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**TE HUI KOTAHITANGA MO TE WHAKA-ORA I ROTO I NGA  
MATAURANGA O TE MATE HINENGARO:**

**The Intergenerational Transmission of healing from the experience  
of mental illness.**

**A thesis completed in partial fulfilment of a  
Master of Philosophy in Māori Studies**

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**February 2015**

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## ABSTRACT

This thesis is based on stories and experiences of living with mental illness shared by members of my whānau to explore the research question *What healing strategies do whānau with mental illness use to find wellness?*. This topic was chosen because mental illness is intergenerational in our whānau weaving through five generations.

The aim of this research was: to collect the stories of whānau members to understand their experiences of mental illness, particularly their experiences of healing; to develop a whānau model of healing; to reduce the stigma and discrimination related to mental illness; and, finally to educate the wider whānau, hapū, iwi and community and to facilitate their own healing pathways.

A kaupapa Māori methodology that adopted a pūrākau approach was used for this research. A kaupapa Māori approach ensures that Māori culture, cultural knowledge and practices, such as pūrākau, underpin the research design and research practices. The research involved face to face interviews with four members of my whānau.

Three key themes with a series of subthemes were from the data;

1. Wellness—as understood within the context of whānau, communicating; environment, awareness, causes and trauma
2. Behaviours associated with emotional and physical responses, denial and acceptance
3. Healing as it relates to identity, support, environment, spirituality, communicating and difference.

The three themes were then used to create a whānau cycle of healing to illustrate how whānau moved from a state of unwellness to healing. Key stages of the cycle included awareness, unwellness, behaviours, denial, acceptance and healing.

What is highlighted in this thesis are the healing techniques each individual uses to maintain wellness, the similarities such as health and fitness, busyness one's belief in 'God' or spiritual other in the search for their identity as Māori an important aspect and strand in the healing steps to wellness.

Recommendations from participants were simple; get to know me, be supportive and caring, don't advise just listen, be non-judgemental, my unwellness doesn't only affect me it affects my wider whānau but most importantly they recommended just being there present made a big difference. I didn't feel alone knowing someone was there and I felt encouraged to find wellness.

On a personal level this project created a tsunami of emotions that lead to the decision to write the thesis from the heart and focus on the stories of whānau. A pūrākau and kaupapa Māori approach enabled this to happen.

## ACKNOWLEDGEMENTS

The research for this thesis has been five years in the making. The driving force behind this research has been our father, grandfather, great grandfather, great great grandfather, kaumātua and respected elder Rupene Mare. His openness to share his experiences of mental illness publically through conferences, workshops, media and television is awe inspiring opening the door to many people coming forth and declaring their own unwellness and sharing their own stories. Other whānau members also experiencing similar unwellness shared their experiences privately therefore this research will be their first public acknowledgement of their unwellness.

A barrier for the researcher was researching her own whānau and the ability to keep boundaries. It was difficult hearing the traumatic moments of a whānau member's life with a sense of helplessness and "why was I not there to help or support that whānau member during those difficult times". What came out of the research was an innate 'knowing' of each individual whānau member in a deeper and more meaningful way. The researcher felt an intense sense of obligation to ensure that if there are further experiences of unwellness for whānau participants she would 'be there' for them in whatever context that looked like.

Acknowledgements go far and wide but first to Io Matua Kore, God and tupuna who were with me during my own moments of unwellness ensuring in some way I would complete this research.

Furthermore gratitude is given to:

1. Ngāti Kuri iwi one of the researcher's five iwi who paid my fees throughout the three year journey.

2. My employer Pillars Incorporated who allowed flexibility in my hours of work to ensure I finished my research.
3. To my whānau participants who without there would not have been this research and to my immediate whānau who believed, encouraged and stood by me especially when doubt started clouding my belief to complete this thesis
4. To Margaret Forster who continued to believe that I would finish this thesis come hail or high water
5. To Massey University Ethic committee who allowed this research to be studied with all the ethical dilemmas that might be faced by the researcher.

What is important to note in this research is that the stories given by whānau participants are a tāonga given to be shared and passed down to future generations.

