or first officer on a ship (Churchwood,

1959). The latter defines mental illness as a half captain of a boat, meaning that the captain does not have full capacity and is operating the boat but with only half the required skill, the boat will, therefore, have no safe destination as it will travel in circles.

*Comments 90 & 91 (Youth).*

Toakase        *Haafe meti.*

English        Half mad/half mate (mate as in first officer on a ship).

‘Inoke        *‘ikai ko e masoli, haafe meti, folo, ngāue ‘aki e folo.*

English        no, it is cracked, half mate, *folo* (swallow), using of *folo*.

‘Inoke raised *folo* referring to someone swallowing something. At the point of swallowing, the body is not in harmony as a foreign body is forced to enter. Facial expressions around swallowing and the body’s reactions – eyes are widened with head slightly moving forward forcefully and some degree of surprise and other physical manifestations of swallowing – are consistent with presentations of people experiencing mental illness. The position of someone whose *folo* is compromised and not in a steady and balanced state is referred to as mental illness.

‘Ili explored some ideas around why children’s thinking is often perceived as being tilted, considering fear as a potential cause and also the devil.

*Comments 196 (Men).*

‘Ili            *Mahalo, ka ko e anga foki ‘a ‘etau fakaofiofi atu ki he me‘a na‘e fakatupunga ki he male‘ei ‘a e fakakaukau ‘a e tamasi‘i. ‘A ia ‘oku sio atu tautolu ia, ‘oku lava pe ‘a e manavahē ia, ‘o tukuaki‘i ko e fakatēvolo, pea ‘i ai ‘a e ni‘ihi ia, ‘oku ‘ikai ko e tupu ia he tēvolo, ka ko e fu‘u lahi e me‘a ‘oku ‘ikai te ne to e lava ‘o makupusi, ‘o fuesia e*

English            Maybe, it is how we make assumptions for what causes the child's thoughts to shift to the side, and we see things like, fear is possible, and blame it on the devil, and some are not caused by devils, but too many things and the brain is unable to absorb mentally, and able to carry eh.

Fear, and how it pressures and influences people's behaviour, arose as a factor in most of the *talanoa* groups. 'Ili discussed fear of the devil but there are other fears as well including fear of expectations from the community. Moa in the Womens' *talanoa* groups talked about how thinking about something contributes to behaviours like mumbling where people interpreted as mental distress or *mahei* (tilted).

*Comments 19 & 21 (Womens)*

Moa                *Ko ha me'a 'oku te nofo 'o fakakaukau'i, 'a ia te te talatalanoa ai pe kita ia ki ai...pea te lue ai pe kita he hala mo valevalelau pē, pea pehē mai e kakai, "sio atu ki he fefine ko e, hangē 'oku meimei mahei e 'atamai".*

English            It is something that I am thinking about, keep talking about it...walked on the road and keep mumbling, and people will look and say, "Look at her, her brain is tilted".

Lemeki explained in the families with mental health service users' *talanoa* groups how the position of the brain inclined and reflected in one's behaviour and communication. He highlighted that even a slight incline can cause mental distress and mental illness.



*Comments 25 (Families with mental health service users).*

Lemeki        *Kiate au mo 'eku sio 'a'aku, ki he puke faka'atamai... 'oku mahino, ko e tatafa pe 'a e 'atamai 'i ha 'uhinga ia 'o 'ikai ha'u 'i he normal 'a e ko e 'oku angamaheni mo kitautolu Tau 'ilo leva 'oku 'i ai 'a 'ene uesia... 'e lava ke ne fakahā mai 'o hangē ko e, 'oku ki'i tuai 'a 'ene fakakaukau, 'o kapau 'e fai ha fehu'i ki ai, pea 'ikai ke ngata ai, 'e lava ke tala ai 'aki 'a 'etau sio ki he anga 'o 'ene fai fatongia, lava ke tala ai 'oku 'i ai 'a e palopalema ki hono 'atamai...ki'i male'ei mei he normal.*

English        For me and how I look at mental illness...it is clear that it is an inclined brain and not normal to how we are used to. We know then, there is something affected...it will show through his/her thinking, if we ask him/her questions, not only that but also his/her actions, we can tell through these that there are problems with his/her brain...slight inclined from the normal.

Positionality (*tu'unga*) discusses the different positions and locations of *fa'unga* (reality) from *mahei* (being tilted), *male'ei* (being inclined), *suei* (being swayed), and *mafuli* (being overturned), to being one-sided as in half mate and broken propeller. Maintaining balance and harmony equates to wellness, whereas unbalance and disharmony result in mental distress.

## Summary

This chapter has discussed the theme, *tufunga faka-Tonga* (Tongan constructions) and its four subthemes, reality (*fa'unga*), directionality (*hu'unga*), temporality (*ta'anga*), and positionality (*tu'unga*). Reality (*fa'unga*) holds and contain the meanings of mental illness and mental distress for the participants and also mental health. Directionality (*hu'unga*) explains mental health as moving within the boundaries of reality (*fa'unga*), and mental illness as moving outside of reality of mental health by way of obsessive thinking (*'āvea*) and/or possession by spirits (*'āvanga*). Temporality (*ta'anga*) refers to the time components relating to mental wellbeing, and positionality (*tu'unga*) relates to balance and stability where well balanced is considered mentally healthy and any forms of unbalance as mental distress. The spiritual world was noted significantly in this research project and relationships with supernaturals were found to be an integral component in defining health and constructing mental distress and illness from a Tongan perspective. The process of *talanoa* was demonstrated through narratives in how Vuna told his story drawing the example from his family. He used his story and personal experiences to support his arguments. Vuna used the circular notions of *talanoa* ('Otunuku, 2011) through storytelling to explain *'āvea* (obsessive thinking) and its relation to mental distress. The next chapter discusses the *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress).

## **Chapter Six: Tongan people *talanoa* about *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions of mental distress)**

### **Introduction**

Chapter Four discussed the data and the seven *talanoa* groups, describing the process of arranging each group, the *talanoa*, and the data that were collected from each of the groups. Chapter Five presented a discussion of the major theme from this research project, *tufunga faka-Tonga* (Tongan constructions of mental illness), in four subthemes: reality (*fa'unga*), directionality (*hu'unga*), temporality (*ta'anga*), and positionality (*tu'unga*). The second theme, *tufunga faka-paiōsaikosōsiolo*, (biopsychosocial constructions of mental distress) that emerged from the data analysis was constructing mental distress according to biological, psychological and social interpretations and definitions. The focus of this chapter is on this theme and its four subthemes: challenging Tongan beliefs, the perception of the contribution of stress to the onset of mental distress, the role of alcohol and drugs, and the influence of medical language and explanation of illness. The chapter begins with an overview of the theme, *tufunga faka-paiōsaikosōsiolo*, followed by a detailed description and analysis of each of the four subthemes.

One main theme that emerged from the data was concerned with Tongan constructions of mental distress (see Chapter Five), however, the research data also shows that mental distress and mental illness were frequently defined, interpreted, perceived, and constructed from

biomedical viewpoints. Notably the youth group and the group of service users and their families suggested more alignment with a biomedical understanding of mental illness as a physiological disorder related to chemical imbalances in the brain. These discussions suggested that mental illness is understood as a disease of the brain, contributed to by social and environmental factors. Other variables such as stress, drugs, and alcohol were also significant issues raised throughout the data. The youth *talanoa* group was the group that most strongly identified with *tufunga faka-paiōsaikosōsiolo* theme, followed, in order, by the mental health service users, the families of service users of mental health services, the women's group, and the community leaders' group, with the men's *talanoa* group making the least contribution to *tufunga faka-paiōsaikosōsiolo*. The discussion of the subthemes starts with the challenges to Tongan beliefs followed by the other three subthemes highlighted under the *tufunga faka-paiōsaikosōsiolo* theme.

### **Challenging Tongan beliefs**

*Tufunga faka-paiōsaikosōsiolo* presents some challenges to theme one, *tufunga faka-Tonga* (Tongan constructions), by countering some of its arguments. *Tufunga faka-paiōsaikosōsiolo* argues that the interpretation and definitions of mental illness are constructed through biomedical lenses: as the concept is not Tongan, mental illness is not viewed as an illness that can be defined in Tongan and is, therefore, better defined by biomedical interpretations. These were demonstrated through participants talking about mental disorders like depression and obsessive compulsive disorder in ways that were different to the *tufunga faka-Tonga* (Tongan constructions). Depression and obsessive compulsive disorder relate to *tā'anga* (temporality) in terms of *taimi tuai* (slow timing) and *taimi vave* (fast timing), but also noted in this subtheme as participants did not explain depression and obsessive compulsive disorder

with timing so it can align with *tā'anga* (temporality). Depression and obsessive compulsive disorders were discussed as mental disorders using biomedical lenses. Samantha explained this by pointing out the diagnoses, Obsessive Compulsive Disorder (OCD) and depression. Samantha challenged the interpretation of *vale* or mental illness in the Tongan context, and she explained how some behaviour may be seen as good behaviour and could be encouraged.

*Comments 106 (Youth).*

Samantha                      There are mental people out there who have actions, they are good. There are mental people that read constantly, but reading is not a bad thing. There are people who have OCD and they clean for obsession, you know, that's a part of a mental illness but it's not *vale* in some Tongan contexts, because cleaning is not a bad thing. But the fact that they are new to it, they do it all the time, you see it as a mental illness. I don't see it as disease unless it is some sort of *mahaki* (illness). I see it as a fall from development when, especially when you are younger and too odd to young people, like you said relationship and depression and all that... yeah, it's from grief and all that stuff. It's the outside, um, factors, that determine somebody to like, get mental illness. To me, that's what I think.

This participant, Samantha, mentioned OCD (Obsessive Compulsive Disorder) and depression (American Psychiatric Association, 2000), and explicitly said that repeatedly doing something is not regarded as *vale* (*tufunga faka-Tonga*) but can be OCD (*tufunga faka-paiōsaikosōsiolo*). Her use of the terms OCD and depression to describe behaviours, therefore, shows that Samantha understands the biomedical model of mental illness and relates those behaviours to it rather than interpreting them through Tongan constructs.

Samantha explained that *vale* associates with negativity which contributes to building stigma and discrimination related to mental distress.

The positive and negative positioning of interpretations of mental distress and illness influenced peoples' understandings and these influences also determined management and treatment options. 'Anau from the group of families without mental illness extended this and shared how her understandings of mental illness influence her family life and decision making around her choice of treatment for her family. She explained that she chooses Western and biomedical treatment before Tongan traditional healing.

*Comments 283 (Families without mental health service users).*

'Anau            *Kiate au ia mo e tauhi fānau ia 'a'aku ia, 'o kapau tenau puke mai nautolu ia, teu 'uluaki feinga ia ki he toketā, ke 'uluaki fai e sivi ia ko ia ke mahino, pea kapau leva 'oku 'ikai ke 'i ai hano ola 'ona 'o e sivi ko ia, pea teu toki feinga leva ki he faito 'o faka-Tonga.*

English            For me and how I look after my children, if they are un-well here, I will firstly take them to the doctor, to firstly investigate and be cleared. If this investigation is not successful, then I will try the Tongan traditional healing.

In contrast to 'Anau, Siale shared in the families with mental illness *talanoa* group, a story about her son, Naua, and how he behaves when he is un-well and their journey through Tongan treatment. Siale said that a Tongan healer had been her first option until her eldest son directed them to the hospital which produced a good outcome.

*Comments 295, 297 & 299 (Families with mental health service users).*

*Siale*      *Teu pehē atu, “tamasi ‘i, ‘ai ka ke mohe, na ‘a ‘iloange kuo ke puke he fu ‘u ‘ā pehē” ...pea a ‘u ki he fo ‘i ‘aho ia ‘e taha ‘oku ou fakatokanga ‘i ‘e au ia...hangē ‘oku hū loki ia ‘o ta ‘ota ‘o, peau ha ‘u ‘o ‘eke atu ki ai, “‘Oku ke puke? ‘Ou sio leva au ki hono fōtunga ‘oku kehe ... “‘Oku ou puke au ia, ‘e ōmai e kakai ia ‘o tamate ‘i au”, ko ‘ene fo ‘i tali eni, peau pehē atu ki ai, “hā e ‘uhinga? Ko hai e kakai na ‘a nau ōmai ‘o talamai he ‘oku ‘ikai ha kakai”, talamai, “‘Ikai, ‘oku ‘ikai ke ke hanga ‘e ko e ‘o ‘ilo mai ‘oku ‘i ai e kakai ia tenau ōmai nautolu ‘o tamate ‘i au”... ‘alu leva ia ‘o hopo ki he loto ‘ā ‘a e siasi he meimei pō kotoa, ‘o nofonofu tokotaha holo pē ia ai, mahalo ‘oku luelue holo pē ia ai...kuo nofonofu loki pē ia, ...ko e ki ‘i mohenga ‘oku ‘i ai, ‘oku fu ‘u ma ‘ulalo pehē, ‘oku hao pē e tamasi ‘i ia, ‘o ‘alu ‘o tokoto he lalo mohenga, ‘o pūpūlou pē ia ai, feinga atu ke kai, ‘alu leva e ‘o kole ‘a e finemotu ‘a hangē ko ‘etau talanoa ha ‘u ia ‘o tulu ‘i faka-Tonga... ‘aluange hoku foha lahi, talamai ‘e ia, “tuku ena ia, tau ō ki falemahaki, fai ‘a falemahaki ke ‘osi”, pea mālohi ange pe ‘a ‘eku tui ki hoku foha kemau ō ki falemahaki, pea mau ō leva e ki falemahaki...tuku ai, fo ‘i pō pe ‘e taha ‘a ‘ene mohe ai, ‘oku tā hengihengi ange ia pe ‘oku ‘i ai ha silini ke totongi tekisī ‘e ‘alu ange ke ‘alu ia ki he ngāue. Pea na ‘e anga pehe, na ‘e ‘ikai ke pehe ia ‘oku fu ‘u tokoto ia ‘i falemahaki, ko ‘ene ongo ‘i pe ko e ‘oku ilifia, talamai ‘e ia ke ‘oange hono vala ‘o ‘ona ia ke ‘alu ia ki falemahaki ... ‘Oku mau fetakai ai, sio na ‘a ma ōmai he 2006, te ‘eki ai ke toe ‘ave ‘a Naua ki falemahaki.*

English

I told him, “have some sleep or you will become un-well for staying up like that” ... and one day I started noticing ... he had been staying in his room under his blanket, and I came and asked him, “Are you sick?” I noticed changes in his appearances ... “I am sick, people will come to kill me”, he replied, and I asked, “Why? Who are these people as I have not seen them?”. “No, you do not know but there are people coming to kill me” ... he went and jumped to the church compound nearly every night and stayed there by himself, maybe pacing around there...staying in his room mostly...his bed is very low, he went under the bed and covered himself there. We tried to feed him so I went and asked a Tongan woman, like our Tongan conversations, she treated him with Tongan traditional medicine...My eldest son came and stopped it and told us to go to the hospital, “We should firstly try the hospital”. I believed my son and we went to hospital ... He was there for one night sleeping there. He called us early hours of the morning to check for money as he wanted to catch a taxi home so that he can go to work. It was like that, he was not at hospital for a long period of time, when he is scared, he told us to pack his clothes as he will go to the hospital...see, we came in 2006 and Naua hadn’t been to hospital.

Nina from the service user group supported Siale and Naua attending the hospital and pursuing the *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions) of mental illness. Nina discussed the shame and stigma that the *tufunga faka-Tonga* (Tongan constructions) perpetuate and she emphasised her point around the Tongan construction as being ‘bad’ and appeared very uncomfortable and laughed anxiously when sharing the Tongan terms *vale* and



*fakasesele*. Nina explains that the hospital system reduces stigma and shame and that draws her towards the *tufunga faka- paiōsaikosōsiolo* (biopsychosocial constructions) over the *tufunga faka-Tonga* (Tongan constructions).

*Comments 50 – 56 (Service users).*

Nina I think it [the hospital system] takes away the shame and the stigma, especially with us island people because there is no shame. But because we make it into something that is meant to be shameful when it's not. That's when I think it perpetuates stigma and discrimination and especially like really bad (emphasising) words that island people will say about people that are living with mental health.

R What sort of bad words?

Nina Like a (pause and giggle) um, I honestly don't, I don't like to think of those words so on the top of my head I can't remember (laughing loudly) what those words are...Oh like *vale*...and *fakasesele*.

Nina's position, then, challenges the use of Tongan terms such as *vale* and *fakasesele* as having a negative impact and being detrimental in terms of causing shame, stigma, and discrimination.

These comments show that participants acknowledged and valued a range of support systems both in Tonga and in A/NZ. The social support is stronger in Tonga as families are closer to each other and get fragmented as Tongan people move to A/NZ. The strong social support in Tonga also increased stigma and discrimination due to the small and close network. Participants reported that stigma and discrimination ease off when moving to A/NZ and the

social media also influenced changes in construction of mental illness by promoting mental health. Naioka added that one can live with mental illness with positive perspectives and that positive perspectives of mental illness are influenced by media. Such portrayals of mental illness through media were reported to be one factor that determined the youths' interpretation and definition of mental illness. Naioka referred to the New Zealand Government-funded mental health campaign, Like Minds, Like Mine (Mental Health Commission, 2013), with information broadcast on television (TV) about overcoming discrimination and stigma associated with mental illness.

*Comments 143 & 145 (Youth).*

Naioka        Yeah, I mean it's best to see a lot of stuff on TV like "know me before you judge me"...and because we are, we can just hear them being, we judge, and if we see someone doing something, we just think "crazy". But it shows that you can live with mental illness, um, it's just, you just got to, acknowledge it and kind of a, I mean like OCD and stuff, the name, disorder, it's then like, title, obsessive something disorder, so, um, yeah, you can live with mental illness, just as long as you know you have it, but we see a lot of campaigns like "know me before you judge me".

Naioka represented young people's views and their interpretation of mental illness which, in A/NZ, is more acceptable these days with media coverage and campaigns that are aimed at making mental illness more accepted in all communities.

## Language – use of English and biopsychosocial language

This subtheme, language, focuses on the influences of both the English language and medical terminologies on construction of mental illness according to Western and biomedical definitions. The use of language is powerful in constructing concepts and ideas as it portrays the root and origin of each concept or idea. This research project identified that both English and medical terminologies are used when Tongan participants attempt to explain the subject matter. Direct Tonganisation of words like ‘*taimi*’ for ‘time’ was constantly noted. There was also the mixing of modern translations (Tonganisation) and old traditional Tongan language to explain concepts and meaning. For example, one interpretation of mental illness discussed in the *ta’anga* (temporality) section, a subtheme in the previous chapter, is *taimi vave: taimi* (time) is linked with *vave* (fast) to define mental illness. This is a mixture of translations, Tonganisation (time/*taimi*) and traditional Tongan (fast/*vave*).

The men's *talanoa* group was the strongest supporting voice for *tufunga faka-Tonga*, as these participants identified that Tongan concepts are most valid for understanding the origins, causes, and treatment of mental distress. Even within this group, however, it was evident that there were participants who saw mental distress as something to do with how people think and that it originates from obsessive thinking and other abnormalities. The women's *talanoa* group addressed the confusion and difficulty in trying to understand mental illness as there is a mismatch in the Tongan translation of mental illness, *puke faka’atamai* – with *puke* as in illness, and *faka-’atamai* referring to the brain – and the term that Tongan people use for mental illness, *’atamai vaivai*, weak brain.

*Comments 20 (Women).*

Melo            *Kiate au ko e puke faka-‘atamai ‘i he lea faka-Pālangi ko e mental illness, ka ‘oku ui ia ‘i Tonga ko e ‘atamai vaivai. Ko e faka-Tonga lelei ia ki he mental health ko e ‘a e me’a ko e ‘atamai vaivai. Ka ko e anga pe ia ‘a e fa‘ahinga fakalea ia mo e fakasino ko e ‘a e kakai Tonga ki he‘enau malava, ko e ‘atamai vaivai, ka ‘oku te’eki ai ke pehe mai ‘e ha toketā ia, ‘oku ngāue makehe ki he ‘atamai, ‘oku vaivai ‘a e ‘atamai, ko e anga pe ia ‘a e faka-Tonga ko e ‘oku fai ‘e he kakai mo e fokotu‘utu‘u ‘oku fai ki ai, ko ha taha pe ‘oku ki’i mateletele, ‘oku pehe, ‘osi tala ia ‘oku ‘atamai vaivai.*

English        For me, *puke faka-‘atamai* in English is mental illness but we call it in Tonga, *‘atamai vaivai* (weak brain). The proper translation for mental health is *‘atamai vaivai* (weak brain). That was how it was put into words by Tongan people, but no doctor had said that it was something specifically for the brain, the brain is weak. It is the Tongan way of wording and organising, if anyone is very near, then it is told that he/she is having *‘atamai vaivai*.

This comment indicates an interpretation of mental illness in terms of pathology of the brain: it is an illness of the brain (*puke faka-‘atamai*) or the brain is getting weak (*‘atamai vaivai*). The construction of the subject matter was through the pathology of the brain. The brain is perceived as weak and interpreted as being ill. This is consistent with the *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions).

Pathologising and focusing on the brain as weak and sick, Melo goes further and directly relates this to presentations of physical illnesses and diseases like typhoid; typhoid has symptoms and criteria that impact on the person who suffers from it. This participant identified how Tongan people had been trying to modify Tongan ideas and knowledge to adapt and fit the *pālangi* system and society. Melo’s comments attempt to highlight the confusion that occurs when going to the doctor to consult about mental health issues as there is no Tongan word for mental illness. She went on to explain the lack of knowledge around the symptoms of mental illness where it made it difficult for Tongan people to identify mental illness and seek help appropriately. Melo’s comment illustrates the challenges of identifying mental illness and also explaining mental illness, and both the former and the latter suggest that mental illness maybe something new to this Tongan woman.

*Comments 41 (Women).*

Melo            *Hangē ko e, ko e puke he taifoti, he ‘ikai ke tau tafoki hake, ko e taifoti ‘oku ta ta ta, ‘oku mahino pē. Ko e taifoti ‘oku ‘i ai e fa’ahinga fua ‘oku lele ‘o tau ki ai e mofi, pea ‘oku ui leva ia ko e taifoti, ‘a ia ko ‘eku tui, hangē ko e fakamatala ko ē, ko e hā ha ‘a tau fa’ahinga lea ke fakalea’aki, he ‘ikai ketau kei ō atu ai pē ‘o pehē atu ki he kau papālangi, “koe’uhi he ‘oku ‘ikai ke ma’u ‘a ‘ene fakakaukau”. Katau hanga ‘o to’o hake ha fo’i lea ke ne hanga ‘o fakafofonga’i, ‘a e ta’e’au ko e ‘a e fakakaukau, pe ko e fu’u mālohi ‘a e fakakaukau ‘o ‘alu ai ia ‘o fai ‘a e me’a kehe.*

English        Like typhoid, when having typhoid fever, we cannot turn around and say, typhoid is ta ta ta [as in bla bla bla]. Typhoid fever has some measurements where a temperature is reached, and then we can call it typhoid fever. What sort of words we should use, we cannot keep

going and say to the *papālangi*, “His/her thinking is not stable”. We need to pick a word to explain it, when we are unable to think clearly, or thinking too much leading to do something different.

The youth group, too, linked mental illness directly to physical illness which is visible using an example which is common in the Tongan community and which other participants could relate to: diabetes mellitus. In this scenario, diabetes mellitus is a physical illness associated with consuming foods high in glucose and with lack of exercise. These were then related to stress and pressure and how they contributed to the onset of mental illness.

*Comments 41 (Youth).*

‘Inoke            *Hangē pe ai ko e ngaahi mahaki ‘oku hoko ia ki hotau sino, ‘i he ‘eku tui pe ia ‘a’aku, teu pehē, hangē ko e suka, ‘a ia ko e hoko e suka ko e lahi ‘etau kai, mo e me‘a, mo e ngaahi me‘akai ‘oku ne fakatupu, mo e ta‘efakamalohisino. ‘Oku ou tui au ia ‘oku hoko pehe pe ia ki hotau ‘atamai, ko e taimi pē ‘oku lahi ai e ngaahi pressure ki he ‘atamai, lahi ‘ene ngāue, mo e ‘ikai lava mālolo mo e me‘a, hei ‘ilo.*

English            I believe that it is like any illness that happens to our body, for example, diabetes mellitus. It happens when we eat a lot, and eat food that contains sugar, and we have no exercise. I believe that something like this happens to our brain, when there is too much pressure on our brain, too much work, with no rest.

The community leaders discussed how migration and moving to new societies shifts perceptions and the interpretations of mental illness. These participants discussed how levels of exposure to new ideas through new environments, and also education and acceptance of

new ideas, were key components in constructing mental illness. Kefi described her interpretation of mental illness.

*Comments 57 & 59 (Community leaders).*

Kefi *But, ko 'ete toki 'alu ko e ki 'Aositelēlia, 'alu ko e 'o ako he 'univēsiti, 'oku te sio leva kita ia he tafa'aki kehe, you know how different society, as in Tonga, and in Aus ... in Western, pea 'oku te sio leva ko e mental illness 'oku 'ikai ke 'uhinga pē ia ki he tamaiki ko e mata'i, he Vaimo'ui (pseudonym for disability service in Tonga) mo e handicapped, si'i faka'ofa honau sino, 'a ia 'oku 'uhinga mai ki he different stages kehekehe pe 'a e 'atamai, but I think comes with stress.*

English But, when I went to Australia and studied at the university, I saw other perspectives, you know how different society is, as in Tonga, and in Aus ... in Western, and looking at mental illness, it is not only to those who look like, in the *Vaimo'ui* (pseudonym for disability service in Tonga) and handicapped, those in poor conditions, but referring to the different stages of the brain, but I think comes with stress.

One youth participant alluded to the fact that mental illness responds well to treatment and therefore should be regarded as an illness. Samantha emphasised that medical treatment works effectively and, therefore, mental illness is said to be a disease because it is best managed by medicine. The references to use of Western medicine and use of the word 'disease' aligned Samantha with *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions).

*Comments 106 (Youth).*

Samantha     I don't see it as a disease but the fact that you need medicine and the fact that you need to get treated medically, that's how you see it as disease.

Nina from the service user *talanoa* suggested that mental illness is associated with chemical imbalances which contribute to a diagnosis of depression. The use of the label depression is significant as this indicates that this participant is more familiar with the *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions) of mental illness, and goes further sharing her diagnosis of depression rather than the *tufunga faka-Tonga*.

*Comments 23 (Service users).*

Nina            Well, as far as I am aware, mental illness is a chemical imbalance of the person's brain, which affects their mind. It will affect the whole person's being, physical, mental, and spiritual. My diagnosis is depression and anxiety, so, what I know of depression is [that it is] a chemical imbalance and I take the anti-depressant to balance the chemical that is missing and causes me to have depression.

Tevita discussed his symptoms and how those symptoms formulated a medical diagnosis and a platform for treatment which was successful. This contributed to Tevita constructing mental illness from a biomedical perspective.



*Comments 126 (Service users).*

Tevita            I was very paranoid, ah, couldn't sleep at night, didn't have faith, didn't have medication, and I did get referred to the mental health. They said what I am experiencing was psychosis, so it's actually, I was good, you know, I was successful, you know.

Nina from the service users alluded to how words can empower and disempower people in relation to mental illness, and the importance of using terms such as health and illness.

*Comments 27 (Service users).*

Nina            Well, personally I have, the thing is with words, it affects people and how they think, so I personally do not like the word illness because we are trying to be proactive and optimistic and give that person hope, so I would prefer that we would call it mental health because we are trying to manage the person's mental side of their being. I don't like the word illness because I don't really think of myself being ill, I just felt that I was going through really hard times and things weren't normal and because I became very, I internalised a lot of my depression at the time, so, and to me it was like my own little world and own little hell on earth (giggling) that nobody else really knows of...I think mental illness is very individual, even though we have the same diagnosis but only my sister knows what she lives with and only I knows what I live and so as 'Esau and Venusi. Because I am working as a peer support worker and I am really, you know, aware and I just think words make

people think and it affects their thinking so if you keep saying to a person that they are ill all the time, that is all they're gonna think of. So if you say to a person, you've got mental health, you are trying to maintain it, your health, which is your whole being, so that's my, that's my own perception, so whenever I am with people cos I support my peers, my sister with the *Palusami* group (pseudonym for mental health service users group), I'd rather use the word, the terminology mental health because immediately you are looking forward, you are trying to deal with what you have rather than an illness. Because people get stuck on the illness, they get stuck on the diagnosis, they get stuck in, instead of trying to bring themselves out of the illness cos at the end of the day, we are all human beings, we all want quality of life, we all want love, a house, clothing, food, so it's rather what connects us that makes us all the same, than what is different.

The use of 'mental health' highlights hope and moving towards wellness. Nina used psychological and social components like the human body, love, house, clothing and food to demonstrate positive mental health. Nina took it further showing how society makes decisions for those who are experiencing mental illness. She expanded on the discussion of someone who was seen as having odd behaviours and interpreted as having mental illness.

*Comments 195( Service users).*

Nina            What that guy did might seems weird, but really if it isn't hurting him or it isn't hurting anybody else, then why not? Like why, why can't he just be riding on his horse but because people perception or frequency of ideas or things that might not be normal to their normality or perception, then all of a sudden it becomes mental health and you got

to give him medication to make him better, so what's wrong with the guy getting on the horse and makes him feels good about himself and it's not hurting him or anybody else, then, you know, sweet as.

Nina suggests here that the intervention was not consistent with the problem, an issue that service users have with services. This also raises some questions about how Tongan understanding of mental illness continues to shift and change and how people with more traditional understanding would be able to accept this point of view.