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## CHAPTER ONE – INTRODUCTION

### 1.1 Introduction: *Tīmata*



**Figure 1: Te Rerenga Wairua. *Whānau photo.***

This is a photograph of Te Rerenga Wairua, the leaping place of spirits, at Cape Reinga. It was from here that the spirits of the dead depart Aotearoa to return to Hawaiki. They descend by way of the root of the pōhutukawa tree. For me, this photograph represents noa, calming and cleansing. The land grounds, centres and keeps us rooted to where we belong and keeps us connected to Papatūānuku (our earth mother). The green scrub and bushes clothe Papatūānuku creating warmth,

nourishment and sustenance. The long flax pods are two; where God created man and woman together growth and change can be created, supporting, awahi, not alone, caring for each other. The small pods their offspring representing the future, vision, dreams and hope. The sun is shining Rangi (our sky father) is watching over his children reminding Papatūānuku that he will always be near.

Combining all aspects of the sea, land and air creates wholeness an identity a belonging, an oneness with Io-Matua- Kore (the supreme one). It portrays “All is well in our world”. It is a connection to our Te Ao Māori where our essence is reclaimed and our mana restored.

From one who comes from a whānau of intergenerational transmission of mental illness Te Rerenga Wairua is our essence for healing. It is the place we go to after all other steps have been completed for the final stage of our healing processes. This is where we can feel the mana and wairua of our tupuna and ancestors and all that is unwell is taken away. This is our healing place. Identifying healing places for those with mental health issues is the focus of this thesis.

## **1.2 The Focus: *Te Arotahi***

This thesis is developed out of whatumanawa (passion) and aroha (love) for my whānau who are entering the fifth generation of what is viewed in the western world as mental illness. The research involved interviewing four whānau members from three generations to explore their experiences of mental illness and remaining well to answer the question: what healing techniques do whānau living with mental illness make use of to find wellness?

Although there are various aspects to mental illness the focus of this thesis will be ‘healing’. (Harris, 2014) who researched recovery pathways for Māori women

diagnosed with bi-polar disorder argues that healing is a journey of transformation and a reclaiming of a positive sense of self and one's roles in life, rather than being a consumer in the mental health system. Healing may not always mean that people will return to full health or regain all their losses, but they may well continue to lead happy lives in spite of them (Commission, 1998)

Healing nurtures the intent to create wellness and transformation (MehI-Madrona, 2010). Māori have a distinct way of conceptualising illness and wellbeing. (Durie, 2004) asserts that the Western scientific model of disease focuses on signs and symptoms of a disorder rather than the individual's capacity to function in a dignified and meaningful manner.

### **1.3 Assumptions: *Whakapae***

There are a number of assumptions that underpin this research. First the research is about Māori, for Māori, is whānau centred and focused on abilities of whānau to engage and support each other during times of unwellness. More importantly it is about maintaining one's 'mana' (authority, control, influence, prestige, power) and 'tapu' (sacred, restricted, and forbidden) (Mead, 2003). Māori believe that mana and tapu are interconnected and inseparable.

Second my experience and worldview are important for providing an insight into this kaupapa. I am a first generation urban born Māori woman, the eldest in a blended whānau of five families consisting of twenty one brothers and sisters. I suffer from bi-polar. This is the position from which this thesis is written. I also draw on my experience of working over thirty years in social services. I have worked with many people who have suffered from some sort of unwellness. It is through these experiences that I have come to understand that we all have the solutions to our struggles and as professionals we are the key to unlocking that potential.

It is envisioned that through stories and journeys shared this thesis will contribute to whānau healing and improved understanding of mental illness without judgement and stigma. It is with forethought that this thesis will build bridges, weave understanding, open doors to forgiveness, grace and move whānau into a brighter future. It is also with optimism that this thesis will open the doors for other Māori whānau suffering in silence, allowing them to see the 'normality' in which they live. Finally to understand a state of wellness it is crucial to listen to people's stories, experiences and their journeys.

#### **1.4 Structure of Thesis: *Hanganga o te tuhinga***

Narratives are used throughout this thesis to complement the lived experiences and stories shared by whānau participants. For example this chapter began with a narrative about Te Rerenga wairua. This narrative was used to indicate to the reader the nature of Māori identity and an idealised state of wellness. Chapter two is the literature review and is a little unconventional as interview data about the lived experiences of the participants is weaved together with literature on the concept of whānau to give substance and voice to contemporary whānau realities. This style or approach fits with a kaupapa Māori perspective towards research and aligns with the notion that culture is passed down from generation to generation through stories.