### **Stress as onset of mental distress**

Stress is a factor that was voiced by all seven *talanoa* groups, and associated with contributing to and/or prompting mental distress and mental illness. Stress was described as feelings of anxiety and excessive worry which affect thinking, resulting in someone behaving differently than usual. Stress was associated with biopsychosocial, financial, cultural, and other related factors. One component of biopsychosocial constructions was financial commitments in A/NZ which was noted to be one important factor that forced people to overwork; some worked very long hours or in multiple jobs to provide for their families and to fulfil their cultural and social obligations. Participants acknowledged that the demanding nature of such work, combined with the financial constraints experienced by many Tongan people, leads to accumulated stress over time which contributes to mental illness.

*Comments 348 (Families without mental health service users).*

Lemeki      *Ko e lahi taha ki he pa'anga ē, tau sio ki he ngaahi fāmili Tonga, 'a ia 'oku mo'umo'ua 'a e 'atamai. Ko e 'uhi ko e toe kau mai ko e mo e lotu, hē, mo'umo'ua e 'atamai ki he fatongia 'o e siasi, mo'umo'ua e*

*'atamai ki he pila, mo 'umo 'ua e 'atamai ki he vavae ha me 'a ki he kai mo e ako e fānau...mo e nofo pē e fo 'i 'atamai he fo 'i me 'a tatau pē ha fo 'i ta 'u 'e fiha heni, hē... 'ikai to e 'i ai ha me 'a kehe ia ke 'alu ai e 'atamai, ko e nofo pē e 'atamai he ngāue pa 'anga...fo 'i stress ia ko ia, ko 'afē, 'e lava ke tuku hifo ai?*

English      It is mostly financial, eh; we look at Tongan families that are busy and stressed. It is because of the involvement of the church, eh, the mind is stressing out thinking about church obligations, stressed about bills, stressed about providing food and educating the children...and the mind struggles with this with so many years, eh,...there is nothing else to think about, always thinking about working financially...that stress, when are we going to give it up?

Environment and traumatic events were identified by the youth group as factors that can lead to mental illness, rather than associating mental illness with disease. The emphasis on stress was more of a psychosocial interpretation than biomedical. Samantha discounted mental illness biomedically through stating that it is not a disease, and she positioned mental illness in the environment which reflects a psychosocial view.

*Comments 106 (Youth).*

Samantha      Well, like me, mental illness to me is not a disease, uh, there is a lot of debate, like you know naming mental illness as a disease. I don't think it's a disease. You develop mental illness from your environment, like traumatic experiences and that's not medically proven.

With regard to the environment, the *talanoa* group of families without mental health service users discussed how education is regarded as one of the priority areas and considered very highly within the Tonga community. Families encourage children to attend and be successful at school, and there may be pressures on Tongan children to do well academically. As in other areas of Tongan society, the child in a family is not regarded as an ‘individual’, but carries the family name and reputation with them on their journey and this also applies to their academic journey. Doing well at school is identified as a particular aspect of success and a good reason for Tongans to move to New Zealand so that children can access a better education and, therefore, a better future for their family. An individual’s failure is interpreted as a failure for the family, relative, village, and community. On the other hand, if there is success, then it is regarded as a family, relative, village, and community success. However, pressures associated with the fear of failure mount up as stories of failure travel further than success stories. Lomio talked about how intelligent people develop mental illness because of stress initiated by thinking too much which again reflects that social pressure and expectations on individuals.

*Comments 30 (Families without mental health service users).*

Lomio            *‘I ai e kakai ia ako lahi lelei, ‘oku nau puke faka-‘atamai nautolu ia, ko e tupunga ia mahalo mei he fu‘u stress hono ‘atamai, ‘ai ke fakakaukau ‘i ha me‘a, ‘o ‘alu ia ai ‘o hē, ‘i ai e fa‘ahinga puke faka-‘atamai ‘e ni’ihi.*

English            There are intelligent people, and they have mental illness, and that is caused by too much stress on the brain when required to think about things, and they go astray, and some become un-well mentally.

Fear of being unsuccessful appeared to be a consistent threat identified in all *talanoa* groups. In the men's *talanoa* group, for example, 'Ili emphasised fear and associated it with education. 'Ili's comment supported the relationship between factors of stress, like fear, with the onset of mental illness. He strongly highlighted too much pressure as a source of stress.

*Comments 190 (Mens).*

'Ili                    *'A ia ko e tupunga ko e ilifia, hangē ko e ako. Fu'u lahi hono teke, fu'u lahi hono teke pea 'oku mafasia 'ene fakakaukau, ilifia na'a 'ikai ke hoko 'a e fakakaukau 'a e kātoa ko eni, ko ee 'oku nau hanga 'o teke ia. 'Oku ou tui 'oku 'i ai e ni'ihī 'oku pehē, 'ikai keu 'ilo 'e au pe ko e tupu he ilifia, ka 'oku hangē ki a au 'oku kau ai mo e ilifia e.*

English              So it is caused by fear, and like education. There is too much pressure, too much pressure and this burdens the way of thinking, fear of being unsuccessful and for those who pressure him/her. I believe some are like that. I do not know if it is caused by fear, but I think fear has something to do with it.

Palu in the women's *talanoa* group discussed psychosocial features further and mentioned changes in people's behaviour being due to having 'too much intelligence', which can be stressful. Palu described particular changes in verbal communication when one mumbles and is difficult to understand.

*Comments 52 (Womens).*

Palu                    *Fanongo he'eku ki'i ma'u, 'oku fu'u, kalasi 'oku fu'u lahi e poto, pea fu'u lahi e me'a 'oku fakakaukau 'i honau 'atamai, pea 'oku hanga leva he fa'ahinga me'a ia ko ia 'o ue'i honau 'atamai 'o mafuli leva ia 'o*

*'ikai kenau to e 'atamai, ke fakakaukau lelei 'enau fakakaukau ka kuo nau valevalelau ai pe nautolu ia.*

English           Some have too much intelligence, and there is too much for their mind to think about, and that causes movement of the mind by turning it, and no longer thinks properly, but they start mumbling.

A biomedical understanding of this would be that the person might be responding to non-apparent stimuli, or have pressure of speech, symptoms of mania, and/or schizophrenia. The men's *talanoa* group added social relationships to education as a cause of the onset of mental distress. The breakdown of social relationships creates worry and stress levels start to build up. One participant associated the break-up of a husband and wife relationship with worry and fear which are components of stress.

*Comments 165 (Mens)*

Soane           *Ta ko e 'oku toutou 'alu e mali 'o e finemotu'a, 'alu pē 'o nofo lotomo'ua, pea 'oku ilifia pea 'oku toutou puke ia ... to e 'i ai pe mo e matu'a tangata ia.*

English           So the partner of the lady usually goes, he goes and she stays worrying with fear and often becoming un-well ... and same with males.

The community leaders also noted social relationship disruptions and breakdowns and discussed this in relation to pre-marital status, in boyfriend and girlfriend relationships. Mosese alluded to how this affected one's thinking.

*Comments 141 (Community leaders).*

Mosese           *Pea 'i ai foki mo e kalasi ia 'oku break up ia mo e girlfriend, pea kovi ai pe mo e 'atamai ia.*

English           And some people, when they break up with girlfriends, their brains are affected badly.

Pita discussed biopsychosocial constructions through social fragmentations where breaking up in social relationships like divorce contributes to mental distress. He commented on how this not only affects the parents, but also extends to children, especially young children.

*Comments 173 (Community leaders).*

Pita               ‘Oku ‘i ai e kakai ia, ko e fānau kei īiki, māvae e mātu’a pea hoko ai e maumau ia ki he tokotaha ko ia.

English           Some people, children are very young, parents divorced and causing problems to that child.

The financial demands were also highlighted by service users. Families of those who were experiencing mental illness also asked for money from those who were un-well mentally which could be an added stressor. Toa discussed how she was financially troubled and desperately needed money to fulfil her cultural obligations, all her children refused to help and she asked for money from her daughter who was using mental health services.

*Comments 78 (Families with mental health service users).*

Toa               ‘Ou lea mai pē he telefoni... “ko au eni kou in trouble”, “pehē mai ko e ha?” “Fiema’u ha help, ha money, he ko e ‘oku ‘ita mai e son mo e tokotaha ko e, talamai ko au ‘oku ‘ulupupula pea hā, pea hā”, pea tangi ange he telefoni ‘o talamai, “Mum, ko e fiha ‘e ‘atu?”, kou pehe atu, “Ha me’a pē”, pea ha’u e ‘oange e tolungeau Nu’usila ‘o lī ange.

English           And I told her on the phone...“I am in trouble”, then she asked me, “What is it?” “I need help, need money, my son is angry with me, the



other one, told me, I am high headed and this and that”, she cried over the phone and told me, “Mum, how much do you want?” I told her, “Anything”, and she sent me three hundred New Zealand dollars.

Toa asked for money from her daughter because her other children refused to give money. This request was likely to pressure Toa’s daughter to contribute and please her mother and three hundred dollars is a significant amount to give. While Toa indicated that she was very happy to receive the money, her recalling that her daughter cried indicates that it is likely the request put pressure on Toa’s daughter to contribute and please her mother.

Lemeki raised coexisting conditions like poor diet and nutrition, leading to conditions such as diabetes and high blood pressure, which also contribute to stress.

*Comments 368 & 370 (Families without mental health service users).*

Lemeki                    *Fakataha pē mo e me‘akai ‘oku tau kai, tau kai heni e me‘a kai kehekehe, hē, pea ‘oku ‘alu e me‘akai kehekehe ia ‘o fakatupu ai e suka, toto mo e hā fua, pea ko ‘ene ha‘u kātoa pe ko ia, stress up ai e fo‘i tama ko eni ‘oku fakakaukau‘i e , “‘Oku ou toto, ‘oku ou suka, ‘oku ou hā”...‘o uesia ai pē mo ‘ene ki‘i ‘atamai ‘a‘ana he‘ene fakakaukau‘i hono ‘ū mahaki...pea ko e kai e ‘i Tonga ko e tunu manioke pe mo e inu niu, ‘ikai ke ‘i ai he me‘a ia e.*

English                    Here we eat different things, eh, and those different foods cause diabetes, high blood and those, and when all those diseases come, that guy will get stressed thinking, “I have got high blood, I have got diabetes, I have got...” and his brain will be affected as he keeps

thinking about his illnesses...but in Tonga, we eat cassava and drink coconut, and nothing happens.

Nina from the service users group shared her experiences, stating that environmental issues and trauma cause stress and is linked to mental distress and mental illness.

*Comments 136 (Service users).*

Nina            Every person has a different story to tell of why they have got mental health in their life. What you are talking about is stress to a person's life, you know, I think, from the sound of it, is the stress factor and how the person's mind, body, and soul deals with it. Because my story is very different from Tevita and different from everybody else's, cos I remember when I was a young child, even when I was a young child, I actually do remember that, I didn't know at the time but I was depressed when I was a young child, but I didn't know what it was at the time and I don't know about all you people, but you know Dad used to beat Mum up, used to beat us children up. I've been sexually abused, so, to me, I am not surprised that I have depression and anxiety, because I think any person would've, had that if the same things happened to them.

Stress and trauma, therefore, were associated with a range of causes from relationship breakups to cultural obligations, pressure to succeed, financial demands, and other factors. As the participants' comments show, the ways of living in Tonga conflicts in some ways with

living in A/NZ and these conflicts may cause Tongan people living in A/NZ to experience stress which is related to mental illness. Not all people who experience stress develop mental illness, but stress is acknowledged as a contributing factor in the development of mental illness. The third subtheme in the *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions) theme is issues with drugs and alcohol which are more widely available and accessible in the A/NZ context.

## **Drugs and Alcohol**

Drugs and alcohol were reported by participants as being strongly linked with mental illness, both in terms of contributing to the development of mental illness and of sustaining the symptoms. While drugs and alcohol are regarded as more accessible in A/NZ than in Tonga the *talanoa* identified that participants are also aware of their use in Tonga. The participants discussed the impacts of drugs like marijuana, ‘magic’ mushrooms and also alcohol on mental health. In the men’s *talanoa* group, for instance, Hale discussed the use of drugs in the form of psychoactive mushrooms at social gatherings and for recreational purposes in Tonga. He shared a story about a person who used mushrooms that changed his way of thinking and who became sad and socially withdrawn.

*Comments 183 (Men).*

Hale           ‘Oku ‘i ai mo e kakai ia ‘e ni’ihi, ‘oku nau puke he, ‘oku ‘i ai e ki’i leka ‘e taha ko hoku kaungātangata, na’e sai ‘aupito pe e ki’i leka ia, ka ko e inu ko eni ko e ‘a e fakamalu tēvolo, sio ‘alu pe e ki’i leka ‘o hē e fakakaukau ‘o ‘alu pe ‘o mate, ‘a ia tau pehe pē, ko e fakatupu he

*lotomamahi mo e ta'elata, 'o kau ki ai mo e drugs, tau pehe pē, kau pe ki ai e fakamalu tēvolo*

English      Some people are un-well, there was one child, one of my friends, he was really well, but drinking of mushrooms (psilocybin), see, it went and his thinking went astray and he passed away, so we say, it was caused by sadness and loneliness, with drugs, with mushrooms.

The families without mental health service users' *talanoa* group discussed the geographical flow and accessibility of marijuana in other countries and how it affects Tongan people travelling overseas. Vikilani gave an example of a person whose behaviour had changed and this was attributed to marijuana use. Previously he behaved well and lived within cultural norms and values; however, this person went overseas and came back with different behaviours, and had changed to be more irritable and acting inappropriately.

*Comments 40 (Families without mental health service users).*

Vikilani      *Mahalo na'e ki'i 'alu ki 'Amelika, mahalo na'e ki'i 'alu 'o toupi, 'o hē ai e fakakaukau... pea 'ilonga pe e taimi ko e 'oku 'ita ai ki ha taha, 'e 'ohovale pē, sio 'oku 'ohovale pe 'emau kalapu 'amautolu,... tu'u atu pē mo e mata'itele 'o hifi'aki e mata he fu'u loto fale kalapu.*

English      Maybe he went to America, maybe he went and took some marijuana, and his thinking went astray, and when he came back to Tonga...it was noticeable when he was angry, suddenly, see, suddenly in our club (referring to *kava* club), he got up with a razor and cut someone's face inside the clubhouse.

Another participant in this group, Lemeki, supported Vikilani and directly connected the use of drugs and alcohol to the increasing number of people with mental illness is due to using illegal drugs.

*Comments 71 (Families without mental health service users).*

Lemeki        *'A e faito 'o konatapu mo e me'a, ko e fakatupu lahi ai pe e fika ko e 'o e kau uesia ko e 'a e 'atamai.*

English        Illegal drugs and that...this increase the number of those who are affected mentally.

This subtheme was voiced consistently throughout the *talanoa* groups, with drugs and alcohol viewed as potent factors in the construction of mental illness. The families without mental illness emphasised the low price of alcohol which makes it more accessible and was thought to contribute to other issues like teenage relationships and pregnancies, relationship issues, divorce, violence and abuse, which can all lead to mental illness.

*Comments 171 (Families without mental health service users).*

Lemeki        *He kuo ma'ama'a leva 'a e pia mo e 'u kava mālohi, pea to e fakatupu ai pē e fo'i leini ko e ki he ifi, pea mo e hē ko ē 'a 'enau taumu'a ē ... 'ikai ke 'i ai ha 'amanaki ke 'i ai ha taumu'a lelei ... hoko pē pea mo e mali kei īiki, 'o ne fakatupu ai e, mali te'eki ke lava ke matu'otu'a lelei e 'atamai ke fa'u e family, pea hoko ai e movete mo e kē, ke abuse leva e fānau, 'o tupu leva e mental, uesia faka'atamai e.*

English        Beer and higher alcohol content drinks are cheap and also contribute to people smoking, and becoming lost from their personal goals eh,...no hope for good goals...end up getting married young, brain is not fully

developed to make a family, and lead to violence and divorce, abusing the children and causing mental illness.

‘Emosi supported Lemeki around the accessibility of illicit drugs and alcohol and shared how people as young as 14 years old are drinking alcohol and sniffing substances, and also smoking cigarettes and marijuana.

*Comments 229, 231, 233 & 235 (Families without mental health service users).*

*‘Emosi       Ka ‘oku inu e to‘utupu ia, ta‘u 14 mo 15, hanga lava e ngaahi me‘a ia ko ia ‘o fakatupunga ai ‘a e fepaki, pea ‘i ai e kalasi ‘oku nau malava‘i, pea ‘i ai e kalasi ‘oku nau li‘aki e ako, ‘i ai e kalasi ō nautolu ‘o ifi ...mihi, inu ...pea manatu‘i e fānau, te‘eki ai matu‘otu‘a fe‘unga honau ‘uto ... ki he ngaahi fetongi ko eni, pea ‘e ala lava lava ke ma‘u kinautolu he fokoutua.*

English       The youth are drinking, 14 and 15 years old, those things create conflicts, and there are some that can handle it, and there are some that leave school, some that go and smoke...sniff, drink... and remember these children, their brains are not fully developed...to these changes, and there is a possibility that they can become ill.

A young participant in the service user *talanoa* mentioned that we are surrounded by chemicals and these chemicals influence people in many ways, contributing to people being mentally un-well.

*Comments 172 (Service user).*

Nina            We are living in a chemical generation as well, and there is lots of drugs and alcohol, so it's like the end before the triggers. Did they become un-well because they took the drugs, or they were un-well before they took the drugs and alcohol?

The use of drugs and alcohol were discussed as contributing to mental distress and illness by affecting behaviours and attitudes. Accessibility was easier in A/NZ, and, as Nina highlighted, alcohol and drugs are part of younger people's socialising. Alcohol and drugs were identified as associated with mental illness by contributing to social relationships breakdown, and related to domestic violence.

## **Summary**

This chapter covered the second theme, *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions), and its four subthemes – challenging Tongan beliefs, English and biopsychosocial language, stress as onset of mental distress, and drugs and alcohol. The ways in which this theme challenges and contrasts with the previous theme, *tufunga faka-Tonga*, have been discussed and presented, along with explanations of how good outcomes associated with accessing mental health services have influenced construction of mental distress and illness. Negative outcomes associated with Tongan traditional healers and society's traditional Tongan interpretation of mental distress and illness drove participants away from *tufunga faka-Tonga* towards *tufunga faka-paiōsaikosōsiolo*. The linear and

individual focus of *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions) was more evident in the literature than the research. The next chapter focuses on the final theme, *tufunga fepaki mo e fetaulaki he vaha‘a ‘o e tufunga paiōsaikosōsiolo mo e tufunga faka-Tonga* (intersections between biopsychosocial and Tongan constructions of mental distress).



# **Chapter Seven: *Tufunga fepaki mo e fetaulaki he vaha'a 'o e tufunga paiōsaikosōsiolo mo e tufunga faka-Tonga*** **(intersections between biopsychosocial and Tongan constructions of mental distress)**

## **Introduction**

Chapter Six presented the findings for *tufunga faka- paiōsaikosōsiolo* (biopsychosocial constructions). *Tufunga faka- paiōsaikosōsiolo* was derived from the data collected from participants in regards to their perceptions, interpretations, constructions, and definitions of the subject matter, mental distress and illness from biological, psychological and social perspectives. The research data analysis produced three main themes which are *tufunga faka-Tonga* (Tongan constructions) and *tufunga faka- paiōsaikosōsiolo* (biopsychosocial constructions). These two themes can be viewed along a continuum with the *tufunga faka-Tonga* (Tongan constructions) – the traditional Tongan view – being more circular and collective while the *tufunga faka- paiōsaikosōsiolo* (biopsychosocial constructions) has more of a linear and individual focus. The linear and individual focus of *tufunga faka- paiōsaikosōsiolo* (biopsychosocial constructions) was less noted in the data than in the literature. The third theme, *tufunga fepaki mo e fetaulaki he vaha'a 'o e tufunga paiōsaikosōsiolo mo e tufunga faka-Tonga* (intersections between biopsychosocial and Tongan constructions of mental distress) sits between these two themes on the continuum, where participants use both sets of knowledge to understand and explain mental health and distress.

The *tufunga fepaki mo e fetaulaki he vaha'a 'o e tufunga paiōsaikosōsiolo mo e tufunga faka-Tonga* (intersections between biopsychosocial and Tongan constructions of mental distress) theme is from the data in which participants identified their position(s) in relation to accepting both biopsychosocial and traditional Tongan concepts as explanations for the causes, valid assessment, and treatment of distress. Participants were influenced by their experiences of mental health and distress. Positions were determined by the level of exposure, influence, and acceptance of both Western and Tongan knowledge. *Tufunga fepaki mo e fetaulaki he vaha'a 'o e tufunga paiōsaikosōsiolo mo e tufunga faka-Tonga* (intersections between biopsychosocial and Tongan constructions of mental distress) is shortened to *tufunga fepaki* for ease of presentation and purpose of discussion.

As suggested by this overview of the themes, the positions adopted by the study participants could be identified along a continuum. For example, the men's *talanoa* group's ontological interpretations of mental illness were constructed from *tufunga faka-Tonga* (Tongan constructions) and *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions) was treated as foreign knowledge. The youth *talanoa* group, on the other hand, was positioned at the opposite end where their knowledge was constructed mainly from *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions). This chapter presents the *tufunga fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress) theme with its five subthemes. The data was mainly derived from the services users, families and youth *talanoa* groups. The subthemes are migration, social networks, services and resources, participants' experiences with distress and Christian faith.

Theme three, *tufunga fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress) plays a pivotal role in this research project as it brings together the other two themes and demonstrates how they interweave. *Tufunga fepaki* is the meeting point or intersection between the previous two themes. At this meeting point participants discussed alignment with both themes, and a mixture of beliefs. For example, although the men's group aligned mostly with *tufunga faka-Tonga*, and the youth group aligned mostly with *tufunga faka-paiōsaikosōsiolo*; not everyone in each of these groups always stuck to this position. In other words, each group showed a range of alignments and sometimes individuals showed a mixture as well. This chapter aims to draw out the discussion of how these intersections appeared in the data.

*Tufunga fepaki* is presented and discussed in terms of its five subthemes. These subthemes highlight where the other two themes intersect, and how they relate to each other, and also reflect how the participants discussed the influences of these subthemes on their perceptions and knowledge. Migration is associated with the geographical movements of the participants, and impacts on social networks that were revealed within these movements, both in terms of their connections with other people and also the environment. Migration is discussed first, followed by social networks, then services and resources, participants' experience with mental illness and outcomes of treatment and lastly, the Christian faith.

## Migration

Migration, in this research, refers to any movement from one geographical location to another, and so includes movement within Tonga, movement from Tonga to New Zealand or Australia, and movement within New Zealand. Movement within one country largely refers to moving from rural to urban areas, such as from outer islands to the main island in Tonga, Tongatapu. The other significant migration is related to leaving Tonga to live overseas, usually New Zealand, but some participants discussed their experiences in Australia. As expected in this research, migration status impacted on how the participants discussed mental illness, and experiences of migration influenced the participants in terms of mental illness. As stated previously, not all participants were migrants as some were born and grew up in A/NZ. It is important to note that those who were born in A/NZ are children of migrants and this still has an impact.

As discussed in Chapters One and Two, mental illness is culturally and historically located (Fernando, 2010; Pilgrim et al., 2011). In this study, it was clear that geographical and environmental positions had influenced the participants' definitions of mental illness, and this was related to exposure to differences in social, health, and education factors, and technological structures, for example. Kefi from the community leader's *talanoa* group explained how she had migrated between Australia, Tonga, and New Zealand and her perceptions and definitions of mental illness tended to shift according to the geographical areas she moved to. While she was grounded with her Tongan values and beliefs that largely influenced her construction of mental illness, she was also exposed to Australian and New Zealand interpretations of mental illness and she was able to identify how she viewed it from two perspectives due to, as she quoted it, "growing up in both worlds".

*Comments 370, 372 & 374 (Community leaders).*

**Kefi**            *So I grew up knowing both worlds, not only the Western side but also my Tongan culture. I also saw the difference between me and my cousins in Australia, 'Oku ou tui au ia ki he ngaahi akonaki ko e 'oku 'omai ko e he 'eku kui ko e ki a au, hangē ko e talanoa ko e ki he tēvolo, pea hangē ko 'eku sio ko e ki he 'eku aunty (who was possessed by a spirit) ... and I believe in it, pea hangē ko e lotu, has a big part in my life, 'uhinga e tui 'Otua. Te sio pe 'i Australia ki he fanga cousin ko e 'oku nau tau 'atāina, ko nautolu ko e 'oku lahi 'enau palopalema, taimi si 'i pē 'oku talamai 'oku puke, pe 'oku commit suicide ha tokotaha, pe 'oku ki 'i mental ha taha, palopalema, but I do agree with that, it has a big part, 'e te environment ko e mo e family mo e foundation ko e na 'a te tupu ai, and I think also young, New Zealand born or Australian born Tongans, 'oku 'ikai ke nau believe nautolu ia as much ... hangē ko e Tonga ko e mei Tonga, you know, 'oku tau tui pe tautolu, 'a ia 'oku tau tui ki he 'Otua, tui ki he 'etau culture pea tau toe tui ki he me 'a faka-tēvolo, 'oku tau 'ilo pe 'oku kau pe ia, he part of our culture, you know NZ born Tongans overseas are quite different because tenau question ia 'e nautolu.*

**English**        *So I grew up knowing both worlds, not only the Western side but also my Tongan culture. I also saw the difference between me and my cousins in Australia. I believe in advice given to me from my grandmother, and like stories about the devil, and like how I saw my aunty...and I believe in it, and like religion has a big part in my life, the meaning of believing in God. I saw my cousins in Australia who*

have freedom, they are the ones with lots of problems. After a while, we are told that that someone is sick or commits suicide, or has a slight mental problem, but I do agree with that, it has a big part, and the environment and the family and the foundation that I grew up in, and I think also young, New Zealand born or Australian born Tongans, do not believe as much...and like the Tongans from Tonga, you know, we believe, we believe in God, we believe in our culture, and we also believe in our devil ways of things NZ born Tongans overseas are quite different because they will question it.

Kefi discussed the foundation of her construction of mental illness and her migration between Tonga, Australia, and New Zealand and explained how these introduced and exposed her to other interpretations and definitions. She was born in Tonga and grew up in Australia and is now living in New Zealand. She chose her foundational knowledge around mental illness (Tongan) to be the one to most strongly influence her construction of mental illness. The strong Christian values and practices of good versus bad were highlighted by Kefi, and these strongly contributed to her understandings of mental illness.

Comments from Sina in the women's *talanoa* group support Kefi's position and emphasise that when the *tufunga faka-Tonga* and *tufunga faka-paiōsaikosōsiolo* meet, this shows limitations of biomedical knowledge, as Tongan people already have treatments for mental distress.

*Comments 15 (Womens).*

Sina            *Pea ko hono kehekehe ia e me'a, na'e 'i ai pe e faito'o ia e kakai Tonga ki ai, 'oku 'i ai pe e fa'ahinga faito'o ia e kakai Tonga ki he mahaki ko ia, 'oku 'ikai lava ia he toketā.*

English            And that is the difference, as Tongan people already have treatments for it (mental illness). Tongan people already have treatments for that illness; doctors will not be able to do it.

Sina's use of "difference" explained the comparison between *tufunga faka-Tonga* (Tongan constructions) and *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions), and also highlights Sina's position where she stands and is able to see both themes. She chose *tufunga faka-Tonga* (Tongan constructions) due to its effective treatment by traditional healers and something that doctors (*tufunga faka-paiōsaikosōsiolo*) are unable to treat.

The management of mental illness using the *tufunga faka-Tonga* interpretations and definitions were discussed in all groups with the least emphasis from the youth *talanoa* group. Some participants, like Kefi and Sina, tend to hold on to and define mental illness according to their initial interpretations which were influenced by their upbringing, and with the environment playing an important role in this process. These participants were grounded with the *tufunga faka-Tonga* (Tongan constructions) and they chose to remain aligned there when it came to meeting with *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions). This raises an important question about understandings the perception that people bring to their experiences and their interactions with clinicians.

Joshua, Naioka, and Samantha were participants in the youth *talanoa* group. They discussed how geographical location, environment, and upbringing influenced their definitions of mental illness in a *tufunga faka-paiōsaikosōsiolo*.

*Comments 152, 154, 156 & 158 (Youth).*

Joshua            It's just cos we haven't grow up in that side of environment.

Naioka I think is that we grew up in a society where it's acceptable...where, we kind of experience mental illness in our family, and it runs in our family. And we kind of know that it has to be treated, so you got to accept it, you know, get counselling, talk about it. Yeah, well, I don't believe it's like a *puke faka tēvolo* thing.

Samantha Yeah, um, we just, cos we've grown up through, you know, horror movies, and we just, we just Westernise sort of, you know, think what the *pālangi's* thinking, like if you don't see it, it's not real, and a lot of white people think that that's not real and we've grown through a society like that, and we see, they make jokes out of it like, you know Jayka (pseudonym for an entertainment centre) and stuff, like we go there and, they make jokes out of us so we think it's not that serious, but if you were, I guess raised in Tonga then it will be different, because we believe more of our elders than we do here. And um, yeah, I don't believe in it [*tufunga faka-Tonga* (Tongan constructions)].

These young Tongans' comments illustrate how New Zealand's environment exposed them to media and the *pālangi* interpretation of mental illness. They grew up in an environment and a society where mental illness is treated through counselling and one has to accept it, and as Samantha highlighted, they are influenced by Westernised ideas. Growing up in that environment has shaped them to construct mental illness through Western and biomedical frameworks. While they were aware of the *tufunga faka-Tonga*, that seemed to be foreign knowledge to them and their environment, and they choose not to accept the *tufunga faka-Tonga* of mental illness.