The structure of each chapter is as follows;

Chapter one describes the spiritual healing place for our whānau namely Te Rerenga Wairua. In this chapter the reader is introduced to the research and the research question. There is also an explanation of why a narrative style has been adopted in the writing of this thesis.

Chapter Two is the literature review and explores the role of whānau through the eyes, experience and stories of my whānau. A key focus will be how our whānau context changed from the traditional Māori whānau setting to contemporary Māori living today as it is necessary to understand the historical experiences that have contributed to Māori disposition in society today (Harris et al, 2014). I will also explore issues related to whānau health and wellbeing in particular how unwellness developed through each whānau member's lifetime and the journey towards wellness.

Chapter Three outlines the methodology and methods used in this project. It was difficult to find a research question that had meaning and depth that would actually address the issues I wanted to explore. I finally settled on the following research question: 'What healing strategies do whānau with mental illness use to find wellness? The will be achieved through interviewing members of my whānau living with a mental illness and through their shared stories and experiences.

Chapter Four are the stories and experiences of my whānau. The healing stories of my whānau are given as a tool and learning base to assist those suffering with unwellness. It is hoped to open the doors of healing for individuals and their wider whānau.

Chapter Five identifies key themes from the whānau stories and are used to provide an understanding of intergenerational healing based on the lived experiences of my whānau. It also highlights through my whānau the similarities, differences and how each whānau member perceived their unwellness and healing process.

Chapter Six are the reflections from different generations. They give insight into their lives and what it is like living with mental unwellness diagnosed from a western

perspective. Different generations describe their experiences of being Māori, growing up in a western dominated environment and being torn between two worlds. They also describe feelings of disempowerment and having no control over their unwellness however they have each reached a point in their lives where they continue to find healing and a confidence in their identity as Māori.

### **1.5 Conclusion: *Mutungā***

It is imagined that the completion of this research will open doors to Māori and non-Māori alike, reducing the stigma and discrimination affecting those with a mental unwellness. It is hoped that our stories and lived experiences will show the normality of which unwellness is seen from their perception and the varied healing techniques they used for healing and to remain well. It also envisioned that this research may open doors for further research particularly for Māori whānau from a Māori perspective. This thesis will be a taonga for future generations.

## CHAPTER TWO – LITERATURE REVIEW

Whaowhia te kete mātauranga

*Fill the basket of knowledge*

### 2.1 Introduction: *Tīmata*

This literature review will explore the role of whānau through the eyes, experience and stories of my whānau. A key focus will be how our whānau context changed from the traditional Māori whānau setting to contemporary Māori living today. I will also explore issues related to whānau health and wellbeing in particular how unwellness developed through each whānau member's lifetime and the journey towards wellness.