Tongan families are aware of the differences in the way young people understand and interpret mental illness. Lita, who is a mother from the families without mental health service users' *talanoa* group, explained that she thought youth mental health relates to the influences of the society and environment. Lita alluded to suicide relating to love relationships which also have some forms of mental disturbance.

*Comments 143, 145 & 147 (Families without mental health service users).*

Lita            *Kuo u tui au ia ko e lahi e pehē 'etau fānau ia 'atautolu heni 'i muli ni, ko e 'uhi 'oku nau tupu hake nautolu ia, 'o muimui ... he 'ātakai 'o muli ni ... ko e lahi taha he taimi ni 'a e me'a ko e hangē ko e ngaahi taonakita, mahino na'e ngāue e 'atamai ia ai, ko e 'uhinga ko 'enau hangē ko e to'onga ko e 'a e kau pa..., ko 'enau faikaume'a, tau sio ko e lahi taha, ko e faikaume'a.*

English        I strongly believe that most of our children here in foreign lands, as they grew up, they follow...this foreign environment...and most things now like suicides, it is clear that brain is affected, and it is because they behave like the *pa* (referring to *pālangi*) for their relationships, and see that most are relationships [relating to onset of mental illness].

Lomio contributed to the *talanoa* with how constructions of mental illness change and should change according to context. Lomio is a father who was born and raised in Tonga, grounded in Tongan values and beliefs, and who primarily holds to the *tufunga faka-Tonga* knowledge. He described accepting a Western view but only to manage mental illness in New Zealand, which should be in the Western and biomedical system.. The thinking behind this is that the village system and traditional healers in Tonga do not exist in A/NZ, therefore it is easier to use what is available in A/NZ.

*Comments 290, 292 & 294 (Families without mental health service users).*

Lomio            *Ka ko e fa'ahinga puke ko eni 'oku lau, 'i Nu'usila ni ia, kuo u tui au ia, kapau 'e puke pehē ha taha ia, ko e hangatonu pe ki falemahaki...mahalo ko e vave pe ia, he 'oku kehekehe 'a Nu'usila ni mo Tonga, ko Tonga ia, ko e ki'i nofo fakakolo, 'osi 'ilo 'oku 'i ai 'a e finemotu'a ia ko e...ko 'ene faito'o, pea ko e hoko pe e me'a ia, leleaki 'i ki a me'a, sio, 'o 'uluaki mu'a ia ki ai.*

English            With this illness that we are talking about, in New Zealand, I believe that when someone is sick here, we should go directly to the hospital...I think that will be quicker, as New Zealand is different from Tonga. In Tonga, people live in villages, everybody knows that this lady treats this...it is what she treats, and when someone is sick, rush to her, go directly to her first.

Lomio use at the start of his comment of, “with this illness” suggests that he looks at mental illness through more than one lens according to the context. These two views were explained well in his comment which showed that Lomio was grounded with the *tufunga faka-Tonga* of mental illness, but had been exposed to new knowledge, demonstrated by his mentioning “the hospital” in his comment. He went further with this exposure and demonstrated acceptance of the new knowledge proposing that one should use the hospital in New Zealand, rather than the old Tongan traditional ways of managing such illness. This discussion thread was consistent throughout the groups: participants identified their original body of knowledge and discussed how they were exposed to foreign knowledge, their relationship with this foreign knowledge, and levels of acceptance and practice. In Chapter Three, this was discussed in relation to people leaving behind or accepting new forms of knowledge when migrating between countries.

Masi from the service users' *talanoa* contributed to this discussion about mental distress and mental illness with his reflection on how mental illness has been interpreted differently over time, the 1960s to the 1980s. Masi explained the different *fa'unga* (reality) of mental distress and mental illness through time and how he migrated to A/NZ and now looking back realising the evolvement of his interpretations through migrations and time.

*Comments 186 (Service users).*

Masi            *Ko e onongofulu 'i Tonga, na'e toki maama kiate au heni, na'e 'i ai pe e kakai pehē ia 'i Tonga. Na'a nau tala 'e nautolu, ko 'ene hoko pe 'a e taimi puke ia, heka ia he hoosi mo 'ene me'atau. Tala ia 'oku 'i ai e kau tau ke nau tau, 'alu ki he liku 'o Loupua (pseudonym for a village in Tonga) e, 'o ne tala 'e ia e 'ū me'a 'oku fakaofu ia. 'A ia kou nofo au he taimi ni 'o sio atu ki ai, ko e schizophrenia ia he. Na'e 'i Tonga pe ia, hoko pe ia 'i Tonga, ka ko e 'uhi na'e 'ikai ke 'i ai ha'atau, ka ko e fota'aki e lau'i'akau, fota'aki e lau'i'akau, 'ikai ke sai ia, he. 'ikai ke sai ia ki ai, 'a ia ko e fo'i me'a ia ko ia na'e 'osi 'i Tonga pe ia, ka ko e 'ikai ke fakatokanga'i, mālō mo e toki 'aluange ko eni 'a Mapa, 'o ne hanga 'o vahevahe ai e me'a. 'A e mahaki, 'āvanga ha, 'āvanga ha. Onongofulu, tokolahi e kakai ia na'e 'ikai sai ia ki he faito'o faka-Tonga, sai pe, puke pe nautolu pea nau sai pe nautolu 'ia nautolu, taimi ko e 'oku nau sai ai, normal pe, pea ko 'ene hoko pe taimi puke ia, tala 'e ia e 'u me'a 'i Pilitania hee. Pea ko e lahi ko e 'a 'ene longoa'a pea puke 'o 'ave 'o fakahū, pea ko 'ene 'ave ko e 'o fakahū, pilisone, ne tala pe 'e ia, kaikaila pe ia mei pilisone e 'ū me'a ko e 'oku hoko. 'A ia na'e 'i Tonga pe ia he 'aho ko e, he, ka ko e 'ikai 'i ai*

*ha faito 'o, ko e toki a 'u mai eni ki he fitungofulu, valungofulu, 'oku 'i ai e me 'a ke faito 'o 'aki.*

English In the sixties there were people like that in Tonga (who) when they were un-well, got on a horse with weapons, declared that he is going to war with his enemy, rides to the cliff bound coast of *Loupua* (pseudonym for a village in Tonga), and spoke of surprising things, and as I am reflecting on it now, it was schizophrenia. It was in Tonga, it happened, but we did not have any...we massaged them with leaves, massaged them with leaves, not getting better eh, so it [schizophrenia] was already in Tonga, but we did not recognise it. Thankfully Mapa came and distributed this thing, *'āvanga* this and *'āvanga* that. In the sixties, there were many people who were not treated with the Tongan traditional healers, some were well, then became un-well and well again by themselves, became normal. When they became un-well again, they talked of something in Britain eh, and when they became very loud, they were arrested, sent to prison, they kept talking, shouting from prison about things that happened. So it [schizophrenia] was in Tonga in those days, eh, but there were no treatments. Seventies, eighties, there was something to treat it with.

The migration subtheme of *tufunga fepaki* has focused on the movement of participants between different environments and societies. Participants described how various factors associated with migration – exposure, engagement, acceptance, and practice – have influenced the ways in which they define and construct mental illness. Migrants experience many changes including differences in social support systems. The next subtheme looks at social networks and their influences.

## Social networks

The social networks and influences subtheme looks at how participants view the social networks and structures in different contexts and how these influence their constructions of mental illness. Lemeki commented on the comprehensive and solid social support structure in Tonga which he believes becomes fragmented when people move to A/NZ. Lemeki thought that young people are not supported well in A/NZ in terms of social support. With the social support in Tonga, family members are conveniently close and available when needed. In A/NZ, families are being fragmented as some still stay in Tonga and families are scattered through A/NZ. Young people are not being looked after as parents are out working which also disrupts the social support structure at home. He commented that supportive structures seem to collapse in A/NZ as participants are pressured by their social requirements to adapt and survive with heavy work commitments. Furthermore, he argued that parents are less available for their parental roles due to work commitments to honour financial commitments in order to get by from day to day in A/NZ society. Two parents out at work is a different expectation than in village life in Tonga.

*Comments 169 (Families without mental health service users).*

Lemeki        *Ki'i olioli 'a Tonga, he na'e ma'u pē e fu'u mei ia 'o fua pē ia 'o tau kai ta'etotongi, pea kole atu ki he neighbour mo e uncle mo e hā. Ko eni ia, kuo pau ke fai e ngāue ia ke totongi, pea 'oku hangē leva 'oku ki'i faingofua ange ai ki he fānau kenau ki'i li'aki 'a e ako ka e ō 'o ki'i ngāue pa'anga, 'i he taumu'a ke totongi mai e pila 'a e fiema'u 'a e mātu'a ke totongi e pila mo e hā.*

English            Tonga is a little bit better, because we will have a breadfruit tree which we can eat from freely, and we can ask our neighbour, uncle, and so forth. Here [in New Zealand], we have to work to pay, and it seems easier for children to leave school and go and work to help the parents paying the bills and fulfil their parent's needs.

Lemeki's comments highlight the pressures that society has on participants in New Zealand and how they are sometimes forced out of school at an early age. This increases the likelihood that they will work in low paid jobs, sometimes multiple jobs and long hours, or potentially become unemployed which are determinants of poor health (Statistics New Zealand and Ministry of Pacific Island Affairs, 2011). The next section discusses aspects relating to services and resources for mental health.

### **Services and resources for people and families experiencing mental distress**

A major issue in discussing services and resources for mental health services for Tongan people is confidentiality. This is due to the small population and also the smaller pool of Tongan mental services and providers. The small size of the Tongan community has the opportunity for people to know about each other. People can identify with family names and are able to relate to one another. This open relationship extends to Tongan health professionals and also their areas of practice. In Tonga, our famous Dr Viliami Tangi is well known throughout Tonga for surgical practise and Dr Mapa Puloka for mental health. The Tongan communities identify people easily and it was challenging to maintain confidentiality

in presenting this thesis. For this reason the data presented referred to no specific services and generalised comments are presented.

The *talanoa* groups discussed their experiences of mental health services. There were discussions about mental illness diagnoses by clinicians and the ways in which this impacted on how mental illness was understood and constructed. Siale from the families with mental health service users described how they decided in Tonga to go to the hospital and the staff at the hospital discussed mental illness using Tongan language, ‘*āvanga*’, but interpreted it through biomedical definitions as mental illness.

*Comments 297 (Families with mental health service users).*

Siale            *Pea mau ō leva e ki falemahaki, ko e o atu ki a* (staff at the hospital), ‘*o toki talamai ‘e* (staff at the hospital) *ia “ko e ‘āvanga”*.

English        And we came to the hospital to see (staff at the hospital), and (staff at the hospital) said, “It is ‘*āvanga*” (mental illness).

When discussing services, mental health workers in Tonga were mentioned by all groups; staff at the mental health services were the symbols for Tongan psychiatry/mental health/mental illness or anything to do with the brain, mind, mental state, psychology, and psychiatry.

The staff at mental health services had been leading (non-traditional) mental health work in Tonga through the Ministry of Health and the hospital. The majority of the participants in all of the groups were aware of that work. The mental health staff had been doing ground-breaking work in Tonga and their work was described throughout the *talanoa* groups as being very helpful and able to enlighten people about mental illness. There were, however, other interpretations of the service that was sometimes portrayed as being different or odd. There

were also references to behaviours of people experiencing mental illness as behaving outside of the Tongan prescribed ‘normal’ behaviours. That behaviour stands out and is identifiable in the community, and this usually separates them as outsiders who end up being laughed at, causing feelings of embarrassment and neglect for people experiencing mental distress.

### **Participants’ experiences with mental distress – treatments and outcomes**

Being involved with mental health services produces outcomes that were identified as a major contributor to constructions of mental illness. Positive, favourable outcomes from treatment – either *tufunga faka-Tonga* (Tongan constructions) or *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions) – attracted interpretations of mental illness towards their respective ends of continuum (see Chapter Four, Figure 4.4). Negative outcomes, on the other hand, drew participants away from the service, either traditional Tongan healers or hospital, and that also influenced the construction mental illness.

Lina, a young female leader, challenged Tongan constructions of mental illness. She discussed symptoms of mental illness using her experiences and stated her position by stating “I am in between” as she had not experienced the Tongan constructions. This demonstrates the intersections of the two constructions where Lina heard about the *tufunga faka-Tonga* from her family at home, and she also witnessed mental illness in what she calls psychosis which aligns more with the *tufunga faka-paiōsaikosōsiolo*. Lina sees herself standing at the intersection and still in the decision making mode.



*Comments 272 – 284 (Community leaders).*

Lina I've heard stories, *pea na'e 'i ai pē 'a e ta'ahine kou tokoua'aki na'e puke, ka 'oku 'ikai ko ha puke faka-tēvolo, ka ko e mental pe ko e psychosis...nofonofo pe ia 'i loki 'o talatalanoa ai pe ia ki ai tokotaha pe ia...pea kiate ia, 'oku hangē 'oku 'i ai ha voices ia 'e tolu 'oku lea mai ki ai, talamai ke fai e, fai e...well, I am in between, 'oku te'eki ai keu sio tonu keu believe but I've heard possessed by demons.*

English I've heard stories, and I have a cousin who was un-well, but it was not *puke faka-tēvolo* but mental or psychosis...isolating herself in her room and talking to herself...and for her, it was like there were three voices speaking to her, "do this, do that"... Well, I am in between, but I have not seen it so I can believe it, but I've heard possessed by demons.

'Inoke in the youths' *talanoa*, again highlighted mental health services in Tonga, attempting to relate mental illness diagnoses to Tongan concepts of *'āvanga*.

*Comments 48 (Youth).*

'Inoke *Pea toki fakakalalakalasi foki ia... 'a e 'ū me'a ko e 'āvanga leke, ko e me'a ko e, ko e puke faka-tēvolo foki 'i he lau 'e ni'ihī 'i he'etau me'a faka-Tonga. Hangē ko e puke faka-tēvolo, lau ia ko e me'a 'a e 'atamai, ka ko e, ka ko e toki 'ilo eni 'e tautolu ia, 'i he taimi ko e 'oku ha'u ai 'a \_\_\_\_\_ (name/s of staff at mental health services) ko e 'o me'a, 'o fakafaikehekehe'i, 'oku 'i ai e puke, puke faka-tēvolo ko e ha, 'āvanga ha, ko e 'āvanga, 'a ia ko e, ki a au ia ko e, 'oku ou tui ko e*

*ngaahi mahaki pē ia 'o e 'atamai, fakatupu 'e he ngaahi me'a kehekehe pē.*

English      Categorized it into different types... '*āvanga leke*, it is the, and *puke faka-tēvolo*, referred to it by some people in our Tongan way. Like *puke faka-tēvolo*, said that it is when the brain is affected, but we know now, since [name/s of staff at mental health services] came and differentiated them, *faka-tēvolo* that is, '*āvanga* what, it is '*āvanga*, so for me, it is, I believe that it is an illness of the brain, caused by different things.

Nina described her experience differently where she listens to the Tongan interpretations but is more aligned with biopsychosocial constructions.

*Comments 32 (Service users).*

Nina      Well, the thing is, with Mum – me and Liana when we were children, we saw Mum probably three times, in the Tongan, in our Tongan cultures, they call it *puke faka-mahaki* where they said that Mum was like possessed by the spirit or demon or you know from beyond, the physical form. But come to think of it now on reflection, my Mum probably naturally just had like a breakdown in life. Maybe there was quite a lot of stress going around for my Mum and, you know, the brain probably was projecting itself and then, you know mental health occurs because the body become, and the mind and the spirit become overloaded.

Participants reported that their experiences of mental distress influenced their treatment options. The outcomes of the treatments contribute to constructions of mental illness. The small size of the Tongan community, both Tonga and A/NZ, made it difficult to present the mental health service data due to the ethical considerations on confidentiality. However, it is important to present these data as it highlights how mental health staff contributes significantly to construction of mental distress and illness amongst Tongan people. The mental health staff represent the Western and biomedical perspectives through services and treatments. This is the modern wave of Western influence on Tonga started by the Christian movements. The following section discusses Christianity and its contribution to construction of mental illness.

### **Christian faith**

Religion and Christianity were mentioned throughout the seven *talanoa* groups as contributors to the construction of mental distress and mental illness. This section discusses the relevant discussion on Christian faiths. The introduction of Christianity to Tonga was discussed in the literature review with the conversion of King Tāufa‘ahau Tupou I which was influential in Tonga. The review also showed the importance of the spiritual dimension of health for Tongan people. This importance was reflected in the data and demonstrated throughout the other themes where participants referred to mental illness as an illness possessed by the spirits or the *tēvolo* (devil). Christian faith was treated as *tufunga fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress) because participants explained the spiritual significance of health, and also highlighted that Tongans had their own spiritual system and ways of worship. Christianity moved to Tonga and replaced the Tongan spiritual system referring to the Tongan spiritual system as old religion,

darkness and the devil. That interpretation involving the devil has a strong correlation with the Christian movement. Naioka from the youth *talanoa* group explained the spiritual services that are provided through Christian faith, and how it is effective in Tongan society.

*Comments 102 (Youth).*

Naioka        Lots of Tongans are quite really religious people and will see mental illness as someone not being strong in their faith and their belief in Christ. So some people believe that if someone does have mental illness he can't go and get treated but can go and be strong with their spiritual side and get better. So mental illness, I don't know if it's true because it's still kind of like a taboo subject amongst Tongans, because we think it's someone who's not, they are not *tui* [faith and referring to believing in God], I mean that's what I like, witness and they think it's like another being taking over you.

Not believing in God was associated with mental illness and emphasised the importance of Christian in mental health. Naioka also mentioned the large Tongan population who attended churches, suggested some form of expectations from the Tongan community to demonstrate Christian faith through attending church and Christian practices.

'Ili who is a church minister from the men's *talanoa* group took this further and described how he came across these scenarios regularly; he believes that mental illness is spiritually driven and he provided evidence from the Bible.

*Comments 228 (Men)*

'Ili            *'O hangē leva 'oku 'alu e fakakaukau ia ki he kau mate ko e, ka e hili ko ia, ko e 'atamai ia, pea 'oku toe 'i ai mo e tafa'aki ia e kautama ko e, laumālie 'uli. Tau tui pē, he 'oku hangē 'oku fakamo'oni ki ai 'a e*

*tohitapu, na 'e kapusi 'e he 'Eiki 'a e fanga tēvolo e, 'a ia ko e ngaahi laumālie 'uli na 'a nau nofo 'ia, 'a e kakai.*

English        So our thinking goes to the dead people, but there is the other side of the dirty spirit. We believe that and it is written in the Bible, how the Lord chased those devils, they were the dirty spirits.

The community leaders supported this idea and they noted that members of some churches do not eat particular animals due to teachings in the Bible. Mosese alluded to pigs being spiritually unsafe as they are associated with the devils.

*Comments 289 – 291 (Community leaders).*

Mosese        *Me 'a ia 'oku 'ikai ke kai puaka ai e kakai Angatonu [pseudonym for a church denomination], na 'e tuli e tēvolo mei he kakai, 'o hū he puaka.*

English        that is why *Angatonu* [pseudonym for a church denomination] people do not eat pigs. Those devils were chased from the people to the pigs.

The spiritual dimension had been identified as having a great impact on interpreting mental health throughout this research project, and Christianity played a significant role in this. There were references from all groups about how Christianity influences Tongan practices today. This is evident from the use of the word *tēvolo* (devil) more than *fa 'ahi kehe* (the other side) (see Chapter Five). The acknowledgment of the Christian God by the saying of a prayer at all *talanoa* groups also highlighted the importance of Christianity. The *talanoa* groups asked God permission to open the *talanoa*, guide, protect, and bless the gatherings.

## Summary

This chapter has discussed data from this research that align with the theme of *tufunga fepaki mo e fetaulaki he vaha'a 'o e tufunga paiōsaikosōsiolo mo e tufunga faka-Tonga* (intersections between biopsychosocial and Tongan constructions of mental distress). This theme was identified as being located between the *tufunga faka-Tonga* (Tongan constructions) and the *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions) themes. *Tufunga fepaki* shows how Tongan people in A/NZ are exposed to both Tongan and Western/biomedical perspectives of mental illness that influences which perspective individuals choose to define mental illness. Choices are largely determined by positive experiences and outcomes. The five subthemes related to this theme include migration, social networks and influences, resources and service providers for mental illness, participants' experiences and outcomes of treatment and managing of mental illness, and the Christian faith. Each of these factors and how they influence constructions of mental illness amongst Tongan people have been considered in turn. The following chapter discusses the findings (Chapters Five-Seven) and considers them in relation to the literature. Tongan concepts that were identified in both the literature and data of the research project, like *vale* (mental illness – process of growth and adapting) and the Tongan process of healing, will be addressed.

## Chapter Eight: *Fofola e falá ka e alea e kāinga* (Roll out the mat for the kin to dialogue)

### Introduction

In this chapter the literature and the findings from the research are integrated into the discussion. The Tongan concept of *fofola e falá ka e alea e kāinga* (rolling out the mat for the kin to dialogue) is utilised for this discussion as it refers to the rolling out of the metaphorical mat so that the extended families can openly dialogue about anything they wish to, without fear of restriction of their participation in the *alea* (discussion) ('Ofisi Ako 'o e Siasi Uēsiliaia Tau'atāina 'o Tongá, 1997). This concept was utilised in health services in Aotearoa New Zealand (A/NZ) through *Le Va* (workforce development for Pacific mental health, addiction, disabilities, and general health), and was used as a guide and framework in engaging Pacific people with health services (Te Pou o Te Whakaaro Nui, 2010). *Fofola e falá ka e alea e kāinga* was also employed by the Ministry of Social Development (2012) as a conceptual framework for guidance when working with Tongan people about violence in A/NZ.

The original concept has a focus on Tongans but was amended by the Ministry of Social Development to replace *alea* with *talanoa* - *fofola e fala ka e 'talanoa' e kāinga*. *Talanoa* and *alea* have a similar meaning about conversing freely and openly about the given subject matter. *Alea* takes *talanoa* into a structured conversation which is a focused discussion including critical analysis examining strengths and weaknesses of the subject matter. In

relation to this study, it is time now to *fofola* (roll out) the *fala* (mat), to provide a space to discuss and consider the literature examined in the literature review (the existing knowledge) and the findings of this research project (the new knowledge).

The *fala* (mat) is an appropriate space to bring existing and new knowledge about meanings of mental distress and mental illness and to have the *kāinga* (kin/extended family) *alea* (discuss) their perceptions, interpretations, definitions and constructions of mental illness (Ministry of Social Development, 2012; Te Pou o Te Whakaaro Nui, 2010). *Kāinga* refers to family connections but can be used for a group of people with similar beliefs and values, such as a church community, for instance, where they are called *kāinga lotu* with *lotu* referring to church (Tau'akipulu, 2000). Here, *kāinga* (kin/extended family) refers to all the *talanoa* groups in this study – service users, men, women, community leaders, families with mental illness, families without mental illness, and youth.

Considering that all the *kāinga* (seven *talanoa* groups) are now on the metaphorical *fala* (mat) the discussion will start with a consideration of the circular, collective Tongan worldview versus individualistic, linear views common in mental health systems in A/NZ. The discussion then considers the dominant movement of Western cultures, and in particular how Christianity displaced certain Tongan concepts and may have influenced some constructions of mental distress and mental illness. The Tongan process of healing follows with the seven *talanoa* groups in their *fale*. This chapter ends with a discussion of the word *vale* with its role highlighted in the literature in relation to growth, adaptation, and acceptance and the Tongan process of healing. Circular, collective Tongan worldview versus individualistic, linear views, Tongan process of healing, the seven *fale* and *vale* are the focus



of this chapter as they are consistent with the presentation of the research findings in the previous three chapters.

## **Circular, collective Tongan system versus linear and individualistic health system**

The discussion of the relationship between social structures and their functions and how they are identified with culture, and the contribution of one's thinking and behaviour, has been a global debate and one that highlights 'Eastern' cultures to be more collective in nature than 'Western' cultures that have more focus on individualistic characteristics (Singelis & Brown, 1995). 'Eastern' refers to Asian and Middle Eastern countries and 'Western' to Western Europe (Chiu & Kosinski, 1995; Green & Deschamps, 2005; Spencer-Rodgers & Peng, 2004; Triandis, Bontempo, & Villareal, 1988). Tongan concepts like *talanoa* reflect the circular and collective nature of Tongan people. The social structures and community expectations of Tongans aligns more with the collective and circular nature of Eastern cultures.

The findings of this research project were consistent with the existing arguments that have identified that Pacific cultures align with collectivism (Singelis & Brown, 1995). Tongan interpretations of mental distress associated with social and spiritual relationships were identified in this research as positioned more within collectivism. Where participants discussed biopsychosocial approaches, with individualist Western interpretations, this was noted to be more focussed on biomedical interpretations than the psychosocial. As can be seen in figure 8.1 below, the linear and individualistic focus of the largely biomedical and sometimes biopsychosocial world, was found to only intersect with some of the lines in the

circular and collective frame, and by doing so, do not touch on the peripheries of the circular collective world, thereby missing significant information (see Figure 8.1).

**Figure 8.1**      **The linear individual and circular collective ideologies**

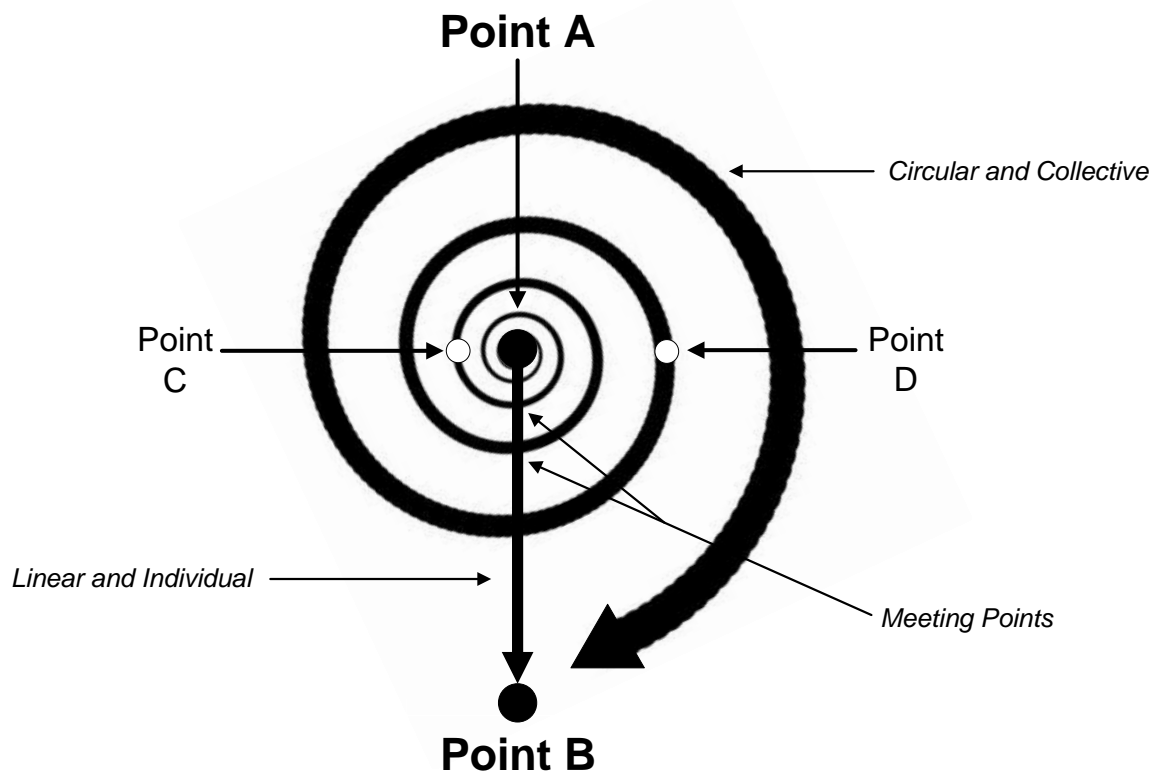


Figure 8.1 demonstrates a journey from Point A to Point B in both linear/individual ideology and circular/collective ideology. The linear, individual journey is demonstrated by the arrow where a straight line travels directly from point A to point B; that is, the focus is on travelling straight to the point of destination. An example from nursing practice would be the introduction stage of a therapeutic relationship, where a nurse would introduce himself/herself by name and profession (Point A), and explain the purpose of the therapeutic relationship by identifying the destination (Point B). Point A would be, “My name is Sione and I am your nurse” and Point B might be “I am here to take your blood pressure”.

The contrasting circular approach is illustrated by a story told by Tongan academic, Tēvita Ka‘ili, about going from Seattle (United States of America) to Maui in Hawaii to conduct a study about Tongans. Ka‘ili introduced himself by name to a Tongan lady who then wanted to know where Ka‘ili came from in Tonga and also who his family was before she was interested in knowing the purpose of his coming to Maui. Ka‘ili explained his study purposes and then he was directed by the lady to the space she believed would accommodate Ka‘ili’s needs (Ka‘ili, 2005). This resonates with an incident in clinical practice where I worked with a Tongan family whose son was experiencing mental illness. The family wanted to know about my family background and to establish the personal connection first and foremost, before any professional information was considered important, including even my professional background.

The circular and collective journey, then, requires a different pathway to Point B from Point A, as is demonstrated in the dark circular arrow in Figure 8.1. The journey here goes around in a circle to get to the destination and indicates attempting to connect on a personal level in order to form the professional relationship. Ka‘ili’s example, above, shows there is a need to know how the nurse identifies herself/himself more from a cultural than from a clinical perspective; this includes the nurse’s relationships and connections within the community and also how they are positioned or perceived by the community. This connection is usually achieved through establishing the nurse’s ethnicity, place of birth or upbringing, and other information by which the service user identifies the points of connection with the nurse. The personal connection is fundamental in this journey and highlights the circular movement while still maintaining one direction focusing on the destination. The therapeutic relationships need to carefully identify these circular and collective lines and to connect on them at all levels, in order to engage effectively. Brannelly, Boulton, and te Hiini (2013), for

example, explain how Māori mental health nurses in A/NZ working with Māori showed a personal responsibility and involvement and had more blurred boundaries about personal disclosure in order to accommodate the Māori worldview, which aligned with circular collective forms.

In the example above, when Sione introduces himself as a nurse, there is also a need for Tongan service users to know Sione's ethnicity, place of birth, ancestors, and *kāinga* (extended family). Before Sione can get to the purpose (destination), service users often ask questions like, "Are you Tongan? Which part of Tonga are you from? Are you related to ....?" Once a point of connection is identified and established, the journey then starts to Point B, "I am here to take your blood pressure". This way of making introductions and establishing connections is consistent with the Māori *mihimihi* where individuals introduce themselves and identify with their mountains, rivers, *waka*, and home (Bishop, 2008). This is in order to set up relationship not only between the individuals but also between ancestors and current families. It does not only form relationships between the individuals but also acknowledging the ancestors who have passed on but reflected the importance of the spiritual world in the Tongan context (Bloomfield, 2002) and also sets up a different sort of relationship to develop further.

Another form of the circular collective approach is illustrated by how Tongan people talk and how things are discussed. These are highlighted in the research project during the *talanoa* groups by the ways in which participants responded and interacted. The open nature of *talanoa* goes hand in hand with the circular collective approach as if there is no agenda, an open forum, circular discussions to get to the point, acknowledgment of key people and knowledge holders as *talanoa* unfolds. For example, often when sharing their points of view

or arguments, participants drew from their surroundings and their community ensuring that the rest of the *talanoa* participants were able to connect to the story. This usually takes the conversation in a circular direction before they reach their desired point. The circularity is vital as the credibility and reliability of the main argument and viewpoints will be validated by who or what is mentioned in the circular talk: if one argues about an issue from the ocean, for instance, it is usual practice to mention a well-known fisherman or village in the story to assist with validating the argument.

The circular collective concept was also evident in how the Tongan participants in the study reconstructed the linear and individual definition of mental illness. The straight line in Figure 8.1 indicates meeting points between the circular and linear from point A to point B. This illustrates that the peripheries represented by Point C and Point D were not in contact with the linear and individual line. This can explain how a linear and individual approach does not fit the circular collective system: the greater part of the circular collective structure was not captured by the linear individual line. Tongan people constructed concepts in a circular collective fashion and highlighted the many layers that need to be addressed when working with Tongan people. These layers symbolise the importance of addressing key players in the community or concerning the subject matter which is essential for health professionals to understand when working with Tongan people, as it will provide a strong platform for engagement.

The research analysis identified findings that are significant because they do not align with Western and biomedical definitions of mental illness. These findings highlight peoples' relationships with the natural and spiritual environment, as well as within the social environment. People become un-well when they do not have good relationships with the

environment, with each other or with ancestors. For example, the participants described how people were possessed by dead peoples' spirits and they experienced psychotic like symptoms. The relationships with the natural environment, ancestors and the world of dead people indicates how these relationships are not linear, but that there are movements that are circular in motion between the 'world of the living' and the 'world of the dead'. This was particularly evident in the *tufunga faka-Tonga talanoa* about the *tēvolo* (devil/spirits) – also known as *fa'ahi kehe* (other side) – and their contribution to the onset of mental illness. Tongan people treat the dead as part of their community and the appearance of the dead amongst the living is not always only associated with illness, and as discussed in the literature. Bloomfield (2002) highlighted that illness happens when there are poor relationships between the living and the supernatural. Good relationships are necessary for good health. People often see their passed away loved ones as coming back to care for them or to pass on a message of guidance. These events are mostly reported as seeing ancestors, and this can include forebears from many generations back, whom one may never have seen or met in real life but only heard of through stories from their grandparents.

The people possessed are usually associated with illnesses like *āvanga*, these possessions largely have no family connections between the un-well person and the dead spirit. These are usually due to a stranger or a person new to a village who breaks some local cultural norms and values. There are also stories in which the dead are obsessed with someone's beauty and have possessed that individual. The *fa'unga* (reality) data under the *tufunga faka-Tonga* (Tongan constructions) in Chapter Five, includes Simi's story of how one person had a relationship with the dead. It is important that there are no clear boundaries between these two kinds of appearances and seeing ancestors only equates to good outcomes. Sometimes

there are crossovers between the two, and seeing ancestors can be harmful and seeing strangers can be harmless.

The other dimension which is missed by the linear individualistic approach is the physical explanations of mental illness through somatic complaints. This has been reported by migrant populations for example, mental distress was explained by Asian people as physical pain and discomfort rather than changes of mood (Chiu & Kosinski, 1995). Furthermore, Chiu and Kosinski (1995) report that mental distress was expected to end once the physical complaints were treated. These forms of explanation of mental illness are also found amongst Irish migrants living in the United Kingdom (Bhavsar & Bhugra, 2009) and in Eastern countries like China and India (Bhugra, 2005; Bhugra & Arya, 2005). Tongan people, too, tend to discuss these physical symptoms of mental illness and struggle to link these to changes in attitudes, behaviours, and brain abnormalities or some form of dysfunction of the brain (Lasalo, 1999). As presented in the findings chapters, Tongan people tended to express mental illness through tangible things like *fale* (houses), balloons, and marbles. The concepts and characteristics of mental illness are then applied metaphorically to these tangible objects making it easier for Tongan people to relate to, and make sense of, the illness.

The use of *fale* (house) as an analogy for mental illness was an interesting choice as *fale* in Tongan society is not only restricted to its literal translation as house, but extends to families and *kāinga* (extended family). The use of *fale*, then, supports the collective arguments from a Tongan perspective while, due to its individual focus on the service user, the linear approach risks failing to address important family members. *Fale* was discussed in the research project as a place or house for people experiencing mental illness. It was suggested that people enter a house during the onset of mental illness and they exit through discharge from the mental

health service or mental illness. Variables like length of stay in the *fale* symbolised the length of experiencing mental illness and relapses symbolised the re-entering of the *fale* when unwell. The number of times re-entering occurs can potentially familiarise an individual with the structure and nature of the *fale* and they end up being part of that *fale*, in this case, the *fale* of people experiencing mental illness. The image of the *fale* and its nature of collecting and sheltering people was another way of interpreting mental illness, employing not only a tangible object but using a traditional Tongan structure to explain mental illness. Moreover, mental illness here has been stretched from its linear and individual definition to a more collective and holistic structure that makes more sense and has meaning for Tongans. The *Fonofale* model which base on a Samoan house (Te Pou o Te Whakaaro Nui, 2010) and Durie's *Whare Tapa Wha* for Māori people (Durie, 1998; Durie & Kingi, 1997) are both illustrations of how *fale* provides a good representation for Pacific people, and could be used to conceptualise aspects of recovery.

The conflict between the circular collective paradigm and linear individual paradigm have been well documented (Chiu & Kosinski, 1995; Green & Deschamps, 2005; Singelis & Brown, 1995; Triandis et al., 1988) and it was clear from this study that Tongan people are circular and collective in nature. In Figure 8.1, the spaces between the circular lines indicate how Tongan mind thinks and interprets things. The participants 'translated' the information into circular formats, such as through the use of *heliaki* and metaphors. Returning to Figure 8.1, metaphors fill these gaps in Point C and Point D and this was illustrated in the study through participants' use of imagery and analogies. The nature of the analogies employed by the participants was circular, multi-layered, and represented collective ideas; for example balloon, marble, and *fale* (house). The analogies were anchored by the Tongan *tā vā* (time-space) theory of reality which is described in the following section.



## ***Tā vā*: time-space theory of reality**

*Tā vā* (time space) theory of reality is a Tongan theory based on *tā* (time) and *vā* (space) (Ka'ili, 2008; Māhina, 2008; Māhina & Potauaine, 2010). The theory was constructed by Māhina and supported by Ka'ili who explains that time and space are central to all things existing naturally, mentally, and socially (Ka'ili, 2008). Tongan people favour the circular and collective arrangements of time and space to conceptualise in “plural, cultural, collectivistic, holistic and circular ways”, rather than conceptualisations of “singular, individualistic and linear modes” (Māhina & Potauaine, 2010, p. 16). The inclusion of *tā vā* is important when considering how Tongan people thinks, lives, summarises importance like memory and telling of stories.

*Tā vā* theory has been instrumental in Tongan and Pacific research and also resonates with this research. The use of *tā vā* theory in relation to the architectural structure of *fale* assisted in explaining *loto* (heart/soul), *fala* (mat), and *fale* (house) (Moa, 2011; Potauaine, 2010; Potauaine & Māhina, 2010). Ka'ili (2008) used *tā vā* theory when studying Tongan social relationships in Hawaii and found this theory to be effective in terms of guiding his research and maintain social relationships amongst Tongan people. In A/NZ *tā vā* (time space) theory of reality has been used by Kalavite (2010) in her research on Tongan tertiary students and Williams (2009) applied it more widely to Pacific people. More importantly in this research is the relationship between *tā vā* theory and the analytic themes; the *tufunga faka-Tonga* (Tongan constructions) has *tā* time components with *ta'anga* (temporality) and *vā* (space) components present in *fa'unga* (reality). *Tā vā* theory was also noted as movements through time, through different spaces, and reflecting on Tongan cultures at different times. As with

all cultures, Tongan culture has changed over time, and some concepts have been replaced by new interpretations. The next section will discuss some of these changes.

The findings of this research relate well within the *tā vā* (time space) theory of reality used to explain the findings and conceptualise mental distress and illness. The *tufunga faka-Tonga* of mental distress and illness were discussed in *vā* (space), in terms of *fa'unga* (reality) and *tu'unga* (positionality). *Vā* (space) refers to not only spaces but also to tangible materials that explains intangibles, like using of marble and balloon for mental distress and illness. *Fa'unga* (reality) explained real and visible spaces (*vā*) as in *fale* (houses), marbles, and circular objects. Any *matiti* (chipped) and *matoli* (cracked) of these *vā* (spaces - tangibles) were regarded as having forms of mental distress. *Tu'unga* (positionality) explained the positions of the spaces (*vā*). These positions should be balanced and symmetrical, *mahei* (tilted) and *suei* (swayed) were interpreted as having mental distress. *Tā* (time) was explained in *hu'unga* (directionality) and *tā'anga* (temporality). Within *fa'unga* (reality), there are *vā* (spaces) where Tongan people interact with each other. There are also movements within *fa'unga* (reality) and in certain directions. Movement away from this prescribed direction and the defined *vā* (space) was called *'āvea* (obsessive thinking) and *'āvanga* (possession by spirits) which are, again, forms of mental distress. *Tā'anga* refers to the timing of the movement within the *vā* (space). Moving too slow (*taimi tuai*) or too fast (*taimi vave*) were also identified in the data as forms of mental distress.

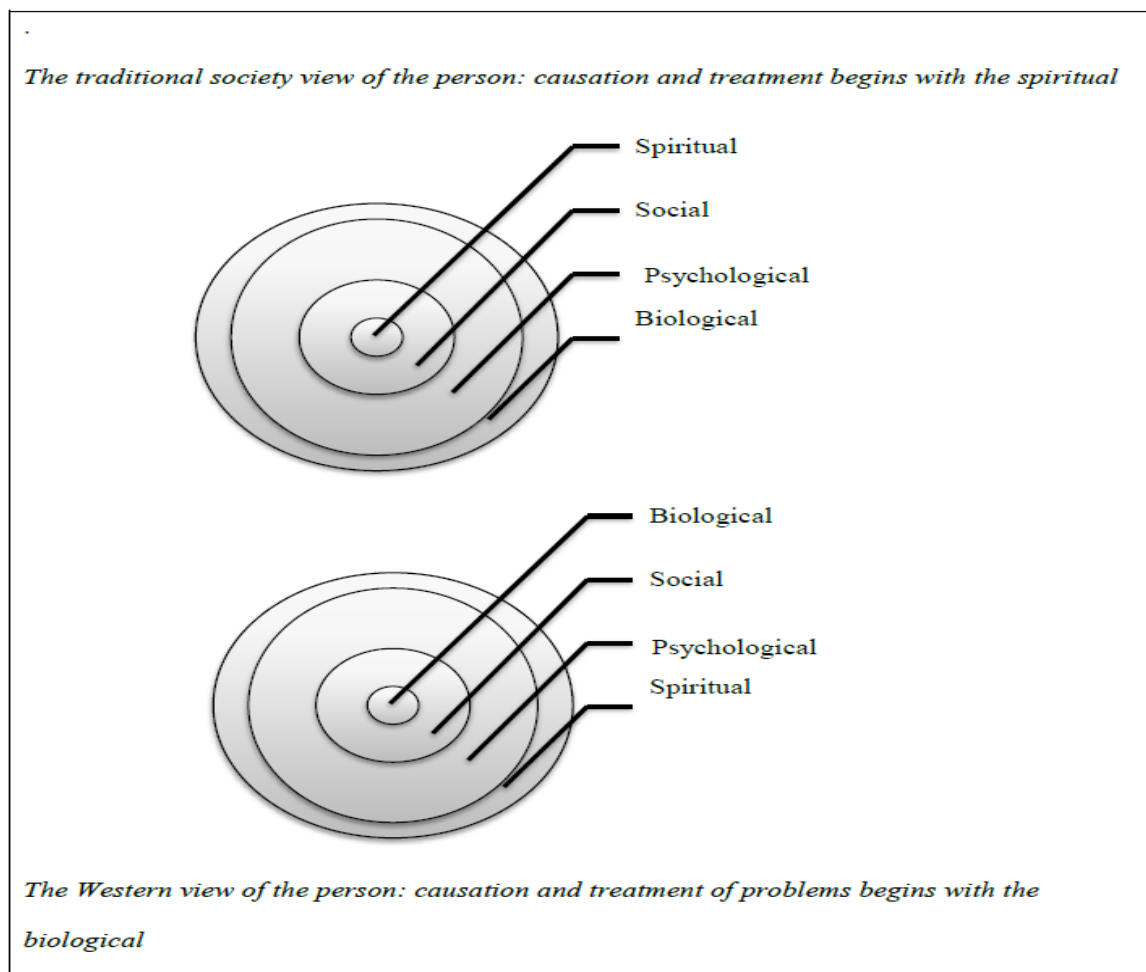
## Displacing Tongan culture

The findings of this research indicate that Tongan culture has to some degree been ‘diluted’ through the processes of colonisation, and, in particular, the influence of Christianity (Wood-Ellem, 1999). This process started back in Tonga before people ever began migrating to A/NZ, and the influence of globalisation continues to change Tongan culture (Bloomfield, 2002; Lātūkefu, 2008; Māhina, 2008). This dilution in Tongan culture was transposed to the interpretation and definition of mental illness. The findings identify that the participants recognised forms of mental illness that existed in Tonga before colonisation, and Tongan people had their own interpretations and definitions for it. It appears that in pre-colonial times mental illness had a Tongan definition associated with *fa’ahi kehe* (the other side) and the supernatural. The biomedical definition of mental illness was an unknown concept in Tonga and emerged through colonisation with the introduction of Western medicine into Tonga (Puloka, 1998, 1999; Toafa et al., 1999).

Recent research has identified that there have always been alternatives to the current models of mental illness, often with a focus on spirituality and relationships as points of difference. Figure 8.2 is adapted from Lakeman’s (2009) description of the Western and the traditional society world views or ideologies. Lakeman argues that spirituality is the focus of the traditional society and travels outwardly to biology, whereas the Western world-view works in the opposite way. Tongan people identify with the traditional society and this explains some of the findings where participants focused on mental illness as a spiritual and social illness and, therefore, needed to be treated spiritually and socially. However, the participants have also been exposed to the Western world, and for decades in Tonga Western influence has been evident. Furthermore, Tonga’s health system operates within the Western world

view with a psychiatric unit to manage the mentally ill. This contributes to the fluid interpretations and definitions of mental illness and evidence of participants trying one pathway first, such as traditional healers and if unsuccessful, then trying the hospital system. There will be some who unfortunately get lost on this journey and may end up going round in circles between the two world views. This was reflected in the study where participants defined and redefined mental illness depending on their experiences of services, resources, and outcomes of those services. Tongan men were heavily aligned with the Tongan world view while youth and service users were more aligned with the Western world view.

**Figure 8.2**                    **The Western holistic view and the traditional cultural view of the person (Lakeman, 2009, p. 611).**

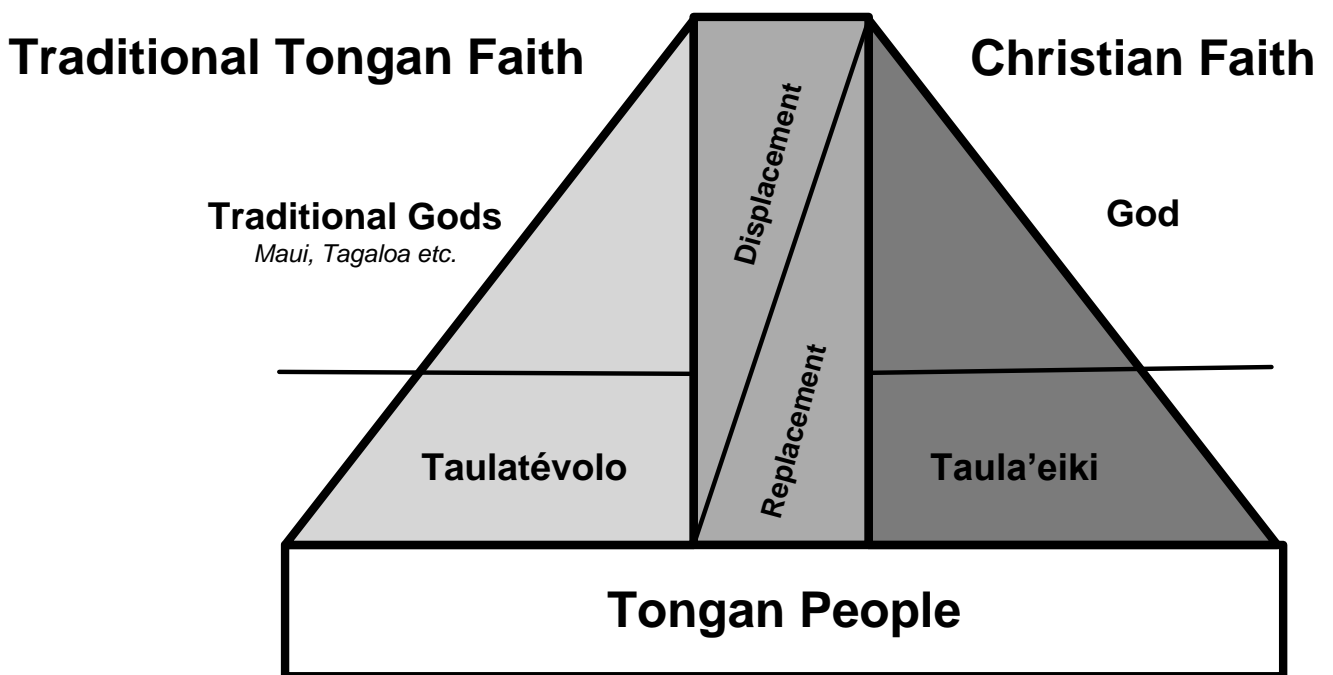


The conflict in defining mental illness was not only about how a person views the causation and treatment of the problem, but also about the social structure of Tonga, given that Tongan society is hierarchical while Western society is more democratic in nature. As explained earlier in Chapter Three, Tongan society has the King at the top of the pyramid, followed by the nobles with the common people at the bottom of the pyramid. This hierarchical system translates throughout the Tongan way of living. This is reflected in Tongan spirituality, faith, and ways of worship. Tongan people worshipped their own traditional gods before Christianity and there were mediators between the people and these traditional gods and these mediators were called *taula'eiki*. *Taula'eiki* is a combination of the word *taula* (anchor) and *'eiki* (lord) which means that a person who was anchored to the land communicated to the lords or gods who resided on higher grounds from the land in the sky. The Christian movement successfully established a strong foundation within Tongan society.

The people of Tonga were converted to Christianity by King George Tupou 1 who had converted to Christianity. Christianity then discounted the Tongan traditional gods and called them the *lotu motu'a* (old religion) or the *faka-po'uli* (dark side) and traditional gods were destroyed and ignored. This was a speedy and effective transformation as Christian missionaries targeted leaders in the Tongan community and the changes transformed society from the top to the bottom. This put the Christian movement in a powerful position able to influence power and governing of the land. Before Christianity there was only one structure with traditional gods at the top, followed by the *taula'eiki*, then the people at the bottom. People went through the *taula'eiki* if they needed anything from their traditional gods or vice versa. There were renowned *taula'eiki* all over Tonga, Kautai is a well-known *taula'eiki* from the eastern side of Tonga, who will be used for the purpose of discussion in demonstrating the displacing of traditional Tongan concepts and replacing them with Christian values.

Figure 8.3 is a diagrammatic representation showing the displacement and replacement of the spiritual dimension and faith in Tonga. This is important as this displacement and replacement of concepts happened at different levels of the Tongan society – including the health system, which influenced interpretations of mental illness.

**Figure 8.3**                    **The transformation of Tongan spirituality**



As suggested by Figure 8.3, the version of Christianity that Tonga adopted retained traditional Tongan spiritual structures and replaced the traditional Tongan practices with Christianity. For example, the traditional Tongan practices were called the “old religion” and associated with Christian notions of darkness and the devil. The Christian movement also took on the old Tongan traditional structures and names, the Christian God is the only God replacing traditional gods who were now referred to as *tévolo*, and the priests who served God were called *taula'eiki* and those – like Kautai – serving traditional gods were called

*taulatēvolo* (anchoring devil). This shift temporarily compressed and pushed the Tongan traditional faiths and practices into deeper layers within the Tongan way of thinking and Tongan ideologies. Lātūkefu (2008) explained how missionaries entered Tonga together with new forms of infectious disease which Tongan traditional treatment failed to treat. The effectiveness of the Western medications brought by missionaries in treating these infectious diseases further suppressed Tongan ideologies of illness and treatment.

However, these Tongan ideologies resurfaced in the Tongan colonised ways of thinking and behaviour from time to time, and appeared particularly around times of distress like when one was ill. It was noted in the findings that when someone goes through challenges, the brain usually reverts back to the original point of knowledge or frame where they first witnessed or heard about mental illness and how it was constructed. In the study, this was shown when some participants reported that they seek Tongan traditional healers in A/NZ after going to the hospital first. When hospital treatment is unsuccessful, they revert back to the Tongan traditional healers. Despite the strong medical movement and its evidence-based practice and philosophy, Tongan people often revert back to the traditional spiritual interpretation of illness. The next section will discuss the Tongan process of healing and the concepts of *to‘o* (removing/uplifting).

### **Healing process, the concept of *to‘o* (removing/uplifting)**

Māhina (2002) explains that there are three stages of the healing process (see Chapter Three): *tofoto‘o* (operating), *faito‘o*, (removal), and *tukuto‘o* (stop removing) as discussed in the literature review. Bloomfield (2002) identifies three kinds of curers in Tonga, “the modern

medical curers, the Tongan traditional curers and other curers” (p. 54). Bloomfield classifies hospital services as modern medical, traditional healers as Tongan traditional curers, and “other curers” refers to religious and other forms such as curing using cards (referring to the use of playing cards for healing in terms of informing treatment). For this discussion, due to its ontological nature and Tongan indigenous format, I am using the three stage process of healing proposed by Māhina – *tofoto‘o* (operating), *faito‘o* (removal) and *tukuto‘o* (stop removing) – and building on it. The key word in this process of healing is *to‘o* which means removing or uplifting the illness. Before attempting to discuss the process of healing, it is important to clarify that the terms *puke* and *mahaki* are used interchangeably for illness and these two words have other meanings as well. For instances, *puke* also refers to holding on to or seizing something and *mahaki* means emptying forcefully. The *talanoa* groups used *puke faka‘atamai* (illness of the brain), *puke faka-tēvolo* (possessed by devil/s) and *mahaki faka-tēvolo* (spirit related illness) as discussed in Chapter Five, Six and Seven.

These interpretations of *puke* and *mahaki* highlight the circular and collective movement within the Tongan community. When an individual is being seized (*puke*) and is unable to participate in their collective responsibilities, wellness can be seen as forcefully emptied (*mahaki*) leaving only emptiness in a still position, *puke* and *mahaki*, illness. The process of healing therefore focuses on removing and uplifting (*to‘o*) the causes of the illness that seized (*puke*) the un-well person. The ill person is also perceived as having high levels of impurity and toxicity that seized (*puke*) one’s movement making them unable to comply with their social responsibilities. The purpose of healing, then, is to purify the un-well through *tofoto‘o*, attempting to investigate the location of the impurity and its nature, then *faito‘o*, which is removing the impurity, then *tukuto‘o*, the termination of the removing process. The following subsections will discuss these stages in detail.



### ***Tofoto* 'o (to operate): Consultation phase**

This is the initial stage of healing where the healer attempts to investigate and operate on the person to identify and locate the problem. The word *tofo* from *tofoto* 'o is a transformation of the word *tafa* which means 'to cut open'. At this stage the healer engages with the service user and the un-well person consults and discloses to the healer their health issues/problems that need healing. The healer then starts to explore and investigate the/se health issue/s or problem/s through assessment. This is often through asking more questions to test and check for signs that the presenting problem is the one they are treating. An example of this test is where the healer puts leaves from their treatment recipe on the body of the un-well person and assesses how the leaves stick to the body of the un-well person. When the presenting problem is confirmed to fit with the healer's form of treatment, the healing process then moves to the next phase of *faito* 'o (Māhina, 2002a).

*Tofoto* 'o involves engagement, consultation, and assessment. The healer investigates through dissecting the un-well person to identify the problem and the source of the problem emotionally and socially. With areas like mental illness, the *tufunga faka-Tonga* (Tongan constructions) means opening the spiritual community between the living and the dead and identifying the dead spirit that possessed and seized (*puke*) the un-well person, calling them *puke* referring to being ill. This is discussed in Chapter Five where participants called mental illness *puke faka-atamai*, *puke faka-tēvolo*. *Āvanga* and *āvea* were also use in Chapter Five to explain the travelling outside of *fa'unga* (reality) and communicating with the supernatural (Bloomfield, 2002). The circular journey between the living and the supernatural should flow

freely and both collectively should maintain good relationships to ensure good health. Illnesses like *'āvanga* and *'āvea* suggest that this circular flow has been compromised and *tofoto'o* is the attempt to investigate this circular collective circuit and to discover what has seized (*puke*) the flow. The other concept, *mahaki*, refers to the un-well person's sense of purity as being forcefully emptied by the power of impurity, referring to the spirit of a deceased person.

This process of *tofoto'o* is consistent with the biopsychosocial approach of the consultation process through engaging with health services, building therapeutic relationships, and assessment. Like *tofoto'o*, these initial engagements allow health professionals to assess and identify the problem before treatment. Assessments will show if the presenting problem fits the services provided or the entry criteria, or needs referral to more appropriate or expert services specifically for that presenting problem. When assessments are done and services are identified and located, the healing process progresses to the next level, *faito'o*.

### ***Faito'o* (removal): Treatment phase**

*Faito'o* is the art of removing impurities and freeing the un-well person (*puke*) to enable them to move again and comply and fulfil their social obligations. *Tofoto'o* locates the problem and *faito'o* is where the healers actively remove and uplift the impurities and illnesses through their healing methods like massage, chanting, and praying, and using their tools like leaves, oil, and herbal remedies. Use of chants usually causes the illness to leave the un-well person and go to the bush or the beach, so that the un-well person can return to their duties;

massage is used to assist this process. *Faito 'o* requires time as it involves tasks that can be demanding in nature and also requires ongoing progress to show positive outcomes and also effective engagement from service users.

The focus of *faito 'o* is twofold: first, the illness (*puke*) is removed from its 'seized' state (*puke*), so that the un-well person can move with the natural rhythm of nature, and second, the empty state (*mahaki*) of the person is filled for wellness and a full recovery into a well and healthy person. The concepts of removing impurities and filling emptiness in traditional Tongan healing are very much spiritually focussed in nature. *Tofoto 'o* locates the issue that is holding/stopping/seizing (*puke* – *'āvea*, *'āvanga*) the circular movement in the collective circuit, and *faito 'o* removes this issue so that the circular flow continues in the collective worlds of the living and the supernatural. *Faito 'o* is reflected in the Western and biomedical world through treatment such as administration of medication and different forms of therapy which are largely biologically focused and evidence based. The initial stage of *faito 'o* is called *fakaheka* (on-board) where the uplifting process begins and when the uplifting and removing process is done, then *kaukau tuku* (the last bath) is the exit stage which confirms wellness and proceeds to the final stage of healing or *tukuto 'o*. *Faito 'o* was discussed in Chapter Five when treating people who were possessed by spirits,

### ***Tukuto 'o* (stop removing): Discharge phase**

There is a need for proper closure with healing to ensure that the illness and impurity is fully uplifted and to also provide a safeguard that there will be no repetition of the same illness.