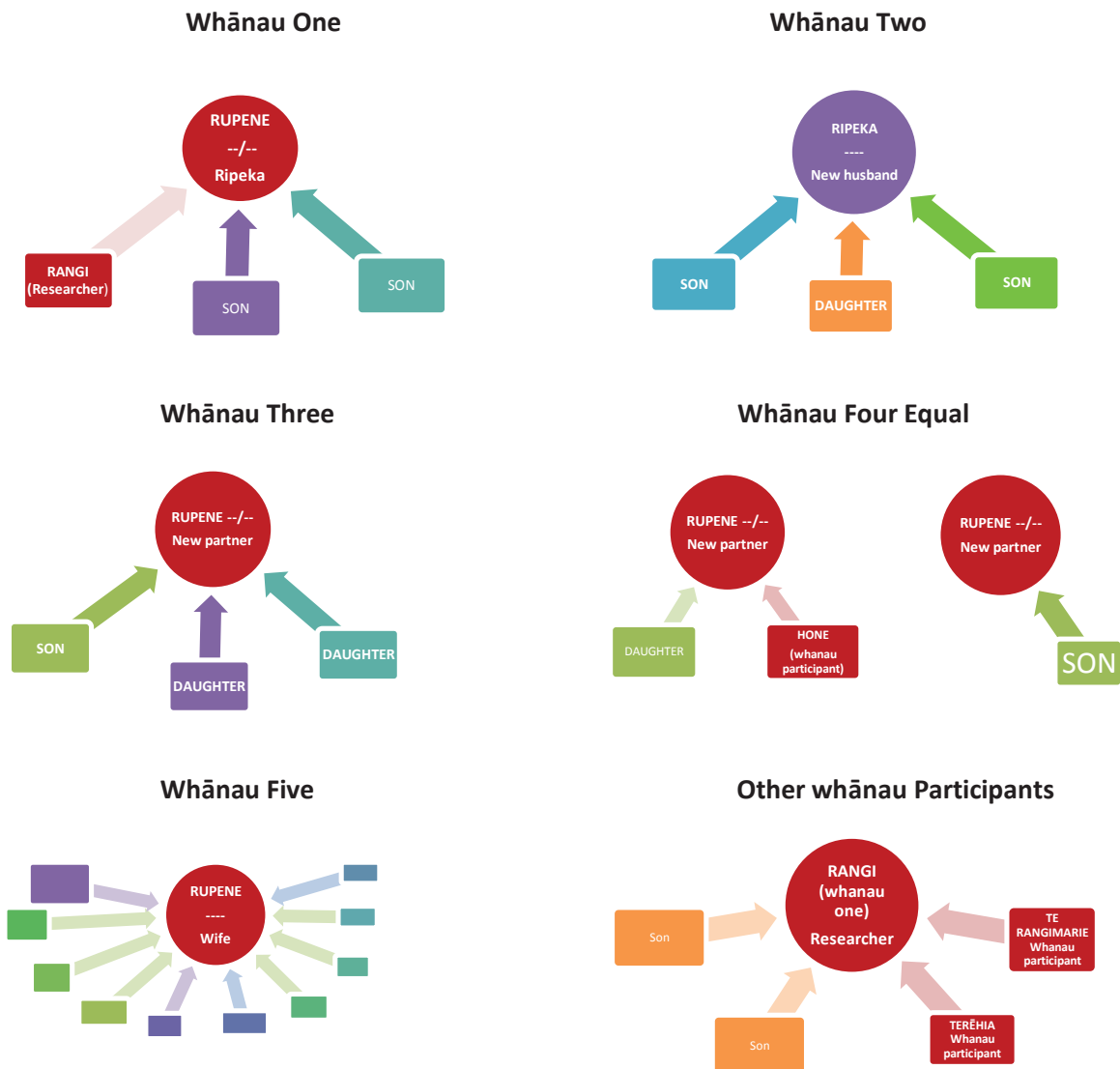
This chapter weaves together views on whānau from the literature and the lived experiences of my whānau to give substance and voice to our whānau realities. Stories, as described by (Lapsley, Nikora, & Black, 2002), are a way of understanding and communicating lived experiences as stories impose order and meaning to our lives, weaving the natural disorderliness of experiences into a fabric of personalities and events.

Whānau tell their stories to fortify their children and grandchildren, to help them cope in an increasingly material and technological world (Lee, 2009). We have to tell stories that re-enforce our identity, build our self-worth and self-esteem and empower. To enlighten the reader I have put together a chart to describe where each participant sits on the whānau tree.

This is our story.

## 2.2 Whānau

### Our Komitimiti (Blended) Whānau tree:



### 2.2.1: Traditional: *Whakapapa whānau*

I begin with the whakapapa of our whānau. Whakapapa whānau are those with shared ancestry and a common line of descent (Cunningham, 2005). What makes our whānau unique is the structure of our whānau. We are a komitimiti (blended) whānau of five families.