*Tukuto 'o* marks the end of the healing phase where the healed person has the opportunity to thank the healer and usually presents some form of appreciation through gifts and offerings like food. Tongan people believe that the illness is not fully healed until *tukuto 'o* is performed. *Tukuto 'o* equates to the discharge from the health service of recovered service users in the modern health system, where the therapeutic relationships are terminated. *Tuku* translates as 'stop', the healing process comes to an end and the process ends here. The three stages of healing in the Tongan context are important as the findings of this research suggest Tongans in A/NZ have retained strong *tufunga faka-Tonga* (Tongan constructions) with a potent spiritual dimension which is clearly identified in defining mental illness. Participants also default back to their Tongan indigenous knowledge when experiencing challenging situations, including mental distress. Any attempt to address mental distress of any form in the Tongan society, therefore, should take note of the Tongan processes of healing.

The process of healing has been explored and discussion will now revisit the focus of this chapter, *alea 'i* (to discuss), through bringing existing knowledge and new knowledge from this research to the metaphorical *fala* (mat). It is, however, important to contextualise the physical position of the *fala* in the Tongan society. The place of the *fala* is always inside the *fale* (house) where the *kāinga* (extended family/kin) have their conversation. The *fale* (house) is the overarching structure that protects and maintains the *talanoa* (talking) and the *alea* (discussion) safely on the *fala* (mat). This highlights the significance of the *fale* (house) for each *talanoa* group. The following section will discuss each *fale* in each *talanoa* group.

## **The *fale* (house/family/people)**

The literal translation of *fale* is house but the meaning of *fale* goes further into the Tongan society and refers to people and how they live and function within this society. *Fale* identifies with a group of people that belongs to one *kāinga* (extended family/kin). The concept discussed in the previous section around having the *fale* as the main structure that shelters and protects the *fala* (mat) and its ongoing functions translates to the idea of the *fale* housing extended family. The physical structure of the *fale* translates into the *kāinga* (extended family) and the *fala* (mat) symbolises the safe platform for *talanoa* (talking) and *alea* (discussion) for the *kāinga*. The following sub-sections discuss the seven *fale* where *talanoa* took place in this research project. The *fale* (participant groups) were presented from *tufunga faka-Tonga* to *tufunga faka-paiōsaikosōsiolo* in the continuum (see Figure 4.4 in Chapter Four). The *fale* are presented in the following subsection building from the *tufunga faka-paiōsaikosōsiolo* to *tufunga faka-Tonga* to continue the discussion on the Tongan concept of *vale*.

### **Youth *fale***

This *fale* had seven members and consisted of youth leaders and youth members. The members of this *fale* had known each other prior to the *talanoa* through church and also the Tongan community. This *fale* discussed mental distress and illness in a *heliaki* (metaphor) as a circular object and gave the example of the marble in regards to *masoli*, *matoli* (Chapter Five) as mental distress and illness. They also used the power supply metaphor as a comparison for our brain: its capacity has limitations and when the limitations are

overstretched, it will explode causing mental illness. These *heliaki* support the open agenda of *talanoa* and the safety of the *fala* (mat) within this *fale* where members were comfortable to use tangible objects they could relate to within their everyday living to explain mental illness.

There were some strong disagreements on this *fala* (mat) in the youth *fale* when some strongly challenged the *tufunga faka-Tonga* (Tongan constructions) of mental distress and illness. The high number of New Zealand born Tongans in this group is reflected in the alignment with *tufunga faka-paiōsaikosōsiolo*; also, the *talanoa* in this *fale* was conducted in both Tongan and English languages. This allowed them to go in depth with their contributions with the confidence of knowing that they did not have to struggle to translate and express their opinions in a language preferred and prescribed by the research project.

The position of this *fale* identified that mental health services required for Tongan youth need more from *tufunga faka-paiōsaikosōsiolo* which means hospital and biopsychosocial approaches. Although *tufunga faka-Tonga* was not favoured by the youth, this *fale* did not totally disregard *tufunga faka-Tonga* and therefore should be considered in youth mental health services. Overall, youth mental health services for Tongan people should have both biopsychosocial and traditional beliefs and practices but more emphasis on the biopsychosocial aspect.

### **Service user *fale***

The members of this *fale* had all had experience of mental distress and illness and mental health services. The *talanoa* on the *fala* in this *fale* was very sensitive due to the nature and

experiences of its members. These members knew each other prior to coming to this *fale*; this prior knowledge amongst members allowed them to engage effectively and they were comfortable with sharing their experiences of mental illness; the mental health system; Tongan, Pacific, and A/NZ communities; migration, and so forth.

The depth of *talanoa* was reflected through sharing of sensitive information and like experiences, including how these participants felt they had been stigmatised and discriminated against by the community. They reported that these issues were potentially detrimental and destructive to them as they were not addressed effectively. These precious and sensitive issues were shared with emotion, usually tears, and it clearly took courage to disclose this sort of information. Sometimes members laughed it out and humour was used to discuss sensitive issues.

Participants disclosed that the names that the community uses for service users are hurtful and damaging and this *fale* was an opportunity for service users to share these safely with the presence of their support people. The *fale*, therefore, not only provided a platform for this research project but also included some therapeutic components for the participants where they could share and off-load issues. This *fale* suggests that there is a need to raise mental health awareness within the Tongan community and address stigma and discrimination. Countering stigma and discrimination through projects like 'Like minds like mine' is one example that will be beneficial when working with this *fale* (Mental Health Commission, 2013; Ministry of Health, 2007).

The members positioned their *fale* around the *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions) and their exposure to mental health services with their experiences contributed

to this positioning. There were participants who discussed mental distress in a *tufunga faka-Tonga* construction frame such as mental illness as a Tongan illness, which suggests the inclusion of traditional healers when working with Tongan service users of mental health services. All participants in this *fale* are users of the *tufunga faka-paiōsaikosōsiolo* mental health services and their discussions regarding *tufunga faka-Tonga* constructions suggested that the *tufunga faka-paiōsaikosōsiolo* services are not meeting their needs. The movement from *tufunga faka-paiōsaikosōsiolo* to *tufunga faka-Tonga* in this *fale* was also reflected by their families' *fale*.

### **Families with service users of mental health services *fale***

Families with family members who use mental health services were gathered into their own *fale* and the *fala* was rolled out for them to dialogue. The challenges were around acceptance by their families and their community as service users were stigmatised due to the illness. There were feelings of being neglected and abandoned by the wider extended family and these participants had to struggle to cope with their family members' mental distress and illness. Participants disclosed that the choice of using the mental health system rather than Tongan traditional healing was also criticised by the community and extended family. In such cases, the parents were blamed and they had developed guilty feelings related to their family members having a mental illness. Caring for people experiencing mental illness at institutions detached the mentally ill from the collective family and community. This *fale* will also benefit from working towards stigma and discrimination of mental illness (Mental Health Commission, 2013; Ministry of Health, 2007) and promoting mental health in Tongan communities.



These families were caught between cultures with conflicting views on mental distress and illness and they struggled to care for their family members and had periods of moving between the two cultures and worldviews and by doing so, prolonged the recovery from mental illness. These families used the *fala* to *talanoa* about their experiences and challenges with mental illness and told the stories about living with someone experiencing mental illness. The sensitivity around the issue of mental illness made this topic very difficult to address and, in addition, their relationship with the family member experiencing mental illness doubled this difficulty, making the topic more complex and uncomfortable to disclose. The criticisms from the community showed the position of this *fale* more to the *tufunga faka-paiōsaikosōsiolo* than *tufunga faka-Tonga*. The youth constructions of mental distress and illness alignment with *tufunga faka-paiōsaikosōsiolo* were influenced by media and the A/NZ environment, services users follow and their constructions were around their experiences with mental distress and illness, and mental health services in A/NZ. This *fale* aligned closer to *tufunga faka-paiōsaikosōsiolo*, and the participants of this *fale* perspectives were influenced by their family members experiencing mental illness which has a Western and biomedical focus.

There were still mention of *tufunga faka-Tonga* and this was the only group who discussed the concept of *vale* as inexperienced rather than association with negativity. There were engagements with Tongan traditional healers even in the hospital where participants discussed how they were recommended traditional healers, and they changed to traditional healers as the hospital was not effective. This *fale* still need mental health services with a biopsychosocial focus but with a more emphasis on acknowledging *tufunga faka-Tonga*. The

*fale* to be discussed next – the families without mental health service users – further focuses on the *tufunga faka-Tonga*.

### **Families without mental health service users' *fale***

It is interesting to note where the two families' *talanoa* groups are positioned on the continuum in this research project. The families without family members using mental health service were closer to *the tufunga faka-Tonga* than the families with mental health service users. This suggests that families in general start moving away from *tufunga faka-Tonga* to *tufunga faka-paiōsaikosōsiolo* when family members start using mental health services. A possible explanation for this is that exposure to *tufunga faka-paiōsaikosōsiolo* introduces new interpretations of mental distress and illness and Tongan people begin to carefully examine the new knowledge of *tufunga faka-paiōsaikosōsiolo* and re-evaluate the *tufunga faka-Tonga* of mental illness. The *tufunga fepaki mo e fetaulaki he vaha'a 'o e tufunga paiōsaikosōsiolo mo e tufunga faka-Tonga* (intersections between biopsychosocial and Tongan constructions of mental distress) theme was also noted. This process of examination and re-evaluation is reflected in comments by participants of this *fale* about how the process of migration influenced their ongoing redefining of mental illness.

The redefining of mental distress and illness also shifted their position through times and context: participants highlighted how they would choose the *tufunga faka-paiōsaikosōsiolo* first and if this was not effective, then they moved to the traditional healers and positioned themselves with the *tufunga faka-Tonga*. These transitions and movement of positions are not easily made as it involves the welfare of family members and, therefore, needs very careful

consideration. Disclosing these transitions and movements to other parties can be difficult and much more complex if they are representatives of either approach; for example, *tufunga faka-paiōsaikosōsiolo* health professionals and researchers.

There were also stories of shame and discrimination which fit *tufunga fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress). Social problems were identified as a significant issue from this *fale*. This focus on social problems indicates movement from a strongly held *tufunga faka-paiōsaikosōsiolo* orientation, to a focus on social involvements, families, and environment – so moving nearer to *tufunga faka-Tonga*, towards the position of the women’s *talanoa* group on the continuum.

It is important to note that this *fale* was the one in the middle suggesting equal contributions from both *tufunga faka-paiōsaikosōsiolo* and *tufunga faka-Tonga*. This should be reflected in mental health services when addressing families without mental service health users through mental health promotions, assessments and so forth.

### **Women’s *fale***

Women hold high rank in Tongan society (Gifford, 1929) and their opinions are highly regarded in this study. This *fale* was built to provide an opportunity for women to safely and freely *talanoa* about mental illness. The topic sensitivity combined with *faka‘apa‘apa* (respect) and the patriarchal nature of the Tongan society can potentially disempower women when men are present in the *talanoa*.

The women's *talanoa* extended the social focus, also seen also in the families without mental health service users' *talanoa* (above), described mental illness in terms of people's behaviours and appearance, and explained how certain behaviours are not accepted within Tongan social groups and are, therefore, interpreted as forms of mental distress and illness. They alluded to Tongan words like '*āvanga* which defines mental illness, but were unable to explain why it was called '*āvanga* and the background information regarding '*āvanga*. However, they were clear about explaining behaviours and appearances of one who is experiencing '*āvanga*. The members of this *fale*, then, defined mental illness in Tongan terms, positioning them closely towards the *tufunga faka-Tonga*.

Providing mental health services for this *fale* starts the new approach which has more emphasis on *tufunga faka-Tonga* but still acknowledging both *tufunga faka-paiōsaikosōsiolo* and *tufunga faka-Tonga*. The high rank of women in the Tongan society needs to be considered in designing mental health service for Tongan people and formulating interventions using ranks to achieve service users' goals. More importantly, women hold high rank and mental health services need provide quality care to suit their high status in the society. The next *fale* in the direction towards the *tufunga faka-Tonga* is the community leaders.

### **Community leaders' *fale***

Because of the hierarchical structure of the Tongan society, community leaders play a vital role in the Tongan community in terms of decision making and guidance. For this reason, this *fale* was built to explore perceptions of mental illness at this level. These leaders positioned their *fale* close to *tufunga faka-Tonga*, discounting some structures of the *tufunga faka-*

*paiōsaikosōsiolo*. The leaders' *talanoa* about the processes and outcomes of mental distress and illness through both *tufunga faka-Tonga* and *tufunga faka-paiōsaikosōsiolo* indicated that, for them, *tufunga faka-Tonga* was the most preferred. This was particularly related to what these participants regarded as the most effective outcomes produced by each approach around managing mental illness, based on their experiences. These members *talanoa* focused largely on the failures of *tufunga faka-paiōsaikosōsiolo* and how it is, therefore, not a reliable option as it failed to produce favourable outcomes.

The *tufunga faka-Tonga* has a stronger emphasis in this *fale* and vital to reflect in working with Tongan community leaders experiencing mental distress and illness. Their influential roles within the Tongan community will be very valuable if incorporated well into mental health services to influence mental health in the Tongan diaspora. This *fale* was strongly supported by the men's *fale* in terms of positioning more towards the *tufunga faka-Tonga*.

### **Men's *fale***

As women hold the highest ranks in Tongan society, men on the other hand hold the authority and act as the head of the family, both in the nuclear and extended setting (Gifford, 1929). The gender issues raised in the women's *fale* (house), therefore, also applied in this *fale* (house), which provided men with the opportunity to *talanoa* amongst themselves about mental illness.

As seen from the findings, the men's *talanoa* analysed the subject matter and examined it from the perspective of their Tongan ways of interpretation and understanding. They

anchored mental illness in the *tufunga faka-Tonga*, within the movement through time and space which is discussed in the *tā vā* theory of *reality* (see *ta'anga* (temporality) in Chapter Five). The men's *talanoa* about *fa'unga* (reality), *hu'unga* (directionality), *ta'anga* (temporality), and *tu'unga* (positionality) – the *tā vā* theory of reality – runs through all these subthemes. This group was the most strongly orientated towards *tufunga faka-Tonga* and attempted to untangle the meanings of Tongan concepts relating to mental illness. There were also strong challenges towards aspects of Western/biomedical interpretations and *tufunga faka-paiōsaikosōsiolo*.

The strong position of this *fale* in the *tufunga faka-Tonga* needs to be addressed strongly in mental health provision for Tongan men. Despite the strong message from the *tufunga faka-Tonga*, note that *tufunga faka-paiōsaikosōsiolo* was also discussed and still an important component in working with Tongan men. The mens' leadership roles should not be ignored and use to its effectiveness in terms of working with people experiencing mental distress and mental illness to lead them towards recovery.

## **Messages from the *fale***

As discussed throughout this thesis, *fale* does not only refer to house, but also families and people. The messages from these seven *fale* showed the dynamics and complexities in trying to define mental illness for Tongan people in order to determine services to address their mental health needs. These *fale* suggest that cultures and societies where Tongan people grow up heavily influence their perceptions and constructions of mental distress and mental illness. This was evident in the youth with the *tufunga faka-paiōsaikosōsiolo* associated with being

born and growing up in A/NZ, where the men on the hand were identified with the *tufunga faka-Tonga*.

It is important to take note of the positions of these *fale* as families without mental health services users was in the centre, and moving towards *tufunga faka-Tonga* were the women, community leaders and men. These three *fale* that stand on the *tufunga faka-Tonga* end are women, community leaders and men, which represent leadership, rank and authority. The *tufunga faka-paiōsaikosōsiolo* on the other hand has youth, service users and families with service users of mental health services, which represent young people and Tongan people who experience mental distress and illness and also their families. The three groups towards *tufunga faka-paiōsaikosōsiolo* can be in a vulnerable position as they are outweighed in terms of leadership, rank and authority. The location of the families without mental health service users in the centre suggests that this will be a good point to start when addressing Tongan community. This *fale* is still in a position that has the ability to see both *tufunga faka-paiōsaikosōsiolo* and *tufunga faka-Tonga* equally. These *fale* also informed us that a single approach cannot address Tongan mental distress and illness and the importance of readjusting care according to gender, age, mental health experiences, roles and responsibilities. In working with Tongan people, consider the Tongan landscapes around authority and power and where they stand in terms of constructing mental distress and illness. It will mean educating youth and service users about *tufunga faka-Tonga* so they can understand Tongan women, community leaders and men's perceptions of mental distress and illness. This could be the same for the Tongan women, community leaders and men, to learn about *tufunga faka-paiōsaikosōsiolo* and understand the voices from the youth, service users of mental health services users and their families. This will enlighten each *fale*, learn more about each other's constructions of mental distress and illness, and start untangling complex issues amongst the

Tongan community. Untangling the meaning of Tongan concepts is challenging as one concept equates to multiple meanings which was challenging and also difficult in terms of translating to English to present in this thesis. *Puke* for instance can mean ‘hold’ and also mean ‘illnesses. *Vale* is one concept which associates with mental illness is discussed in the next section.

## **Reconceptualising *vale*: Process of growth and adaptation**

The literature review explored Māhina’s (2008) definition of *vale* as ignorance, silly/eccentric (see Chapter Three). Māhina also discussed *vale* in relation to inexperience as in *tamasi’i vale* (inexperienced/innocent boy). Therefore, *vale* is a stage of a process of learning. When the desired maturity, skills, behaviours, and knowledge are achieved the individual is referred to as *poto* (skilful/wise), meaning that they have grown out of *vale*.

*Vale* was frequently used throughout the *talanoa* when participants referred to people experiencing mental illness. This use was related to how people experiencing mental illness behave differently from the society’s defined norms and values. When people experiencing mental illness take a different direction from how Tongan society prescribes normality, then Tongan society reads that these people are *vale*, as they still behave like children and have not grown to be skilful and demonstrate wisdom.

This interpretation extends to education where *vale* is applied to one who is inexperienced, whereas when the individual demonstrates *’ilo* (knowledge/knowledge production) they have become *poto* (wise/knowledge application) (Māhina, 2008). *Vale* therefore, refers to inexperience, tasks are not completed, and goals not achieved according to expected



outcomes: someone with delayed behavioural development, unable to perform according to the expectations of the society can be equated to having some forms of mental illness.

The word *vale* was also identified in the literature review as a regular term in the art of Tongan poetic writings. This was demonstrated through the case of Queen Salote's lament for the loss of her son (Wood-Ellem, 1999). The emotions she expresses are consistent with the DSM IV criteria for clinical depression – having significantly low mood with feelings of hopelessness, helplessness, and worthlessness. The poetic notion of *vale* was not directly discussed in the research project; this may be related to the focus of the *talanoa* on mental illness which can potentially cast a medical, rather than a poetic, focus on illness of the mind. There were, however, occasions in the research project where participants discussed some sense of loss associated with relationships, like marital breakups, where a person just walks aimlessly, staring at things and appears to be living in their own world. Participants described these behaviours as *vale*, as in behaving outside the Tongan defined norms and values. *Vale* can be a verb and also a noun: *vale* is used as a verb to explain that person's behaviour, and also as a noun whereby the individual is labelled as *vale*, thus 'defined' or identified by their behaviour.

While in Tongan poetry the focus on emotions and mood changes are related to loss or relationship breakdown where one experiences low mood and feelings of helplessness, hopelessness, and worthlessness, these mood changes are interpreted by the DSM IV as changes in an individual's way of thinking and behaviour and therefore, have some correlation to mental illness. The composer or poet uses *vale* as a figure of speech, to portray those low mood feelings experienced by someone when they are in love or lose someone special. Use of *vale*, then, does not necessarily refer to an illness of a person, but describes

the certain point in time where one went through low mood due to the nature of the relationship, for example, divorce. Symptoms of *vale* are consistent with symptoms of mood disorders in the DSM IV as so can be confused with having a mental disorder in the non-Tongan context.

## Summary

This chapter rolled out the *fala* (mat) and brought existing and new knowledge together with the *kāinga* (seven *talanoa* groups) to dialogue openly in this safe space. The concepts of circular, collective Tongan worldview versus individualistic, linear Western health systems were discussed. *Tā vā* theory of reality was discussed and how it explained circular, collective and individualistic linear worldviews. The displacement of Tongan concepts and replacement by Christianity was addressed. The *talanoa* groups were discussed in their own *fale* with the concept of *vale* ending this chapter highlighting the complexities of interpreting mental illness in Tonga. The following chapter summarises and concludes this study, discusses its limitations, and makes some recommendations.

## Chapter Nine – Conclusion and recommendation: *Ūloa*, a Tongan model of practice

### Introduction

The future lies in the hands of our own people, not of those who would prescribe for us, get us forever dependent and indebted because they can see no way out.

(Hau'ofa, 2008, p. 440)

The *fala* (mats) were *fofola* (rolled out) in the previous chapter and the *kāinga* (seven *talanoa* groups) were presented together as a discussion of (*alea*) the research findings, the existing knowledge from the literature, and what this research is able to contribute. This chapter takes a step back to look at the *fala* (mat) and review the processes throughout the research project. The Tongan concept of '*auhia ka e kisu atu pē* (struggling to reach shore and taking on water) is used in this section as it symbolises the journey ashore. '*Auhia ka e kisu atu pē* refers to a swimmer who is focused on the destination and determined to get there despite the strong current, challenging weather, and nature of the ocean. Even though seawater is taken in, swallowed and spat out by the swimmer, the journey onwards to the destination continues ('Ofisi Ako 'o e Siasi Uēsiliana Tau'atāina 'o Tongá, 1997; Collocott & Havea, 1922). This metaphor is chosen as it describes the slow progress, with challenges and triumphs, during which the swimmer requires determination and strength. Reflecting on my own academic journey during this PhD study, I often felt like I was literally searching for land while swimming in the deep ocean, an ocean so vast and deep, with unpredictable weather, strong currents, and powerful waves coming toward me from different directions. Interestingly, this

academic journey was searching for the meanings of mental illness for Tongan people. This chapter reflects on the research process and identifies potential limitations of this research project, makes recommendations, proposes a model, *ūloa* to address Tongan conceptualisations of mental illness emerged from the findings and the literature review, and suggests future research in this area.

### **Limitations of the research**

This section acknowledges the limitations of this research project and includes consideration of what could be done differently if this research were repeated. There were challenges with working in two languages, Tongan and English. The translation of Tongan terms into English for presentation in the thesis presents its own difficulties in terms of accuracy of concepts. This process was handled carefully through translating Tongan concepts into English by researcher which were then discussed with, and validated by, two other Tongans, translator and expert.

The use of *talanoa* to accommodate the circular and collective nature of Tongan people did not follow a conventional approach to research. This relates to Smith's work on decolonising research methodologies to suit indigenous populations (Smith, 1999). *Talanoa* may not be conventional in research, but fits with Tongan ways of communicating, living, ways of thinking and constructing knowledge. Tongan people demonstrate their way of understanding through *talanoa*. It is important to note that the groups were self-selecting and therefore, generalisations about Tongan peoples' perceptions' of mental illness and distress cannot be made. However, every attempt was made to collect data from a wide range of Tongan groups reflecting the different positions in the community.

This research examines the meaning of mental distress and illness for Tongan people using *talanoa* and proposes recommendations which are discussed later in this chapter, including a Tongan model for working with Tongan people. Through this process, it is acknowledged that there are areas that need further research, for instance, investigating Tongan experiences of mental distress and illness, mental health responses for Tongan and Pacific people, effectiveness of traditional healers and their availability to Tongan service users, validation of the proposed model and barriers to Tongan people accessing mental health services.

### **Implications of the research findings**

The notion of mental illness has been found to be an unstable, challenging, and fluid subject in the Tongan community. Definitions of mental illness have been influenced by many diverse factors like migration and exposure to new cultures and ideas. The collective and circular nature of Tongan ways of thinking and worldviews were reflected in how mental illness was interpreted and defined by participants in this research project. The circular movement is illustrated in the interpretation of illness as *puke* or hold/held and coming to a complete stop. The spiritual dimension between the world of the living and the supernatural world were noted significantly throughout the data. The spiritual flows between people were maintained through good social relationships ensuring good health, *langimālie*, a beautiful sunny peaceful day, which also mean healthy. Health for Tongan people means good social relationships amongst people and also with the supernatural world. The spiritual dimension flows freely between the living world and the supernatural world, and the land, sky and ocean are peaceful maintaining a sense of balance and harmony. Any disruptions to these spiritual flows that risks the relationships and cause a stop/hold (*puke*) is considered illness (*puke*).

Then the processes of healing, *tofoto 'o*, *faito 'o*, and *tukuto 'o* work on removing the obstacles that stopped these movements and enable movement again. This needs to be reflected in the mental health services when working with Tongan people.

### **What might need to look different in services?**

The previous section on implications of the research highlighted the complexities of understandings of mental illness amongst Tongan people and the need to address it comprehensively and accurately. Current mental health services in A/NZ have limited resources for Pacific people, and these resources are for all Pacific people, rather than recognising diversity within Pacific cultures. *Le Va* has been instrumental in producing resources like the *Seitapu* framework (Te Pou o Te Whakaaro Nui, 2007) and the *Talanoa talking therapies* (Te Pou o Te Whakaaro Nui, 2010) which discusses existing models for Pacific people such as the *Fonofale* model, *Kakala* model, and *Tivaevae* model. These emphasise the real skills required around *tapu* (sacredness) and how to maintain boundaries with relationships (*vā*) when working with Pacific people. *Tapu* is highlighted as a key skill area: “every mental health worker needs to be open minded to the cultural, spiritual and relationship environments and belief systems that may accompany Pasifika service users and their families” (Te Pou o Te Whakaaro Nui, 2010, p. 35). This openness should be reflected in how the worker interacts with the service users without breaching the *tapu*. The breaching of the *tapu* can result from a lack of cultural awareness causing culturally unsafe practice which has problematic consequences for effective therapeutic relationships.

The other resources for Pacific mental health in A/NZ is through the government's District Health Boards where cultural services are set up for Pacific people; for example, the three District Health Boards in Auckland each have their own Pacific mental health services. There are also non-governmental organisations who provide services for Pacific people with mental health problems. Whilst these services are set up to meet the needs of Pacific service users, there are limitations around service delivery, including ethnic specific diversity amongst Pacific population and resources.

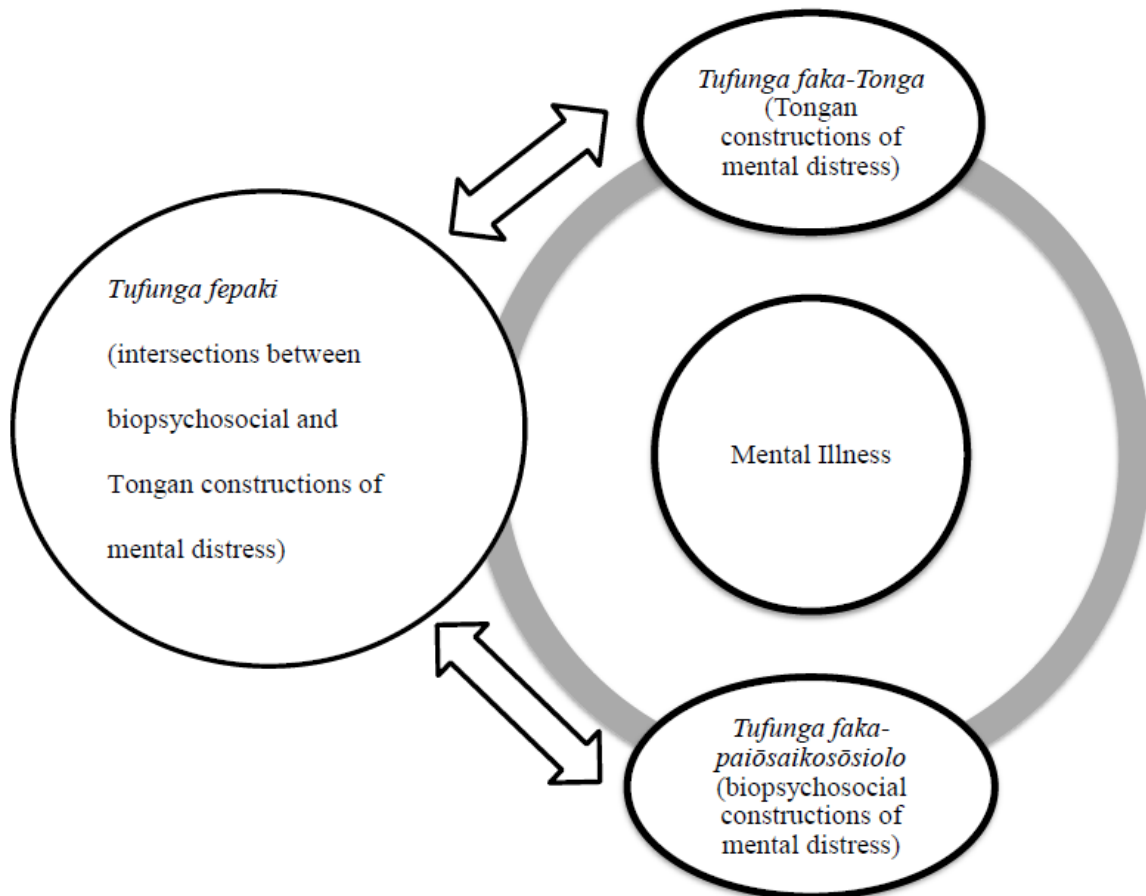
The current services for mental health have been unable to adequately meet the needs for Tongan people and the same applies to Pacific people, with little checking of the meanings of mental illness, for example, there is a need for ethnic specificity say for Tongan people in this case, to ensure accuracy. This project has revealed that there are many interpretations among the Tongan community of mental illness and all lie between *tufunga faka-Tonga* and *tufunga faka-paiōsaikosōsiolo* with *tufunga he fetaulaki, fekau 'aki mo e fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress) in the middle, and addressing these holistically is very important. This project proposes a Tongan model of care based on the ocean and a communal fishing technique called *ūloa*, which will capture these Tongan interpretations of mental illness.