We are the children of Ngā Iwi o Te Hiku o Te Ika-a-Maui or Origins of the Far North Tribes also known as Muriwhenua. We are descendants of Ngāti Kuri, Te Aupouri, Ngāi Takato, Te Paatu, Te Rarawa and Ngāti Kahu. Our whakapapa whānau begins with our tupuna Alfred John Murray who came from Scotland in 1837. He married Kataraina Te Koni the daughter of a Te Rarawa chief, and together they produced thirteen children. William Piri Murray was Alfred and Kataraina's third son. William married Mereana Wahanui Kingi of Ngāti Kuri descent, producing eleven children and raising one whangāi (adopted). Our grandfather, Reihana Murray, was one of four sons to William and Mereana. Reihana married Nellie Norman with no issue. Reihana then married Raheka Kanara, producing eleven children and raising two whangāi children. Our father Rupene was born in Te Kao of Te Aupouri and Ngāti Kuri descent and is the youngest son of Reihana and Raheka Murray.

Ripeka (our mother) was also born in Te Kao but her father was of Ngāti Kahu descent and her mother was of Ngāi Takato descent. Ripeka's whakapapa goes back to Germany and Prussia but that is another story to tell. Rupene and Ripeka are related. Rupene's mother and Ripeka were first cousins. Rupene and Ripeka are whānau one and produced three children one daughter and two sons. Rupene and Ripeka are both proficient in tikanga Māori and fluent speakers in Te Reo. Both attended a native school in the far north and shared stories of being reprimanded for speaking Te Reo in addition both were raised in an environment of poverty. Rupene and Ripeka were born in an era when gum digging in the far north was how whānau survived.

Rupene fathered nine children to four blended whānau. Ripeka remarried and has six children to her two marriages. Rupene's fifth marriage brought into the whānau another ten siblings increasing our siblings to twenty two in toll. Rupene's parent's

converted to the Seventh Day Adventist religion becoming the first Māori Adventists in the far north. As a result of becoming a Seventh Day Adventist and attending a native school where he was reprimanded for speaking Te reo, Rupene's identity as being Māori was compromised resulting in Rupene not passing on the reo or tikanga to his children. It is well documented that religion and early education had an impact on the transmission of Māori knowledge and culture (William, 2001).

### **2.2.2: Urbanisation: *Tāone***

Following World War II there was an immense upheaval in Māori life as whānau migrated in ever-increasing numbers to the cities (Walker, 1990). Rupene moved to Auckland at the age of 15, shortly after the death of his mother. Rupene's older siblings and father had already relocated to Auckland for employment. Urbanisation led to the massive relocation of 80 percent of rural Māori into the cities in search of employment and with the hope of creating a better life for themselves (G. Smith, 1997). Urbanisation led to a breakdown in Māori social structures and impeded the transfer of Māori knowledge and culture. Māori were forced to change their lifestyles from the collective support of the whānau to a more 'nuclear' family (Tangaere, 1998).

It wasn't an easy transition for Rupene moving from rural to urban living. His older siblings were working and they regularly partook of alcohol as a means to relax. Rupene was not accustomed to this type of lifestyle. Rupene learnt to adjust quickly resulting in becoming involved in the same lifestyle as his older whānau members. This constant use of alcohol often led to fights with his siblings where Rupene was subject to much physical abuse. This led to Rupene finding a means to protect himself and he was drawn to body building, weight lifting and various forms of fighting. His story is told in his own words in Chapter Four.

Rupene and Ripeka moved into a Māori Affairs home in West Auckland when their children were young. Unable to sustain their marriage they separated when their eldest child was 5 years old. The marriage was fraught with alcohol and violence including adjustments to a new lifestyle away from their traditional rural upbringing. Rupene raised their three children with the support of extended whānau that had also moved to the city.

### **2.2.3: Kaupapa whānau**

Māori society became destabilised to such an extent that many Māori became alienated from their own whānau structures, values and culture (Tangaere et al 1998). This is certainly the experience for our whānau.

Hone, Terēhia and Te Rangimarie are urban born Māori and were not raised amongst their extended whānau that is their cousins, uncles and aunties due to leaving New Zealand at young ages to live in Australia.

Hone, Terēhia and Te Rangimarie had to create relationships with people outside their immediate whānau known as kaupapa whānau. Although they had members of their immediate whānau present the extended whānau context was missing. (Metge, 1995) noted increasing numbers of Māori turned for support to whānau which are kaupapa-based when denied access to whānau which are whakapapa-based, especially in urban centres.