### **Tongan understandings of mental illness**

The idea around circular movement is the subject matter being at a steady position, while the movements determined the interpretations of mental illness. Figure 9.1 shows the subject matter in the middle with the *tufunga faka-Tonga* and *tufunga faka-paiōsaikosōsiolo* in

opposite directions while *tufunga fepaki* stands at the meeting points of *tufunga faka-Tonga* and *tufunga faka-paiōsaikosōsiolo*.

**Figure 9.1** Tongan understandings of mental illness



This represents the fluid nature of interpreting mental illness amongst Tongan people; the movement from one point to another can take a significant amount of time and conviction. It was difficult to position *talanoa* groups into certain points as the interpretations of mental illness were changeable depending on processes and outcomes. The definition of mental illness lies within the boundaries of Figure 9.1 and many different definitions and



understandings of mental illness are present. As shown in the diagram, the definition of mental illness varies within the Tongan community and is defined by one's location in the diagram and how they viewed mental illness from their own respective positions. This therefore, suggests that there are many definitions of mental illness in the Tongan community. This may be quite challenging in terms of addressing mental illness, but is useful in practice to understand what people view as the causes of their distress. It is important to understand this to provide approaches that are seen as useful by the person experiencing the distress in order to engage them in the processes of assessment and treatment, to make progress to decrease distress. This research revealed that all the interpretations lie across a continuum (see Figure 4.4 in Chapter Four).

## **Recommendations**

The study has a number of recommendations to make explicit the meanings of mental illness for Tongan people and improve mental health services for the Tongan diaspora.

- Recommendation 1: To develop a framework or model that informs working with the Tongan diaspora, and which may be applicable to the Pacific population in general.

This recommendation proposes a health and community model that will reflect how the Tongan community functions and use it as a platform for mental health services and providers working with Tongan people. This model may be applied to other Pacific groups and those who have similar values and social structures with Tonga. This model captures the circular and collective nature of constructing mental illness, addresses the relationship

between the living and the supernatural, and acknowledges the significant spiritual dimension. A Tongan communal fishing technique called *ūloa* is the metaphor used for the proposed model which is presented in detail below.

- Recommendation 2: To inform health providers about Tongan interpretations of mental distress and illness and how these can contribute to Pacific mental health in general.

The findings suggest that Tongan leaders, authorities and people in high status (community leaders, men and women) identified more with *tufunga faka-Tonga* which is currently not addressed by mental health providers effectively. This research recommends that health providers who work with Tongan people be informed about the Tongan interpretations of mental illness, in particular to be aware of the relationship between the living and the supernatural, and the need to keep this relationship flowing freely and free from ill feeling in order to maintain mental health. The significant spiritual dimension in constructions of health in general is also important, as these interpretations can be extended to areas outside of mental health such as general medicine and surgery. This was noted in the Tongan word for illness, *puke*, which is a) not the only word for illness, and b) which applies to all illnesses in Tonga, not only mental illness. This recommendation may extend to other Pacific populations as they have similar values and practices with Tongans and these interpretations can apply to them as well.

- Recommendation 3: To incorporate Pacific interpretations of mental distress and illness into health policy.

Informing mental health clinicians about Pacific interpretations of mental distress and illness will increase awareness, and these interpretations can be incorporated into health policies. This will ensure that clinicians include the Pacific interpretations of mental distress and illness in their practice. This study recommends that its findings should be considered by policy makers as it will inform service development and increase awareness and knowledge about Pacific mental distress and illness. This will also enhance skills in working with Pacific people using Pacific interpretations of mental distress and illness, producing good mental health outcomes for the Pacific community.

- Recommendation 4: To engage with mental health nurses and other practitioners to reflect on their practice on how they can integrate more fully social and spiritual aspects into their practice with Tongan people.

On the basis of understandings about Tongan constructions of mental distress, mental health nurses and health practitioners working with Tongan people need to know about the collective needs of Tongan people and how they construct mental distress differently from youth at the biosychosocial constructions to the men at the Tongan constructions with the families at the intersections of these two constructions.

- Recommendation 5: To incorporate Pacific interpretations of mental distress and illness into curricula of health practitioners.

Education of health practitioners in A/NZ should include the findings from this study so that health practitioners are aware of the Tongan interpretations of mental illness and are able to work with them effectively. With regard to nursing education, these findings could be included as part of cultural safety learning as it will enhance nursing competencies. The mental health education in A/NZ is informed by recovery approaches (Fotu & Tafa, 2009; Malo, 2000; Ministry of Health, 2008, 2010b; O'Hagan, 2001, 2002, 2009) focussed on service user centred care with the service users defining their experiences and making decisions with the care they need. It is therefore recommended that health professionals in training are aware of how Tongan people view mental health and illness.

- Recommendation 6: To review current mental health services and providers for Pacific people with a focus on their current cultural capability and capacity.

This research argues that current mental health services and providers be reviewed to look at how community engagement is initiated and what channels are open and available for communication between mental health service providers and the Tongan community. Good channels will ensure that messages are two-way, sending and receiving well. This includes engagement with churches, due to the powerful influences of the church on Pacific people and high number of Pacific attendees.

The Free Church of Tonga has 22 branches all over Auckland and also has national coverage in A/NZ has a social service, called *Taulanga Ū*. It is recommended that mental health

services engage with organisations like this as they are already well established within the Tongan community. This will be effective in terms of promoting mental health for Tongan people and working with people experiencing mental distress and illness to improve their mental health, and also Tongan and Pacific mental health outcomes. Places like *Taulanga Ū* will also be effective in terms of implementing the model recommended in Recommendation 1, *ūloa* due to their community positioning and engagement.

### ***Ūloa*: A potential model for Tongan practice**

This is the beginning of a development of a model on the basis of the findings from the research. I have explored a possible model to present to the community using the communal fishing concept of *ūloa*. Consultation on the model will help to refine it, but *ūloa* is a proposed guide for interventions to work well with Tongan people in A/NZ. It is based on a Tongan fishing approach, and the metaphoric symbols relate well to how Tongan people function and engage. *Ūloa* is a communal fishing technique used in Tonga and all the fish collected are shared amongst the community. This fishing technique requires large numbers of people and usually the whole village or community participates including all ages and genders. *Ūloa* is a more communal activity that is still practiced throughout Tonga and has been used in villages, outer islands, and even church communities (personal conversations with Manase Lua, Suli Tu‘utafaiva, Sōsaia Manu Soatame (Vakaloa), ‘Atunaisa Sevelino Makasini (Tō e La’ā e ‘Otu Tonga), Tēvita Fuimāono, Sione Mālafu, Reverend ‘Ifalame Teisi, Reverend Sione Kaloni, and Penisio Kautai Hau, 2009, personal conversation with Māhina 2013). My time in the mental health profession working with Tongan people always challenged me to consider a framework that encompasses Tongan concepts and values. The

characteristics of *ūloa* attracted my interest and I have been talking to different people about *ūloa* and its proposed implementation in mental health on reflection of the research findings. My *talanoa* with Reverend ‘Ifalame Teisi and Manase Lua in 2009 led to a *faikava* group with Manase Lua, Suli Tu‘utafaiva, Sōsaia Manu Soatame (Vakaloa), ‘Atunaisa Sevelino Makasini (Tō e La’ā e ‘Otu Tonga), Tēvita Fuimāono, Sione Mālafu, Reverend ‘Ifalame Teisi, Reverend Sione Kaloni, and Penisio Kautai Hau, 2009 where we have in depth *talanoa* about *ūloa*. *Ūloa* was a topic that I have usually brought up since then in many *talanoa* sessions to expand my knowledge. I revisited *ūloa* again in 2013 on numerous occasions with the *Pakileni* Old Timer Band *faikava* club in Mangere, Auckland and the *talanoa* were consistent with our *faikava* in 2009 and many *talanoa* sessions with other Tongan people.

*Ūloa* was selected as a tool to inform health professionals about the important concepts identified in the literature review and this research analysis to explain mental illness amongst Tongan people. These include the circular collective nature of the relationships between the living and the supernatural world, and the spiritual dimension. *Ūloa* is a traditional Tongan way of fishing that captures all of these elements. The concepts identified will be demonstrated in the *ūloa* technique through the ‘collective’ of *ūloa* participants, the ‘circular’ shape of the *au* (coconut leaf net), the ‘relationship’ flow between each participant, and the connection to the land, sea and the sky which also symbolises the ‘spiritual dimension’. The process of healing of *tofoto* ‘o (operating), *faito* ‘o, (removal), and *tukuto* ‘o (stop removing) are also addressed in the *ūloa* where Tongan community are working together through these three stages of removal and regaining wellness.

*Ūloa* involves the use of *au* (coconut leaf net) which consists of small pieces made by each *ūloa* participant according to how they were instructed by the *toutai* (main fisherman). *Toutai*

also means fishing and both meanings of *toutai* are used here. In brief, the *toutai* (main fisherman) sets and announces the fishing day, all participants bring their small pieces of *au* and stand in their allocated position, connecting their pieces together by holding on to one another and moving close, trapping the fish inside until they all meet at the *tuki* (collection sack). Holding on to one another signifies the social relationships amongst participants and the movements within the water to trap the fish reflect the spiritual relationship with nature and the supernatural world.

The model captures what has been discovered and explored in this study. There are components of *ūloa* I will use, these are *au* (coconut leaf net), *main au* (coconut leaves that connects to each *au* to make the main *au*), *tuki* (collection sack), and *toutai* (main fisherman). I have divided it into four phases: *tufunga* (construction), *toutai* (fishing), *tufa* (distribution), and finally *tofu* (peace and harmony). I purposely drew these terms from *ūloa* as it aligns with the Tongan community in terms of worldviews and also approaches.

I have allocated each component of the *ūloa* to relate to the current context in A/NZ and what each component represents. The *au* (coconut leaf net) represent family which also symbolise by *fale* (house), *main au* (coconut leaves that connects to each *au* to make the main *au*) symbolise the community, *tuki* (collection sack), symbolise the mental health services and providers, *toutai* (main fisherman) signify the mental health worker and the fishes represent the service users. These components were linked to other Tongan concepts and tools like *talanoa*, *loto*, *fala*, and *fale*.

The *toutai* (main fisherman) will assess the community (*main au* - coconut leaves that connects each *au* together to make the main *au*), and community refers to people holding the

main *au* and also the properties of the main *au*. The *toutai* (main fisherman) then assess and allocates to each *au* (family) their roles in the *ūloa* day. The fishes (service users) are also assessed and the plans of getting them to the mental health services (*tuki* – collection sack) are addressed by the *toutai* (main fisherman), *au* (family) and community (main *au* - coconut leaves that connects each *au* together).

Preparation of the *au* (family) requires weaving of the *au* where the themes from this research are used to weave the *au*. The *tufunga faka-Tonga* (Tongan constructions), *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions) and *tufunga fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress) threads are woven together to produce *au* in each family, which will be able to metaphorically hold and secure fishes, the service users. Communication is vital throughout this weaving process and *talanoa* fits this task well due to its open nature and structure. These *au* are then brought together and connect to each other to make the main *au* (community) at the *ūloa*.

*Talanoa* are used throughout the *ūloa*, the weaving of the *au* are done in the participants house (*fale*) where the *toutai* (main fisherman) gets to the participants' *fale* (house), sit on their *fala* (mat) and communicate to their *loto* (heart/soul) through *talanoa*. *Talanoa* is also vital when the *au* are connected together to make the main *au* (community) as these connections need to be firm, strong and secure. Moving towards the mental health services (*tuki* – collection sack) also needs transparent and clear communication which is best addressed by *talanoa* due to its collective and circular nature.

This model ensures that any presentations and constructions of mental illness from service users are captured by the *toutai* (mental health worker), *au* (family) and main *au*



(community) and, the *toutai* (mental health worker), *au* (family) and main *au* (community) also have the ability lead the service user to mental health services. This mental health service can be traditional Tongan services or Western and biomedical services or a mixture of both. This model is important in addressing these dynamic and complex situations holistically. This project proposes this Tongan model of care based on the ocean and a communal fishing technique, which will capture these Tongan interpretations of mental illness. The process of *ūloa* is divided into four phases.

### ***Tufunga* (Construction)**

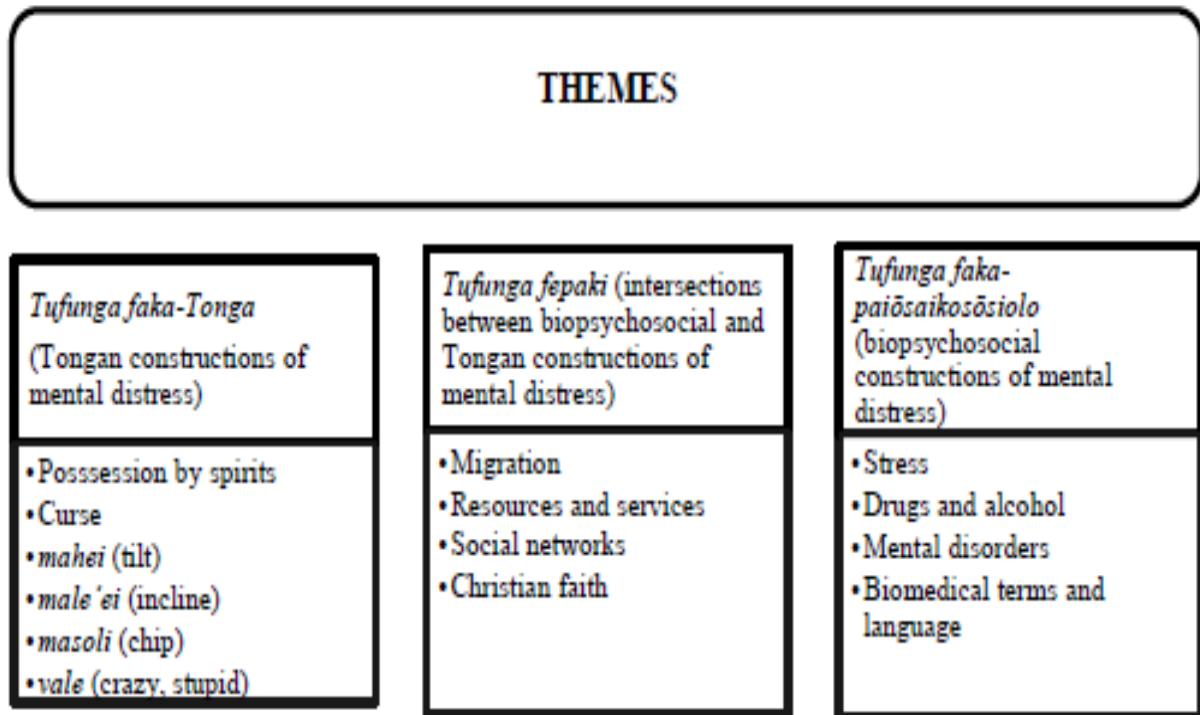
*Tufunga* involves assessment, planning, consultation, and giving instructions to all *ūloa* participants. This involves meetings and ensuring that all the required materials are gathered, and assessing resources, both human and natural. Assessing the *ūloa* participants and the targeted shore for the fishing allows the *toutai* (main fisherman) to plan how he will position each participant on the fishing day.

One important task is predicting a good day for the *ūloa*, which requires clear and fine weather. *Ūloa* starts at high tide and the fish are collected at low tide. The *toutai* (main fisherman) will have to select a day where high tide and low tide both fall before sunset. A *ūloa* that drags into the evening shows wrong timing as the *ūloa* fails to arrive at the *tuki* (collection sack) before sunset. This is an embarrassment for the community and an utter shame on the *toutai* (main fisherman). This also applies to failing to catch abundant fish for distribution in the community. The *toutai*'s goal is to predict a good day for *ūloa*; such a day will be *langimālie* (have a clear and peaceful sky), which is also the Tongan word for good

health. Becoming skilled at this involves a long process of learning to assess the environment. Predicting the weather is not an easy task as the *toutai* will have to learn about the land, sea, sky, and environment and have the ability to predict the future's weather. It is during this process of learning that the *toutai* (main fisherman) learns about the circular relationship between the land, sea, sky, and environment. Mastering these circular relationships help the *toutai* (main fisherman) predict the weather and a *langimālie* day for the *ūloa*. In relation to health, I see mastering these skills as addressing the spiritual dimension as learning about the circular relationship between the land, sea, sky, and environment and predicting the weather require some form of spiritual guidance. The *toutai* also seeks guidance from the community and elders in terms of predicting the *langimālie* day. Therefore, the *toutai* leads and facilitates, but the decision for the *langimālie* and the day for the *ūloa* is usually a joint effort between the *toutai* (main fisherman) and the community.

This process can be applied to mental health services where there is a need to work closely with the Tongan community. The *toutai* represents the mental health worker who needs to fully assess the community and the services needed. When preparing for the *ūloa* the *toutai* goes to each participant's *fale* and discusses the requirements and their participation in the *ūloa*. In the same way assessment of mental health service users by means of the Tongan concepts of *fala* and *fale* can effectively include all the people who can contribute to assessment and help with treatment. This involves assessing the appropriate people to involve in the treatment and what capacity they can help with. There is also some contribution from the *ūloa* participants about their involvement which can also apply to service users' participations in the mental health setting. These conversations are done inside the participant's *fale* on their *fala* (mat).

**Figure 9.2**                      **Assessment of mental distress**



Considering the three themes from this research, *tufunga faka-Tonga* (Tongan constructions), secondly, *tufunga faka-paiōsaikosōsiolo* (biopsychosocial constructions), and *tufunga fepaki* (intersections between biopsychosocial and Tongan constructions of mental distress), the mental health worker can see the Tongan population within these themes and readjust his/her approach to ensure that all themes are covered in the *fale*. For example: as showed in Figure 9.2 this can be applied in the assessment phase examining where the service users position themselves within the three themes. The mental health worker will identify from the responses that that service user may fall into *tufunga faka-Tonga* if they talk about spirits and

courses. If the responses are more focused on services or migration and other beliefs, this suggests that service user may be positioned around the *tufunga fepaki*. If they are talking about stress, drugs, and alcohol then the *tufunga faka-paiōsaikosōsiolo* would be considered.

### ***Toutai* (Fishing)**

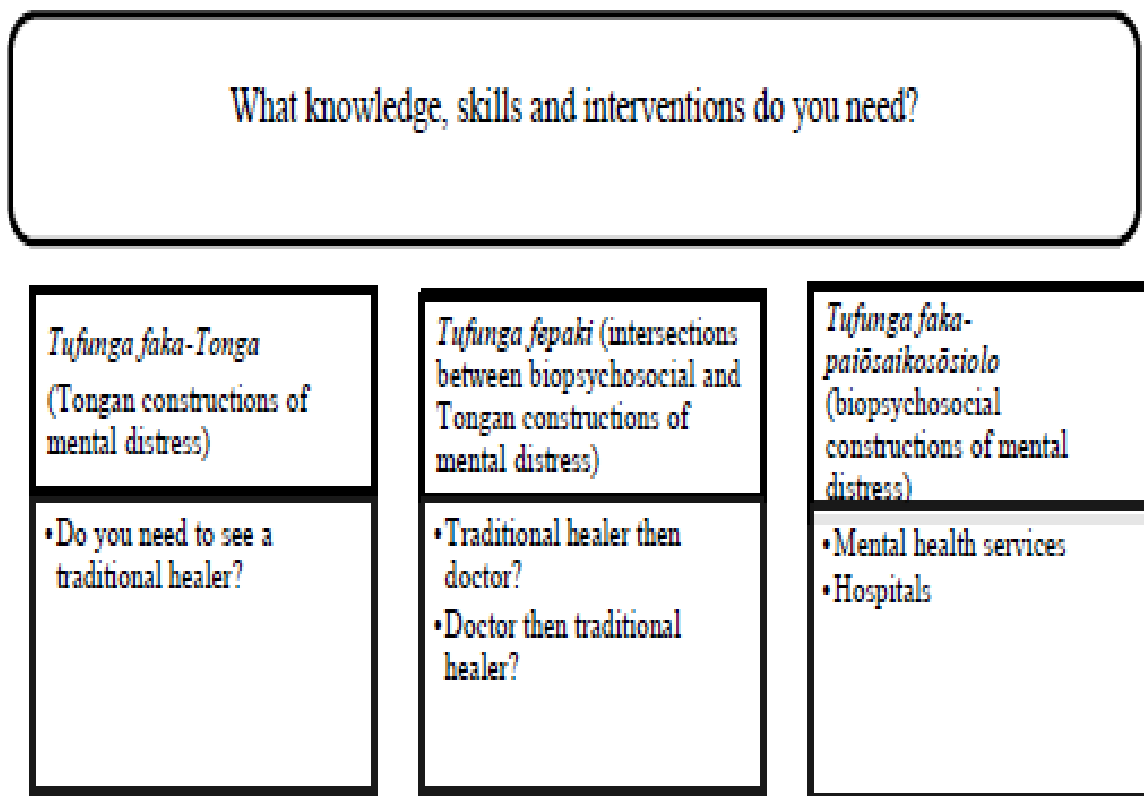
With large numbers of people participating in *ūloa*, leadership is very important and there is only one voice that keeps directing and managing the whole process. This is the *toutai* (main fisherman) who always stays alert and fully aware of all activities in the *ūloa*. If one end of the *au* (coconut leaf net) gets stuck, the *toutai* will attend to this by loosening the other end until the whole *au* (coconut leaf net) is free to move again to its desired position.

The *toutai* also continuously checks that the connections between participants are maintained safely in order to secure the fish. There is an understanding that this is a collective fishing effort and everyone works together for the benefit of whole collective. Individual fishing is considered stealing and it is shameful when caught. It is important to note that some participants may be fishermen and experts in their own way of fishing but this is an opportunity where all the community comes together for the benefit of the whole group. Everyone listens to and follows the instructions of the *toutai* (main fisherman) in order to have the greatest chance of success.

The application of this phase into mental health practice suggests that the *toutai* (mental health worker) needs to stay alert, know all connection points and how each is linked, how to

strengthen and pulled the *au* (coconut leaf net) to the *tuki* (collection bag) successfully. The skill and reputation for success of the *toutai* (main fisherman) is earned through service, skills, knowledge, credibility, and the respect of the community. The mental health worker, too, needs to learn how to gain this key position in the Tongan community.

**Figure 9.3 Knowledge, skills and interventions**



The example in Figure 9.3 shows the mental health workers assessing the community and placing each individual within suitable locations in the *ūloa*. The assessment is important as individual and community will lead in terms of identifying their locations in the *ūloa*

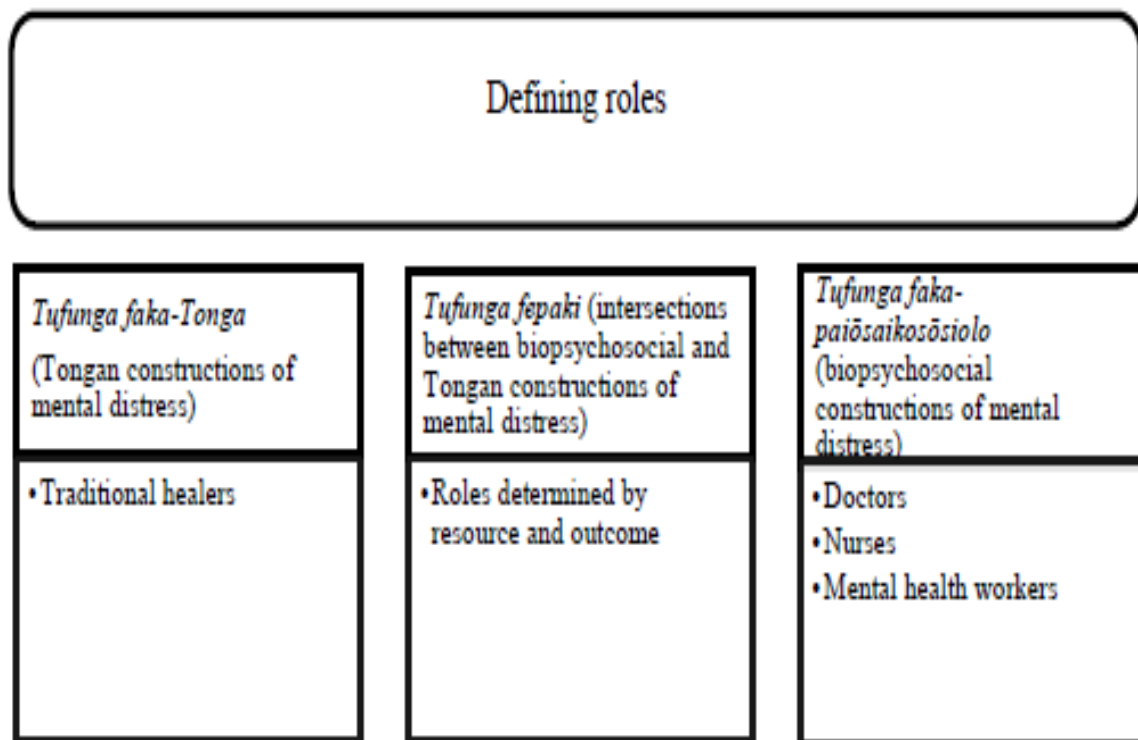
according to their knowledge, skills and intervention needed. Their placement of the individual is usually determined according to their skills and abilities. This is important as the service user decides their position, then the mental health worker works with them towards their mental health goals. With *tufunga fepaki* Bloomfield (2002) discussed healthcare in Tonga where people seek both traditional and hospital and at times, doctors joked when they were unable to treat people, that they “need *peni* Jehovah rather than penicillin” (p. 26) which demonstrates that doctors in Tonga still consider forms of traditional and spiritual healers. Poltorak (2012) supports Bloomfield but taking a different angle by looking at it from a traditional healer perspective, and incorporating hospital medicines in her treatment and also working closely with the hospital. Bloomfield and Poltorak bring the examples from Tonga which needs to consider in A/NZ while caring for Tongan people to recover from mental distress and illness.

### ***Tufa* (Distributions)**

When all the fish are collected in the *tuki* (collection sack), they are counted and distributed according to the hierarchy of the society. When all the community leaders and people at the top have their share, the rest of the fish are evenly distributed to all participants. No fish are used for commercial purposes and every single member of the village/community has a fair share. Selling fish from the *ūloa* is regarded as breaking of the *ūloa* protocols, or moving beyond or breaking the *ūloa* norms and values. Stealing or cheating in distribution of fish can have social implications and causes shame and embarrassment for that individual and his/her family.

This phase is important as it is taking back the outcome of the *ūloa* to the community and distributing the results equally and fairly. The application of this phase to the mental health service is akin to taking the outcome from the mental health service back to the community. A good day in the community is symbolised by a good catch for the *ūloa*. If the *ūloa* fails and the catch is poor then the whole community has nothing to share, and often signals poor skills from the *toutai* (main fisherman) who has failed to do his duty. This also applies for the mental health worker in terms of working with the Tongan community.

**Figure 9.4**                    **Mental health worker roles**



This phase emphasises the importance of roles in the mental health setting in A/NZ. It is important to take note of the different types of curers. Bloomfield (2002) distinguished between modern medicine, traditional healers, and ‘others’. Modern medicine translates to the *tufunga faka-paiōsaikosōsiolo*, the traditional healers fit *tufunga faka-Tonga*, and ‘others’ equates to the *tufunga fepaki*. This translates to the mental health setting, sorting mental providers for Tongan people into Tongan traditional healers, mental health services and professionals, and other religious healers and using of playing cards (using of playing cards to explain illness and treatment) healers. It is important and crucial for the mental health worker to firstly know their professional identity and roles so that he/she can safely position himself/herself in the Tongan context amongst other mental health providers. This will allow the mental health worker to know the layout of the Tongan context and to be able to navigate his/her way around while working with the service user towards their common goals and destinations. It is important that these goals are discussed and agreed in partnership between the mental health worker and the service user.

### ***Tofu (Accurate, calm and peace)***

Churchwood (1959) defines *tofu* as everyone receiving evenly. This can be applied to a cover of a table. A table cover should be able to fully cover what it is designed to cover, for example, to fully cover the whole table. These show that *tofu* refers to something that the table is able to receive evenly across all its surface area. Then we can say that the table cover covers the table well and accurately. That is *tofu*, every part of the table is covered well by the table cover. This definition of *tofu* translates to the ocean as well and refers to calm,



smooth and clear seas. Seas where they are smooth like the table cover that distributes evenly on the table.

The concept of *tofu* refers to the need for ongoing reflection throughout the whole process of *ūloa*. From the start of the process, nature (weather and sea conditions), all the *ūloa* participants, and the *toutai* (main fisherman) need to have some sense of calmness and smoothness in order to engage and connect effectively with each other. The *au* (coconut leaf net) needs to be *tofu* (accurate) with the *ūloa* participants. The length of the main *au* (coconut leaf net) should equate to the number of the *ūloa* participants. The *ūloa* participants need to be *tofu* (accurate); that is, to fit the targeted shore for the *ūloa*. There has to be *tofu* (accuracy) with the weather forecast and the ocean has to have some sense of *tofu* (calmness). The assessment of *tofu* at all levels rests heavily on the *toutai* (main fisherman) and (s) he also has the responsibility of managing and maintaining *tofu* all the way from *tufunga* through *toutai* to *tufa*.

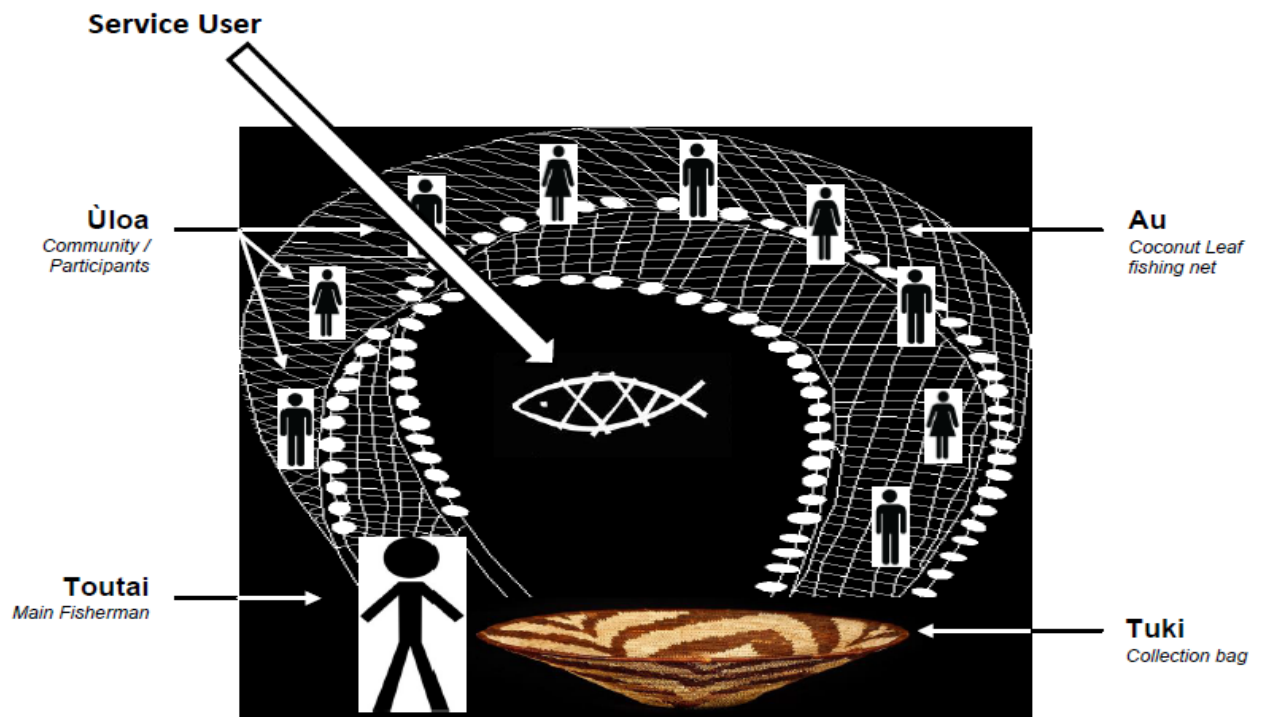
Maintaining *tofu* (accuracy) in the *tufa* (distribution) phase means ensuring that everyone receives their share (*tofu*), everyone has been covered well (*tofu*), in the same way that the table cover (above) covered the table well. The community is calm and peaceful (*tofu*). Achieving this calm and peaceful community equates to the Tongan concept of health discussed earlier in the literature review: *langimālie* (clear and peaceful sky). There is a need to have *tofu* (share, peaceful) at all levels in the Tongan community (collective) and the relationships between people and nature should be well maintained and free from bad feelings. This relationship extends by the spiritual dimension to the spiritual world, which then flows in a circular manner between the living and spiritual world. This connects *ūloa*

with the interpretation of health and mental health (*langimālie*): mental illness is any obstacle that hinders and seizes (*puke*) the free flow of good relationships between people and also the spiritual world.

Figure 9.5 shows the processes, roles, and tools of *ūloa*: how the *au* is laid out, the collaborative position and role of the participants, the position of the *tuki*, and the overseer role of the *toutai*. The *au* is the main tool used for harvesting the *ūloa*. This tool and how it will be used is discussed by the *toutai* with the families on the *fala* (mat) in their own *fale* (houses). With everyone working together, the tool is taken and used in the *ūloa*, and the harvest is then distributed to all the *fale* who participated in the preparation. The *toutai* (main fisherman) is responsible for coordinating this communal activity. In mental health, *tofu* is one where the mental health worker and service providers will be aiming at, accurate, calm, peace and harmony which represents mentally healthy.

To translate *ūloa* to mental health: the mental health worker plays the role of the *toutai* (main fisherman), and starts working with Tongan people on the *fala* in their *fale*, preparing them with tools needed to ensure that they will be successful. Successful treatment of the individual impacts on everyone within the community and everyone will achieve a state of *langimālie* (peace, harmony).

Figure 9.5 *Ūloa Model*



The main *au* (coconut leaf net) consists of many small pieces made by each family in their own *fale* (house) before the *ūloa* day. Every family comes together, standing side by side, and connecting their pieces of *au* to the next to make the one whole main *au*. People then stand and hold the *au* together side by side, and move forward together, trapping and dragging the fish into the *tuki* (collection bag). It is important to coordinate, control, and ensure that both ends of the *au* arrive at the *tuki* (collection bag) at the same time to secure the catch.

*Ūloa* is an opportunity to weave the three themes emerged from this research project into an *au* and use it as a tool to address mental health for Tongan people. An *au* made from these three threads will be able to capture any form of mental illness presentation in the Tongan context.

## **Conclusion: *Talatala 'i fale* (tell it in the house) – Tongan concept to reflect on the process and conclude the project**

The journey in this research project has been rolled out like an open *fala* (mat) inside the *fale* (house). The term *fale* has been explained as not only being restricted in meaning to “house” but also meaning people and families, with more emphasis on *kāinga* (extended families) in the Tongan context. These *kāinga (fale)* are positioned within the Tongan hierarchical society discussed in Chapter Eight. *Kāinga* interact with each other to comply with their social obligations in this hierarchical pyramid. The people at the lowest level of the hierarchal pyramid are called commoners (*tu'a*). While *tu'a* are at the bottom of society, they do play significant roles and are important in Tongan society. They are there to serve the people at the next level, nobles, and the nobles serve the next level, the King. The views and opinions of the *tu'a*, however, are regarded as worthless due to their societal position, duties, and functions as their role in the society is to serve.

This notion of *tu'a* (commoner) may also be applied to the *fale* as *tu'a* also means outside/outdoors (Moa, 2011; Potauaine, 2010; Potauaine & Māhina, 2010). The *fale* is the place that provides accommodation, protection, warmth, acceptance, approval, love, and so forth for the *kāinga*. *Tu'a* (outside) is the place of dirt and insignificance, unknown and unsafe. Inside the *fale* is the place to talk, and I have chosen to use the Tongan concept of *talatala 'i fale* (tell it in the house) to sum up and conclude the discussion about this research project.

The *talanoa* in all the seven *fale* (*talanoa* groups) showed the importance of *fale* and how it provided a safe, warm, and sheltered place for the research. *Talatala 'i fale* (tell it in the house) implies that the *fale* (house) is the space where advice and guidance is given to the younger generations. Any space outside the *fale* (house) is not safe for Tongan elders to pass on their knowledge to their young ones. Demonstrations of skills and tasks can be done in appropriate settings outside of the *fale* (house) but if anything requires discussion of a sensitive and sacred nature, it will be brought into the *fale*. The young ones will explain the issue and the elders/parents will give advice, options, and solutions with a clear explanation about the issue and defining it in detail. People share from their *loto* (heart/soul) when they *talatala 'i fale* as they are setting the path for the future. This project has highlighted the importance of the *fale* in the Tongan context. It highlights that the tool for *talanoa* inside the *fale* is the *fala*; that this is a place to enter into the Tongan community and listen to authentic Tongan voices. The proposed *ūloa* model recommends the mental health worker to go into Tongan people's *fale* and assess them there using the right tool for the *ūloa* so that they will have a good outcome to share within their community, so that they are *tofu* (calm and peaceful) and achieve *langimālie*.

The research journey has been rough and uneven at times. From the starting of this project, initiating and refining the research question, designing the research, implementation, analysing the findings and the writing up. Language was a challenge and attempting to communicate and translate Tongan concepts into English was not easy at times. Cultural differences was also challenging, the individual and linear health system versus the collective and circular Tongan system. In addition to these were other commitments to the Tongan communities, professional and personal.

Like the concept that opened this chapter, *'auhia ka e kisu atu pē* (struggling to reach shore and taking on water), however, despite the hardships and challenges, there is a need to get to the Tongan *fale*, to *talatala 'i fale* (tell it in the house) as talking from outside cannot be heard from inside and is, therefore, worthless. The swimming must continue as the journey will be worthless if the destination is not reached. Despite obstruction by the currents, the journey continues and taking on water has paid off, as we have now landed on a *langimālie* day and are in good health, through identifying constructions of mental distress and illness amongst Tongan people and also having a Tongan tool, *ūloa* to address mental distress and illness.

However, the dynamics and complexities of Pacific people have been highlighted throughout this project and so it is urged that the findings here are considered for their usefulness to other Pacific people, for example whether *ūloa* can apply to other Pacific nations. This research also raised different ways of constructing mental distress and illness amongst Tongan people which provide a platform for further research on managing and treating mental illness, measuring outcomes, and evaluation of services. As Hau'ofa (2008) writes, Pacific populations now expand to countries like New Zealand, Australia, and United States and “the future lies in the hands of our own people, not of those who would prescribe for us, get us forever dependent and indebted because they can see no way out” (Hau'ofa, 2008, p. 440).

## References:

- ‘Ofisi Ako ‘o e Siasi Uēsiliana Tau‘atāina ‘o Tongá. (1997). *Ko e ngaahi palōveape ‘i he lea faka-Tongá*. Nuku‘alofa, Tonga: TongaPRINT.
- ‘Otunuku, M. (2011). Talanoa: how can it be used effectively as an indiginous research methodology with Tongan people. *Pacific-Asia Education*, 23(2), 43-52.
- Abbott, M. W., Wong, S., M., W., Au, M., & Wilson, Y. (1999). Chinese migrants' mental health and adjustment to life in New Zealand. *Australian and New Zealand Journal of Psychiatry*, 33, 13-21.
- Allen, J. S., & Laycock, J. L. (1997). Major mental illness in the Pacific: a review. *Pacific Health Dialog*, 4(2), 105-117.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR*. Washington: American Psychiatric Association.
- American Psychiatric Association, & DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders : DSM-5* (5th ed.). Washington, D.C.: American Psychiatric Publishing.
- Ape-Esera, L., Nosa, V., & Goodyear-Smith, F. (2009). The Pacific primary health care workforce in New Zealand: What are the needs? *Journal of Primary Health Care*, 1(2), 126-133.
- Barrera, I., Schulz, C. H., Rodriguez, S. A., Gonzalez, C. J., & Acosta, C. A. (2013). Mexican-American Perceptions of the Causes of Mental Distress. *Social Work in Mental Health*, 11(3), 223-248. doi: 10.1080/15332985.2013.774922
- Bathgate, M., & Pulotu-Endemann, F. K. (1997). *Pacific people in New Zealand*. Wellington: Ministry of Health.

- Bennardo, G. (2009). *Language, space, and social relationships. A foundational cultural model in Polynesia*. Cambridge: Cambridge University Press.
- Bentall, R. (2004). *Madness explained psychosis and human nature*. London: Penguin Books.
- Bentall, R. (2011). The psychology of psychosis. In D. Pilgrim, A. Rogers, & B. Pescosolido (Eds.), *The SAGE Handbook of mental health and illness*. Los Angeles: SAGE.
- Bhavsar, V., & Bhugra, D. (2009). Bethlem's Irish: migration and distress in nineteenth-century London. *History of Psychiatry*, 20(2), 184-198.
- Bhugra, D. (2005). Cultural identities and cultural congruency: a new model for evaluating mental distress in immigrants. *Acta Psychiatrica Scandinavica*, 111, 84-93.
- Bhugra, D., & Arya, P. (2005). Ethnic density, cultural congruity and mental illness in migrants. *International Review of Psychiatry*, 17(2), 133-137.
- Biersack, A. (1991). Kavaonau and the Tongan chiefs. *Journal of Polynesian Society*, 100(3), 231-268.
- Bishop, R. (2008). Freeing ourselves from neocolonial domination in research. A kaupapa Maori approach to creating knowledge. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The Landscape of Qualitative Research* (pp. 145-183). California: SAGE.
- Blackburn, S. (2008). *The Oxford Dictionary of Philosophy* (2nd ed.). New York: Oxford University Press.
- Bloomfield, S. F. (2002). *Illness and cure in Tonga, traditional and modern medical practice*. Nuku'alofa, Tonga: Vava'u Press.
- Boddington, P., & Räisänen, U. (2009). Theoretical and Practical Issues in the Definition of Health: Insights from Aboriginal Australia. *Journal of Medicine & Philosophy*, 34(1), 49-67. doi: 10.1093/jmp/jhn035
- Bott, E. (1981). Power and rank in the Kingdom of Tonga. *Journal of Polynesian Society*, 90(1), 7-82.



- Braun, V., & Clarke, C. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 2*, 77-101.
- Breen, L. J. (2007). The researcher 'in the middle': negotiating the insider/outsider dichotomy. *The Australian Community Psychologist, 19*(1).
- Bridgman, G. (1997). Mental illness and Pacific people in New Zealand. . *Pacific Health Dialog, 4*(2), 95-104.
- Burnham, J. C. (1980). Psychotic delusions as a key to historical cultures: Tasmania, 1830-1940. *Journal of Social History, 13*(3).
- Capstick, S., Norris, P., Sopoaga, F., & Tobata, W. (2009). Relationships between health and culture in Polynesia - a review. *Social Science and Medicine, 68*, 1341-1348.
- Caron, J., Fleury, M.-J. e., Perreault, M., Crocker, A., Tremblay, J., Tousignant, M., . . . Daniel, M. (2012). Prevalence of psychological distress and mental disorders, and use of mental health services in the epidemiological catchment area of Montreal South-West. *BMC Psychiatry, 12*(1), 183-194. doi: 10.1186/1471-244x-12-183
- Chiu, R. K., & Kosinski, F. A. (1995). Chinese cultural collectivism and work-related stress: implications for employment counselors. *Journal of Employment Counselling, 32*, 98-110.
- Churchwood, C. M. (1959). *Tongan Dictionary*. Tonga: The Government Printing Press.
- Collocott, E. (1921). Legends from Tonga. The Maui. *Folklore, 32*(1), 45-58.
- Collocott, E. (1923). Sickness, ghosts and medicine in Tonga. *The Journal of Polynesian Society, 32*(127), 136-142.
- Collocott, E. (1927). Kava ceremonial in Tonga. *Journal of Polynesian Society, 36*(141), 21-47.

- Collocott, E., & Havea, J. (1922). Proverbial sayings of the Tongans. *Occasional Papers of the Bernice Pauahi Bishop Museum of Polynesian Ethnology and Natural History*, 8(3), 40-154.
- Craig, R. D. (2011). *Historical Dictionary of Polynesia* (3rd ed.). Lanham: The Scarecrow Press, Inc.
- Crawley, L., Pulotu-Endemann, F. K., & Stanley-Findlay, R. T. U. (1995). *Strategic Directions for the Mental Health for Pacific Island People*. Wellington: Ministry of Health.
- Cross, W. M., & Bloomer, M. J. (2010). Extending Boundaries: Clinical communication with culturally and linguistically diverse mental health clients and carers. *International Journal of Mental Health Nursing*, 19, 268-277.
- Crowe, M., & Carlyle, D. (2007). Mental health nursing research: the contemporary context. *International Journal of Mental Health Nursing*, 16(365-370).
- Cunningham, C. (2000). A Framework for addressing Māori knowledge in research, science and Technology. *Pacific Health Dialog*, 7(1), 62-69.
- D'Arcy, P. (2008). *Peoples of the Pacific. The history of oceania to 1870*. Hampshire: Ashgate Publishing Limited.
- Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE Handbook of Qualitative Reserach* (4th ed.). Los Angeles: SAGE Publications.
- DeSouza, R. (2006). Sailing in a new direction: multicultural mental health in New Zealand. *Australian e-Journal for the Advancement of Mental Health*, 5(2).
- DeVries, M., Müller, N., Möller, H.-J., & Saugstad, L. (2008). Emil Kraepelin's legacy: systematic clinical observation and the categorical classification of psychiatric diseases. *European Archives of Psychiatry & Clinical Neuroscience*, 258, 1-2. doi: 10.1007/s00406-008-2000-7

- Djuretic, T., Crawford, M. J., & Weaver, T. D. (2007). Role of qualitative research to inform design of epidemiological studies: a cohort study of mental health of migrants from former Yugoslavia. *Journal of Mental Health, 16*(6), 743-755.
- Durie, M. (1998). *Whaiora Māori Health Development. New Zealand*. Oxford: Oxford University Press.
- Durie, M. (2007). Counselling Maori: Marae encounters as a basis for understanding and building relationships. *New Zealand Journal of Counselling, 27*(1), 1-8.
- Durie, M., & Kingi, T. K. R. (1997). *A Framework for Measuring Maori Mental Health Outcomes. A report prepared for the Ministry of Health*. Palmerston North.: Department of Maori Studies, Massey University.
- Dwyer, S. C., & Buckle, J. L. (2009). The space between: on being an insider-outsider in qualitative research. *International Journal in Qualitative Methodology, 8*(1), 54-63.
- El Sendiony, M. F. M., Abou-El-Azaem, M. G. M., & Luza, F. (1977). Culture change and mental illness. . *International Journal of Social Psychiatry, 23*(1), 20-25.
- Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys. *Lancet, 359*(9306), 545.
- Fernando, S. (2010). *Mental health, race and culture* (3rd ed.): Palgrave MacMillon.
- Foliaki, S. (1997). Migration and mental health: The tongan experience. *International Journal of Mental Health, 26*(3), 36-54.
- Foliaki, S. (1999). Mental health among Tongan migrants. *Pacific Health Dialog, 6*, 288-294.
- Foliaki, S., Fakakovikaetau, T., Waqatakirewa, L., & Pearce, N. (2004). Health research in the Pacific. *Pacific Health Dialog, 11*(2), 199-203.
- Foliaki, S., Kokaua, J., Schaaf, D., & Tukuitonga, C. (2006). Twelve-month and lifetime prevalences of mental disorders and treatment contact among Pacific people in Te

- Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry*, 40(10), 924-934.
- Foliaki, S., Nosa, V., Birkenhead, S., Kanongata'a, H., & Faamoe, T. A. (2009). *Qualitative study of elderly Pacific informal caregivers of a young person with an illness or disability*. . Wellington: National Health Committee.
- Fonua, P. (2005, 22 Dec 2005). Talanoa, talking from the heart, *Matangi Tonga*.
- Fotu, M., & Tafa, T. (2009). The Popao model: a Pacific recovery and strength concept in mental health. *Pacific Health Dialog*, 15(1), 164-170.
- Fu, C., & Parahoo, K. (2008). Causes of depression: perceptions among people recovering from depression. *Journal of Advanced Nursing*, 65(1), 101-109.
- Gifford, E. G. (1923). *Tongan Place Names*. Honolulu, Hawaii: Museum.
- Gifford, E. G. (1924). Tongan myths and tales. *American Anthropologist*, 26(4), 554-558.
- Gifford, E. G. (1929). *Tongan Society*. Honolulu: Bernice P. Bishop Museum.
- Goffman, E. (1970). *Asylums. Essays on the social situation of mental patients and other inmates*. Chicago: Aldine Publishing Company.
- Gove, W. R. (1970). Societal Reaction as an Explanation of Mental Illness: An Evaluation. *American Sociological Review* 35(5), 873 - 884.
- Grann, M., Danesh, J., & Fazel, S. (2008). The association between psychiatric diagnosis and violent re-offending in adult offenders in the community. *BMC Psychiatry*, 8, 92-92. doi: 10.1186/1471-244x-8-92
- Green, E. G. T., & Deschamps, J. (2005). Variation of individualism and collectivism within and between 20 countries, a typological analysis. *Journal of Cross-Cultural Psychology* 36(3), 321-329.
- Gross, S. R., & Livingston, D. (2002). Racial profiling under attack. *Columbia Law Review*, 102(5), 1413-1438.

- Gunson, N. (1993). Understanding Polynesian traditional history. *Journal of Pacific History*, 28(2), 139.
- Gunson, N. (1997). Great families of Polynesia. *Journal of Pacific History*, 32(2), 139.
- Haasen, C., Demiralay, C., & Reimer, J. (2008). Acculturation and mental distress among Russian and Iranian migrants in Germany. . *European Psychiatry*, 23, 10-13.
- Halapua, S. (2002). *Talanoa Process: The case of Fiji*. East West Centre. Honolulu, Hawaii.
- Halapua, W. (1997). NEED TITLE. In P. Culbertson (Ed.), *Counselling Issues & South Pacific Communities*. Auckland: Snedden & Cervin Publishing Limited.
- Hau'ofa, E. (2008). Our sea of islands. In P. D'Arcy (Ed.), *Peoples of the Pacific. The history of Oceania to 1870*. Hampshire: Ashgate Publishing Limited.
- Herman, H. (2011). Promoting mental health. In D. Pilgrim, A. Rogers, & B. Pescosolido (Eds.), *The SAGE Handbook of Mental health and illness* (pp. 403-429). Los Angeles: SAGE Publications Ltd.
- Hofmann , B. (2001 ). Complexity of the concept of disease as shown through rival theoretical frameworks *Theoretical Medicine* 22, 211 – 236
- Holloway, I., & Freshwater, D. (2007). *Narrative research in nursing*. United Kingdom: Blackwell Publishing.
- Huber, M., Knottnerus, J. A., Green, L., van der Horst, H., Jadad, A. R., Kromhout, D., . . . Smid, H. (2011). How should we define? *BMJ*, 343, 235-237.
- Jensen, H., Johansson-Fua, S., Hafoka-Blake, B., & 'Ilohia, G. R. (2012). *National study on domestic violence against women in Tonga*. Kingdom of Tonga.
- Jeon, H. J., Lee, J., Lee, Y. M., Hong, J. P., Won, S., Cho, S., . . . Cho, M. J. (2010). Unplanned versus planned suicide attempters, precipitants, methods, and an association with mental disorders in a Korea-based community sample.(Report). *Journal of Affective Disorders*, 127, 274 -280. doi: 10.1016/j.jad.2010.05.027

- Ka'ili, T. O. (2008). *Tauhi Vā: Creating Beauty through the Art of Sociospatial Relations* (Doctor of Philosophy), University of Washington, Washington.
- Ka'ili, T. O. (2005). Tauhi vā: nurturing Tongan sociospatial ties in Maui and beyond. *The Contemporary Pacific*, 17(1), 83-114.
- Kaepler, A. L. (1971). Eighteenth century Tonga: new interpretations of Tongan society and material culture at the time of Captain Cook. *Man, New Series*, 6(2), 204-220.
- Kalavite, T. (2010). *Fononga 'a Falahalafononga: Tongan students' journey to academic achievement in New Zealand tertiary education.*, The University of Waikato, Hamilton.
- Kaplow, J. B., Layne, C. M., Pynoos, R. S., Judith A. Cohen, J. A., & Lieberman, A. (2012). DSM-V Diagnostic Criteria for Bereavement-Related Disorders in Children and Adolescents: Developmental Considerations. *Psychiatric* 75(3).
- Kataoka- Yahiro, M. R., Ceria, C., & Yoder, M. (2004). Grandparent caregiving role in Filipino American families. *Journal of Cultural Diversity*, 11(3).
- Kavaliku, S. L. (2007). *Pasifika Leadership: an issue of quality and relevance.* Auckland: Massey University.
- Kelly, B. D. (2005). Structural violence and schizophrenia. *Social Science and Medicine*, 61, 721-730.
- King, A. (2002). *The Pacific Health and Disability Action Plan.* Wellington: Ministry of Health.
- Kokaua, J., Schaaf, D., Wells, J. E., & Foliaki, S. A. (2009). Twelve-month prevalence, severity, and treatment contact of mental disorders in New Zealand born and migrant Pacific participants in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Pacific Health Dialog*, 15(1), 9-17.

- Laing, P., & Mitaera, J. (1994). Samoan and Cook Islanders' perspectives on health. In J. Spicer, A. Trlin, & J. A. Walton (Eds.), *Social dimensions of health and disease: New Zealand perspectives*. Palmerston North: Dunmore Press.
- Lakeman, R. (2009). Ethics and nursing. In P. Barker (Ed.), *Psychiatric and mental health nursing. The craft of caring*. London: Hodder Arnold.
- Lasalo, P. (1999). 'Lolo Mai' syndrome. *Pacific Health Dialog*, 6(2), 259-260.
- Latu, M. (2009). *Talanoa: a contribution to the teaching and learning of Tongan primary school children in New Zealand*. (Master of Education), Auckland University of Technology, Auckland.
- Latu, P. (2011). *Fakaongo and tau'ataina: the influences of the Tongan traditional religion, the European civilization and Wesleyan teachings on the formation of Tongan religious identities* (Master of Philosophy), Massey University, Auckland.
- Lātūkefu, S. (2008). The case of the Wesleyan Mission in Tonga. In P. D'Arcy (Ed.), (pp. 340-428). Hampshire: Ashgate Publishing.
- Leotta, G. (2013). *Cultural competency scoping project. Final report*. NSW Government: Family & Community Services. Ageing, disability & home care.
- Loewenthal, K. (2007). *Religion, culture and mental health*. Cambridge: Cambridge University Press.
- Loftin, C., Hartin, V., Branson, M., & Reyes, H. (2013). Measures of cultural competence in nurses: an integrative review. *The Scientific World Journal*, 2013, 1-10.
- Lui, D. (2007). Spiritual Injury: A Samoan perspective on spirituality's impact on mental health. In P. Culbertson, M. Agee, & C. O. Makasiale (Eds.), *Penina Uliuli: Contemporary Challenges in Mental Health for Pacific Peoples* (pp. 66-76). Honolulu: University of Hawaii Press.

- Macpherson, C., & Macpherson, L. (Eds.). (1990). *Samoan Medical Belief and Practice*. .  
Auckland: Auckland University Press.
- Mafi, G. H. (1999). Mental dis-ease in a Tongan general practice. *Pacific Health Dialog*,  
6(2), 196-198.
- Māhina, O. (1992). *The Tongan Traditional History Tala e Fonua: A Vernacular Ecology-  
Centred Historico-Cultural Concept*. (PhD), Australian National University,  
Australia.
- Māhina, O. (2002a). 'Atamai, fakakaukau and vale: 'mind', 'thinking' and 'mental illness' in  
Tonga. *Pacific health dialog : a publication of the Pacific Basin Officers Training  
Program and the Fiji School of Medicine*, 9(2), 303-308.
- Māhina, O. (2002b). *Psychoanalysis and Tongan poetry: Their investigative, aesthetic and  
therapeutic value*.
- Māhina, O. (2008). From Vale, Ignorance, to 'Ilo, Knowledge, To Poto, Skill, The Tongan  
Theory Of Ako, Education: Theorizing Old Problems Anew. *AlterNative(Special)*, 67-  
96.
- Māhina, O., Māhina, A. N., & Māhina, M. (2007). Tongans at the University of Auckland: A  
cause for celebrations. In O. Mahina, N. Seve-Williams, A. Faaiuasoo, & D. Hosking  
(Eds.), *Atea, Moana and Vanua: Voices from the Brown Edge*. Auckland: Langiatea  
Moana Press.
- Māhina, O., & Potauaine, S. (2010). Tatau: A ta-va (Time-Space) Transformation. In O.  
Māhina, J. Dudding, & K. Māhina-Tuai (Eds.), *Tatau: Fenapasi ó e fepaki*. Auckland:  
LRS Publishing.
- Makoul, G., Clayman, M. L., Lynch, E. B., & Thompson, J. A. (2009). Four Concepts of  
Health in America: Results of National Surveys. *Journal of Health Communication*,  
14(1), 3-14. doi: 10.1080/10810730802592213



- Malo, V. (2000). *Pacific people in New Zealand talk about their experiences with mental illness*. Wellington: Mental Health Commission.
- Manu'atu, L. (2000). *Tuli Ke Ma'u Hono Ngaahi Mālie: Pedagogical possibilities for Tongan students in New Zealand secondary schooling*. (PhD), University of Auckland, Auckland.
- Marcus, G. E. (1980). Role distance in conversations between Tongan nobles and their 'people'. *Journal of Polynesian Society*, 89(4), 435-454.
- Marshall, C., & Rossman, G. C. (2011). *Designing qualitative research* (5th ed.). California: SAGE.
- Marshall, R. D., Spitzer, R., & Liebowitz, M. R. (1999). Review and critique of the new DSM-IV diagnosis of Acute Stress Disorder. *American Journal of Psychiatry*, 156, 1677 - 1685.
- Mason, J. (Ed.). (2002). *Qualitative Research* (2nd ed.). London: SAGE Publications Ltd.
- McFall-McCaffery, J. (2010). *Getting started with Pacific research: finding resources and information on Pacific research models and methodologies*. MAI Review, Library Workshop 8. University of Auckland. Auckland.
- McGrath, B. B., & Ka'ili, T. O. (2010). Creating project talanoa: a culturally based community health program for U.S. Pacific Islander adolescents. *Public Health Nursing*, 27(1), 17-24.
- McLaughlin, H. (2009). What's in a name: 'client', 'patient', 'customer', 'expert by experience', 'service user'- what's next? *British Journal of Social Work*, 39, 1101-1117.
- Mental Health Commission. (1998a). *Blueprint for Mental Health Services in New Zealand. How things need to be*. Wellington: Mental Health Commission.

- Mental Health Commission. (1998b). *A travel guide - for people on the journeys toward equality respect and rights for people who experience mental illness*. Mental Health Commission. Wellington.
- Mental Health Commission. (2011). *Measuring social inclusion for people with mental illness*. Wellington: Mental Health Commission.
- Mental Health Commission. (2012). *Blueprint II. Improving mental health and wellbeing for all New Zealanders*. . Wellington: Mental Health Commission.
- Mental Health Commission. (2013). Like minds, like mine. Whakaitia te whakawhiu i te tangata. from <http://www.likeminds.org.nz/>
- Mila-Schaaf, K. (2010). *Polycultural capital and the Pasifika second generation: negotiating identities in diasporic spaces*. Massey University, Auckland.
- Mila-Schaaf, K., & Hudson, M. (2009a). The interface between cultural understandings: negotiating new spaces for Pacific mental health. *Pacific Health Dialog*, 15(1), 113-119.
- Mila-Schaaf, K., & Hudson, M. (2009b). *Negotiating Space For Indigenous Theorising In Pacific Mental Health And Addictions*. Auckland: Le Va: Te Pou.
- Mila-Schaaf, K., Robinson, E., Schaaf, D., Denny, S., & Watson, P. (2008). *A Health Profile of Pacific Youth: Findings of Youth2000. A National Secondary School Youth Health Survey*. Auckland, NZ: The University of Auckland.
- Miles, M. B., & Huberman, A. M. (1994). *An extended sourcebook. Qualitative data analysis*. (2nd ed.). California: SAGE Publications Inc.
- Ministry of Health. (1994). *Looking forward: strategic directions for the mental health services*. Wellington: Ministry of Health.
- Ministry of Health. (1997). *Moving forward: the national mental health plan for more and better services*. Wellington: Ministry of Health.

- Ministry of Health. (2005). *Te Orau Ora. Pacific Mental Health Profile*. . Wellington: Ministry of Health.
- Ministry of Health. (2007). *Like minds, like mine*. Wellington: Ministry of Health.
- Ministry of Health. (2008). *Let's get real: real skills for people working in mental health*. Wellington: Ministry of Health.
- Ministry of Health. (2010a). *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010-2014*. Wellington: Ministry of Health.
- Ministry of Health. (2010b). *Let's get real. Real skills for people working in mental health and addiction. Implementation plan*. Wellington: Ministry of Health.
- Ministry of Justice. (2000). *Pacific peoples' constitution report*. Wellington: Ministry of Justice.
- Ministry of Pacific Island Affairs. (2006). *Pacific analysis framework 2006 with Pacific consultation guidelines. Analysing public policy through Pacific lenses*. Wellington: Ministry of Pacific Island Affairs.
- Ministry of Pacific Island Affairs. (2008). *Briefing to the Incoming Minister of Pacific Island Affairs*. Wellington.
- Ministry of Pacific Island Affairs. (2009). *Auckland Pacific Strategy*. Wellington: Ministry of Pacific Island Affairs.
- Ministry of Social Development. (2008). *Diverse communities - exploring the migrant and refugee experience in New Zealand*. Ministry of Social Development.
- Ministry of Social Development. (2012). *Fofola e fala kae talanoa e kāinga; a Tongan conceptual framework for the prevention of and intervention in family violence in New Zealand*. Ministry of Social Development.
- Mitias, M., & Al-Jasmi, A. (2004). Intercultural dialogue. *Dialogue and Universalism*, 3(4), 143-161.

- Mladovsky, P. (2009). A framework for analysing migrant health policies in Europe. *Health Policy, 93*, 55-63.
- Moa, B. S. (2011). *Langi Royal Tombs: The beginning of Tu'i Tonga Architecture* (Master of Architecture), University of Auckland Auckland.
- Möller, H. (2009). Development of DSM-V and ICD-11: Tendencies and potential of new classifications in psychiatry at the current state of knowledge. *Psychiatry and Clinical Neurosciences, 63*, 595-612.
- Myers, F., McCollam, A., & Woodham, A. (2005). *National programme for improving mental health and well-being. Addressing mental health inequalities in Scotland. Equal Minds*. Edinburgh.
- Myers, G., & Macnaghten, P. (1999). Can focus groups be analysed as talk? In J. Kitzinger, & R. S. Barbour (Eds.), *Developing focus group research: politics, theory and practice*. London: SAGE Publications Ltd.
- Nazroo, J., & Iley, K. (2011). Ethnicity, race and mental disorder in the UK. In D. Pilgrim, A. Rogers, & B. Pescosolido (Eds.), *The SAGE Handbook of mental health and illness* (pp. 80-102). Los Angeles: SAGE.
- Nursing Council of New Zealand. (2012a). *Code of conduct for nurses*. Wellington: Nursing Council of New Zealand.
- Nursing Council of New Zealand. (2012b). *Guidelines. Professional boundaries*. Wellington: Nursing Council of New Zealand.
- O'Hagan, M. (2001). *Recovery competencies for New Zealand Mental Health Workers*. Wellington: Mental Health Commission.
- O'Hagan, M. (2002). *Living well*. Mental Health Commission.

- O'Hagan, M. (2009). Recovery article for mental health today. from [http://www.maryohagan.com/resources/Text\\_Files/Recovery%20for%20Mental%20Health%20Today.pdf](http://www.maryohagan.com/resources/Text_Files/Recovery%20for%20Mental%20Health%20Today.pdf)
- Oakley-Browne, M. A., Wells, J. E., & Scott, K. M. (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.
- Office of the Deputy Prime Minister. (2004). *Mental Health and Social Exclusion*. London: Social Exclusion Unit.
- Otsuka, S. (2006). *Talanoa Research: culturally appropriate research design in Fiji*. Paper presented at the *International education research conference*, University of Sydney.
- Palm, U., & Möller, H.-J. (2011). Reception of Kraepelin's ideas 1900-1960. *Psychiatry and Clinical Neurosciences*, 65(4), 318-325. doi: 10.1111/j.1440-1819.2011.02226.x
- Peace, R., Kell, S., Pere, L., Marshall, K., & Ballantyne, S. (2002). *Mental Health and Independent Housing Needs*. Wellington: Ministry of Social Development.
- Perry, B., & Pescosolido, B. (2011). Children, culture and mental illness: public knowledge and stigma toward childhood problems. In D. Pilgrim, A. Rogers, & B. Pescosolido (Eds.), *The SAGE Handbook of mental health and illness* (pp. 202 - 217). Los Angeles: SAGE.
- Peterson, D. (2007). *I haven't told them, they haven't asked. The employment experiences of people with experience of mental illness literature review*. Auckland: Mental Health Foundation of New Zealand.
- Pilgrim, D., Rogers, A., & Pescosolido, B. (2011). *The SAGE Handbook of Mental health and illness*. London: SAGE Publications Ltd.
- Poltorak, M. (2007). Nemesis, speaking, and tauhi vaha'a: interdisciplinarity and the truth of "mental illness" in Vava'u, Tonga *The Contemporary Pacific*, 19(1), 1-36.

- Poltorak, M. (2010). 'Traditional' healers, speaking and motivation in Vava'u, Tonga: explaining syncretism and addressing health policy. *Oceania*, 80(1), 1-23.
- Poltorak, M. (2012). The efficacy and self-efficacy of treatment. *Medical Anthropology Quarterly*, 27(2), 272-291.
- Potauaine, S. (2010). *Tectonic of the Fale: Four Dimensional, Three Divisional*. (Master of Architecture), University of Auckland, Auckland.
- Potauaine, S., & Māhina, O. (2010). *Loto inside, tu'a outside, and fale house: a ta va time-space theorising*.
- Potter, R. B., & Phillips, J. (2006). Mad dogs and transnational migrants? Bajan-Brit second-generation migrants and accusations of madness. *Annals of the Association of American Geographers*, 96(3), 586-600.
- Prescott, S. M., & Hooper, K. C. (2009). Commons and anti-commons: Tongan business experiences in New Zealand. *Pacific Accounting Review*, 21(3), 286-303.
- Puloka, M. H. (1998). A commonsense perspective on Tongan folk healing. *International Journal of Mental Health*, 26(3), 69-93.
- Puloka, M. H. (1999). 'Avanga: Tongan concepts of mental illness. *Pacific Health Dialogue*, 6(2).
- Rabe, M. (2003). Revisiting 'insiders' and 'outsiders' as social researchers. *African Sociological Review*, 7(2), 149-161.
- Ramsden, I. M. (1990). *Kawa whakaruruhau : cultural safety in nursing education in Aotearoa*. Wellington: Ministry of Education.
- Read, J. (2004). The intervention of 'schizophrenia'. In J. Read, L. R. Mosher, & R. P. Bentall (Eds.), *Models of Madness* (pp. 21-34). New York: Brunner-Routledge.
- Richardson, F. I. (2010). *Cultural safety in nursing education and practice in Aotearoa New Zealand* (PhD), Massey University

- Robinson, D., & Robinson, K. (2005). *Pacific ways of talk - hui and talanoa*. Wellington, NZ: Social and civic policy institute.
- Rogers, A., & Pilgrim, D. (2011). *A Sociology of Mental Health and Mental Illness* (4th ed.). Berkshire: Open University Press.
- Rogge, B. (2011). Mental health, positive psychology and the sociology of the self. In D. Pilgrim, A. Rogers, & B. Pescosolido (Eds.), *The SAGE Handbook of Mental health and illness* (pp. 49-66). Los Angeles: SAGE Publications Ltd.
- Rognmo, K., Torvik, F. A., Ask, H., Roysamb, E., & Tambs, K. (2012). Paternal and maternal alcohol abuse and offspring mental distress in the general population: the Nord-Trøndelag health study. *BMC Public Health*, *12*(1), 448-459. doi: 10.1186/1471-2458-12-448
- Samu, K. S., & Suaalii-Sauni, T. (2009). Exploring the 'cultural' in cultural competencies in Pacific mental health. *Pacific Health Dialog*, *15*(1), 120-130.
- Scambler, G. (2011). Stigma and mental disorder. In D. Pilgrim, A. Rogers, & B. Pescosolido (Eds.), *The SAGE Handbook of mental health and illness* (pp. 218 - 238). Los Angeles: SAGE.
- Schmidt, L. R., & Frohling, H. (2000). Lay concepts of health and illness from a developmental perspective. *Psychology & Health*, *15*(2), 229-238.
- Schultz, A. (2001). Tongan Accent. *Oceanic Linguistics*, *40*(2), 307-323.
- Searles, V. B., Valley, M. A., Hedegaard, H., & Betz, M. E. (2013). Suicides in Urban and Rural Counties in the United States, 2006–2008. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*. doi: 10.1027/0227-5910/a000224
- Seimyr, L., Welles-Nyström, B., & Nissen, E. (2013). A history of mental health problems may predict maternal distress in women postpartum. *Midwifery*, *29*(2), 122-131. doi: 10.1016/j.midw.2011.11.013

- Sengall, M., Lonner, W. J., & Berry, J. W. (1998). Cross-cultural psychology as a scholarly discipline: on the flowering of culture in behavioural research *American Psychologist*, 53, 1101-1119.
- Sharma, S. (2012). Psychological distress among Australians and immigrants: Findings from the 2007 national survey of mental health and wellbeing. *Advances in Mental Health*, 10(2), 106.
- Shirres, M. P. (1992). Tapu. *The Journal of Polynesian Society*, 19(1), 29-51.
- Silverman, D. (Ed.). (2001). *Interpreting Qualitative Data. Methods for Analysing Talk, Text and Interaction*. London: SAGE Publications Ltd.
- Simpson, A. I. F., Brinded, P. M., Fairley, N., Laidlaw, T. M., & Malcolm, F. (2003). Does ethnicity affect need for mental health service among New Zealand prisoners? *Australian and New Zealand Journal of Psychiatry*, 37(6), 728-734.
- Singelis, T. M., & Brown, W. J. (1995). Culture, self, and collectivist communication. Linking culture to individual behavior. *Human Communication Research*, 21(3), 354-389.
- Smith, L. T. (1999). *Decolonizing methodologies, research and indigenous peoples* London: Zed Books Ltd.
- Solorzano, D. G. (1997). Images and words that wound: Critical race theory, racial stereotyping, and teacher education. *Teacher Education Quarterly*(Summer), 5-20.
- Spencer-Rodgers, J., & Peng, K. (2004). Dialectical Self-Esteem and East-West Differences in Psychological Well-Being. *Society for Personality and Social Psychology*, 30(11), 1416-1432.
- Statistics Department. (2008a). *Tonga 2006 Census of Population and Housing, Volume 2: Analytical Report*. Nuku'alofa: Statistics Department



- Statistics Department. (2008b). *Tonga 2006 Census of Population and Housing. Volume 1. Administrative Report and Basic Tables*. Nuku'alofa, Tonga.
- Statistics New Zealand. (2006a). *QuickStats about culture and identity 2006 Census*. Wellington: Statistic New Zealand.
- Statistics New Zealand. (2006b). *Tongan people in New Zealand*.
- Statistics New Zealand. (2008). *Cook Island Maori People*. Wellington: Statistics New Zealand.
- Statistics New Zealand. (2013). Statistics New Zealand. from <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-national-highlights/cultural-diversity.aspx>
- Statistics New Zealand and Ministry of Pacific Island Affairs. (2011). *Health and Pacific peoples in New Zealand, Pacific progress*. Wellington.
- Stillman, S., McKenzie, D., & Gibson, J. (2009). Migration and mental health: Evidence from a natural experiment. *Journal of Health Economics*, 28(3), 677-687.
- Suaalii-Sauni, T., Wheeler, A., Saafi, E., Robinson, G., Agnew, F., Warren, H., . . . Hingano, T. (2009). Exploration of Pacific perspectives of Pacific models of mental health service delivery in New Zealand. *Pacific Health Dialog*, 15(1), 18-27.
- Szasz, T. (1971). *The Manufacture of Madness. A comparative study of the inquisition and the mental health movement*. London: Roulledge & Kegan Paul.
- Tamasese, K., Peteru, C., Waldegrave, C., & Bush, A. ( 2005). Ole Taeafo Afua, the new morning: a qualitative investigation into Samoan perspectives on mental health and culturally appropriate services. *Australian and New Zealand Journal of Psychiatry*, 39(4), 300 - 309.

- Tau'akipulu, L. B. J. (2000). *Individualism and community: a case study of Tongan identity in Aotearoa New Zealand and its social and political implications*. (Masters thesis), University of Auckland, Auckland.
- Taufatofua, P. (2011). *Sub-regional office for the Pacific Islands TCP/TON/3302 Migration, remittance and development Tonga*. Food and Agriculture Organization of the United Nation.
- Taumoeofolau, M. (2012). Tongans - Migration. *Te Ara - the Encyclopedia of New Zealand*. <http://www.TeAra.govt.nz/en/tongans/page-1>
- Te Pou o Te Whakaaro Nui. (2007). *Seitapu Pacific Mental Health and Addiction Cultural and Clinical Competencies framework, The National Centre of mental Health Research and Workforce Development*. Auckland.
- Te Pou o Te Whakaaro Nui. (2010). *Talking therapies for Pasifika peoples; best and promising practice guide for mental health and addiction services*. Auckland: Te Pou o Te Whakaaro Nui.
- Tee, S., Brown, J., & Carpenter, D. (2012). *Handbook of Mental Health Nursing*. London: Hodder Arnold.
- Thaman, K. H. (2004). Tauhi vaha'a: a possible foundation for peace and inter-cultural understandings,. *Intercultural Education*(Summer), 32-36.
- Thomlinson, E., McDonagh, M. K., Crooks, K. B., & Lees, M. (2004). Health beliefs of rural Canadians: Implications for practice. *Australian Journal of Rural Health*, 12(6), 258-263. doi: 10.1111/j.1440-1854.2004.00627.x
- Tiatia, J. (2003). *Reasons to live: N.Z. born Samoan young people's responses to suicidal behaviours*. (Doctoral Thesis), University of Auckland, Auckland.

- Tiatia, J. (2007). New Zealand-born Samoan young people young people, suicidal behaviors, and the positive impact of spirituality In P. Culbertson, M. Agee, & C. O. Makasiale (Eds.), *Penina Uliuli: Contemporary challenges in mental health for Pacific peoples* (pp. 94-104). Honolulu: University of Hawaii Press.
- Tiatia, J. (2012). Commentary on 'Cultural Diversity Across the Pacific': Samoan Cultural Constructs of Emotion, New Zealand-Born Samoan Youth Suicidal Behaviours, and Culturally Competent Human Services. *Journal of Pacific Rim Psychology*.
- Toafa, V. M., Moata'ane, L., & Guthrie, B. E. (1999). Belief and trust: health caring for migrant Tongan healers & patients in New Zealand. *Pacific Health Dialog*, 6(2), 160-167.
- Tolhurst, R., Theobald, S., Kayira, E., Ntonya, C., Kafulafula, G., Nielson, J., & van den Broek, N. (2008). 'I don't want all my babies to go to the grave': perceptions of preterm birth in South Malawi. *Midwifery*, 24, 83-98.
- Toluta'u, T. K. (2008). *Talanoa: matala 'o e fonua*. (Master of Art & Design (Graphic Design)), Auckland University of Auckland, Auckland.
- Triandis, H. C., Bontempo, R., & Villareal, M. J. (1988). Individualism and Collectivism: Cross-Cultural Perspectives on Self-Ingroup Relationships. *Journal of Personality and Social Psychology*, 54(2), 323-338.
- Tuku'aho, N., Taumoefolau, M., Kaeppler, A. L., & Wood-Ellem, E. (2004). *Songs and poems of Queen Salote*. Tonga: Vava'u Press.
- Vaioleti, T. M. (2006). Talanoa research methodology: a developing position on Pacific research. *Waikato Journal of Education*, 12.
- Vaioleti, T. M. (2011). *Talanoa, manulua and founa ako: frameworks for using enduring Tongan educational ideas for education in Aoteaora/ New Zealand*. (PhD), University of Waikato, Hamilton, New Zealand.

- Vaka, S., Stewart, M., Foliaki, S., & Tu'itahi, M. (2009). Walking Apart But Towards the Same Goal? The View and Practices of Tongan Traditional Healers and Western-Trained Tongan Mental Health Staff. *Pacific Health Dialogue*, 15(1), 89-95.
- Vaka'uta, N. (2009). Tālanga: theorizing a Tongan mode of interpretation. *AlterNative*, 5(1), 126-139.
- Walker, R., & Sonn, C. (2010). Working as a culturally competent mental health practitioner. In N. Purdie, P. Dudgeon, & R. Walker (Eds.), *Working Together : Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Canberra: Australian Institute of Health and Welfare.
- Walliman, N. (2006). *Social research methods*. London: SAGE Publications.
- Warelow, P., & Holmes, C. (2011). Deconstructing the DSM-IV-TR: a critical perspective. *International Journal of Mental Health Nursing*, 20, 383-391.
- Wepa, D. (2009). *Cultural safety in Aotearoa New Zealand*. North Shore 0632: Pearson Education New Zealand.
- Williams, N. (2009). *A view from the back, times between spaces: equality of educational opportunity and Pacific students at a university*. University of Auckland, Auckland.
- Wilson, D., & Neville, S. (2009). Culturally safe research with vulnerable populations. *Contemporary Nurse*, 33(1), 69-79.
- Wilson, S. (2008). *Research is ceremony. Indigenous research methods* Canada: Fernwood Publishing.
- Wolcott, H. F. (2001). *Writing up qualitative research* (2nd ed.). London: SAGE Publications.
- Wood-Ellem, E. (1999). *Queen Salote of Tonga. The story of an era 1900 - 1965*. Honolulu: University of Hawaii.

World Health Organization. (1946). *Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference* New York.

World Health Organization. (2001). *The world health report: new understanding, new hope*.

Young, G. (2010). The DSM-5 draft: critique and recommendations. *Psychological Injury and law*, 3(4), 320 - 322.

# Appendices

## Appendix I: Massey Human Ethics Approval



**MASSEY UNIVERSITY**  
ALBANY

1 December 2009

Sione Vaka  
c/- Associate-Professor A Huntington  
College of Humanities and Social Sciences  
Massey University  
Wellington

Dear Sione

**HUMAN ETHICS APPROVAL APPLICATION – MUHECN 09/043**

**“An exploration of the meaning of mental illness for Tongan people born in NZ and Tongan people immigrating to NZ from Tonga”**

Thank you for your application. It has been fully considered, and approved by the Massey University Human Ethics Committee: Northern.

Approval is for three years. If this project has not been completed within three years from the date of this letter, a reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Dr Denise Wilson  
Chair  
Human Ethics Committee: Northern

cc: Associate-Professor A Huntington  
College of Humanities and Social Sciences

Te Kunenga  
ki Pūrehuroa

**Office of the Assistant to the Vice-Chancellor (Research Ethics)**  
Private Bag 102 904, North Shore City 0745, Auckland, New Zealand Telephone +64 9 414 0800 ex 9539  
humanethicsnorth@massey.ac.nz

## Appendix II: Confidentiality Agreement for Intermediary Person

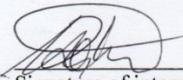


**Project Title:** *An exploration of the meaning of mental illness for Tongan people born in New Zealand and Tongan people immigrating to New Zealand from Tonga.*

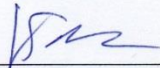
### CONFIDENTIALITY AGREEMENT FOR INTERMEDIARY PERSON

I, Manu Fotu [name of intermediary person], agree to assist  
Sione Vaka [name of researcher], with this study by  
the intermediary person [list research tasks]. I agree that I  
will:

1. keep all research information shared with me confidential by not discussing or sharing the information in any form or format (e.g., disks, tapes, transcripts) with anyone other than the primary investigator of this study;
2. give all research information in any form or format (e.g., disks, tapes, transcripts) to the researcher when I have completed the research tasks;
3. erase or destroy all research information in any form or format that is not returnable to the researcher upon completion of the research tasks.
4. not disclose the identity of any participants.

  
\_\_\_\_\_  
Signature of intermediary person

2/06/2010  
Date

  
\_\_\_\_\_  
Signature of researcher

02/06/2010  
Date

## **Appendix III: Information Sheet**

### **III.a Information Sheet**

#### **Researcher(s) Introduction**

My name is Sione Vaka and I am doing research to explore the meanings of mental illness for Tongan people born in New Zealand and Tongan people immigrating to New Zealand from Tonga. I am a student at Massey University and this research contributes to completion of my Doctor of Philosophy (PhD).

#### **Project Description and Invitation**

This research project will help Tongan people with mental illness. The purpose of this research is to explore the meanings of mental illness for Tongan people. The result of this study will show some Tongan definitions of mental illness. This will help in caring for Tongans and Pacific people with mental illness. This will also be valuable information for health providers, policy makers and funders in health care services.

I would like to invite you to take part in this research. Your participation is entirely voluntary (your choice). You do not have to take part in this study. If you do agree to take part, you are free to withdraw from the study at anytime, without having to give a reason. It is also important to note that you would not be able to withdraw any information you shared in the focus group. To help you make your decision, please read this information sheet.

#### **Participant Identification and Recruitment**

- Tongan people who live in Auckland
- Aged over 18
- There will be approximately 8 groups and the number of people in each group will vary from 5-12.

#### **Project Procedures & Data Management**

If you decide to take part, then you will be part of a group of Tongans to talk about mental illness. These conversations will be recorded on audiotape and will be transcribed after the discussions. The information collected from the recorded audiotape and the transcribing materials will be analysed. Our conversation will take about an hour and a half to complete. Confidentiality will be maintained throughout this research project. Your identity will be protected by using pseudonyms. All the information for this research project will only be available to me and my supervisors, Associate Professor Annette Huntington, Dr 'Okusi Mahina and Dr Petula Brannelly. Any other persons that may access this information will sign a Confidentiality Agreement before accessing this information. This



information will be stored in a locked cabinet at the School of Health and Social Services, Massey University, Albany Campus.

### **Participant's Rights**

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study at anytime;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

### **Project Contacts**

If you have any queries about this study, please feel free to contact:

Researcher: Sione Vaka  
Phone: Work: (09) 968 8000 ext 8321  
Mobile: (021) 130 8283

Supervisor: Associate Professor Annette Huntington  
Phone: Work (04) 801 5799 ext 6315

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application MUHECN 09/043. If you have any concerns about the conduct of this research, please contact Dr Denise Wilson, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x9070, email [humanethicsnorth@massey.ac.nz](mailto:humanethicsnorth@massey.ac.nz).

## III.b Information Sheet - Tongan

### PEPA FAKAMATALA

#### Fakafe'iloaki 'o e tokotaha fakatotolo pe fekumi

Ko hoku hingoa ko Sione Vaka pea 'oku ou fai ha fekumi ki he 'uhinga 'o e puke faka'atamai ki he kakai Tonga fanau'i 'i Nu'usila ni, pea mo e kakai Tonga folau mai mei Tonga ki Nu'usila ni. 'Oku ou lolotonga ako 'i he 'apiako 'Univesiti 'o Massey. 'Oku kau 'a e fekumi ni ki hono fakakakato 'a e fiema'u fakaako ki si'oku ki'i mata'itohi Toketa Filosefa pe ko e PhD.

#### Fakamatala ki he fakatotolo pe ko e fekumi, pea mo e fakaafe

'E tokoni 'a e fekumi ni ki he kakai Tonga 'oku puke faka'atamai. 'Oku taumu'a 'a e fekumi ni ke fakatotolo 'a e 'uhinga 'o e puke faka'atamai ki he kakai Tonga. 'E ma'u mei he fekumi ni ha ngaahi 'uhinga faka-Tonga 'o e puke faka'atamai. 'E tokoni lahi eni ki hono tokanga'i 'a e kakai Tonga mo e Pasifiki 'oku puke faka'atamai.

'Oku ou fakaafe'i atu ko e ke ke kau mai ki he fekumi ni. 'Oku tau'ataina pe ke ke kau 'i he fekumi ni pe 'ikai, 'i ho'o fili tau'ataina pe 'a'au. Kapau te ke loto ke ke kau 'i he fekumi ni, 'oku malava pe ke ke nofo 'i ha fa'ahinga taimi pe 'o ka fiema'u, pea 'ikai fiema'u ha 'uhinga pe fakamatala ki ho'o nofo. 'E tokoni atu 'a e ki'i pepa ni ki ha'o fili pe te ke kau ki he fekumi ni. To'o ha taimi lahi fe'unga ke ke fakakaukau ai pe te ke kau ki he fekumi ni pe 'ikai.

#### Kakai ki he fekumi mo e founa kau ki he fekumi ni.

- Kakai Tonga 'oku nofo 'i 'Okalani
- Ta'u motu'a lahi hake he ta'u 18
- 'E fakafuofua ki he kulupu 'e 8 'o meimei 'i he toko 5-12 'i he kulupu

#### Ko e ngaahi ouau 'o e fekumi, pea mo hono founa tokanga'i 'o e naunau mei he fekumi

Kapau te ke fili ke ke kau ki he fekumi ni. Te ke kau ai ki ha kulupu kakai Tonga 'oku nau talanoa fekau'aki mo e puke faka'atamai. 'E hiki tepi'i 'a e ngaahi talanoa ni pea toki hiki ki ha pepa 'i he hili ko ia 'a e talanoa. 'E toki 'analaiso 'a e ngaahi fakamatala mei he ngaahi talanoa ni. 'E fakafuofua ki he houa 'e taha mo e konga 'a e loloa 'o fepotalanoa'aki ko eni. 'E malu'i 'a e ngaahi fakamatala ko eni 'o 'ikai to e 'ilo ki ai ha taha mei au mo 'eku kau supavaisa pe faiako, Palōfesa Annette Huntington, Toketa 'Okusi Mahina mo Toketa Petula Brannelly. 'E ngāue'aki ha ngaahi hingoa fakatenetene 'o malu'i'aki ho hingoa totonu. Kuo pau ke fakamo'oni 'i ha aleapau ha fa'ahinga tokotaha pe te ne fiema'u ke ne 'ilo ki he ngaahi fakamatala fekau'aki mo e fekumi ni. 'E loka'i 'a e ngaahi fakamatala ni



## **Appendix IV: Consent Forms**

### **IV.a Consent Form**

I have read the Information Sheet and have had the details of Sione Vaka's study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I AGREE /DO NOT AGREE (please circle one) to the interview being sound recorded.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name - printed**

.....

## IV.b Consent Form – Tongan

### PEPA FAKANGOFUA KE KAU 'I HE FEKUMI

Kuo u 'osi lau 'a e Pepa Fakamatala pea fakamatala mai mo e ako fakatotolo 'oku fai 'e Sione Vaka.  
Kuo tali mai 'a 'eku ngaahi tāla'a pea kuo u fiemalie peau mahino'i 'a e ako ni. 'Oku ou 'ilo teu lava 'o  
'eke fehu'i ha fa'ahinga taimi pe.

Kuo u LOTO / 'IKAI KEU LOTO (kātaki 'o siakale'i ha taha 'oku ke loto ki ai) ke hiki tep'i 'a 'eku  
talanoa

Kuo u loto keu kau 'i he fekumi/fakatotolo ko eni 'o fakatatau ki he ngaahi fakamatala kuo 'omai 'I he  
Pepa Fakamatala.

**Fakamo'oni:**

**'Aho:**

**Hingoa      Kakato**  
**(mata'itohi lalahi)**

## **IV.c Focus group participant consent form**

I have read the Information Sheet and have had the details of Sione Vaka's study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree not to disclose anything discussed in the Focus Group.

I agree to participate in this study under the conditions set out in the Information Sheet.

**Signature:**

**Date:**

.....

**Full Name – printed**

.....