On a whole kaupapa whānau relationships are an integral part of living away from whakapapa whānau. The key to a successful adjustment to urban life is voluntary association (Walker, 1990). The essence of Māori voluntary association is group membership with a common goal of promoting kaupapa of perpetuating Māori identity, values and culture. Walker also adds these are formed through becoming

linked to family, culture and sports clubs, family and tribal organisations, benevolent societies, Māori committees, Māori wardens, councils and the Māori Women's Welfare League. However, there can be negative connotations in forming kaupapa whānau relationships. For example, a person or group may not have the same beliefs changing the thinking and perceptions of a person with strong cultural ties.

Hone moved to Australia in his youth after the marriage breakup of his parent's. Hone chose to live with his father after the marriage breakup. Hone had to form new relationships and this started with a church group he and his father attended. Prior to the move to Australia, Hone was privy to watching his father's unwellness escalate and eventually witness his father attempt to take his life. It was through the witnessing of these incidents that Hone's unwellness possibly began.

Terēhia was born and raised in Auckland till the age of nine years then her family uprooted and moved to Sydney, Australia. Terēhia was at an age where the excitement of travelling somewhere new intrigued her yet there was also the sense of fear leaving all that she knew behind. Terēhia did not respond well to the move and this would become evident throughout her adolescence and into her womanhood. These were not good times for Terēhia and during her interview commented that she suspected this may have been where her unwellness surfaced.

Te Rangimarie was born and raised in Sydney, Australia. Te Rangimarie was raised around kapa haka as her parents were tutors. Te Rangimarie also attended a kohanga reo therefore she had some connections to her Māori World. Te Rangimarie however only had her immediate whānau support, her kaupapa whānau support and her school friends. There was an eleven year age difference between Te Rangimarie and her older sister who was not always around while she was

growing up. Te Rangimarie during her interviewing commented that she felt the impact of not having a connection to Aotearoa and although her parents were engaged in kapa haka for many years and travelled back to New Zealand on a regular basis, she still felt disconnected spiritually. It has only been since she has returned back to New Zealand to live and she is raising and educating her tamariki (children) through Te kohanga reo and Te Kura kaupapa that she is encompassing her spiritual connection to her Māori culture. Alienation from Māori cultural, social, physical and intellectual resources provides a barrier to identity (M. Durie, 2003). This is certainly a lived experience of Te Rangimarie and our whānau.

Hone, Terēhia and Te Rangimarie all did not complete their education. Hone and Terēhia were born in an era where they did not have the opportunity to attend any form of Māori education and found that mainstream education did not cater for their needs. Hone's father is a fluent Māori speaker but his mother is English therefore English was the primary language in his home. Terēhias' parents, both Māori knew the basics of Te Reo and shared what knowledge they had however Terēhia was not ready to encompass her Māori culture. It has only been since Terēhia has returned back to New Zealand to live that she has grasped her Māori identity and is thriving knowing that this also contributes to her wellness. Although Hone and Terēhia have been able to secure employment of all three whānau participants, Terēhia acknowledged in her interview that without stable employment her unwellness would worsen as this adds to her ability to keep busy an integral part of her wellness.

“Māori students are two and a half times more likely than non-Māori students to leave school with no qualifications” (Robson, 2001) furthermore “the New Zealand education system is two and a half times more likely to fail Māori students than non-Māori students”.

Hone lives where employment is scarce and although he would like to work he uses physical fitness as a form of busyness to keep him in a good headspace. Te Rangimarie is a stay at home mother and finds it very rewarding. Although she and her family struggle financially it is important for her that she be home to meet her children's needs. Te Rangimarie sees her children as her busyness and says this is what keeps her focused and well. She is planning her future that once all her children are at Te kohanga reo and Te Kura kaupapa she will look into studies or training in a bid to gain employment.

Colonisation, assimilation and urbanisation changed the Māori world view through religion and education. Although early mission schools were taught in Māori, Governor Grey in his 1847 Education Ordinance insisted that instruction be conducted in English. It was his expressed hope that the schools would take the children away from the 'demoralising influences of their villages', thereby 'speedily assimilating the Māori to the habits and usages of the European' (Walker et al, 1990).

The whānau participants in this thesis encountered changes to the forms and functions of their whānau through the processes of colonisation, assimilation and urbanisation. All whānau participants attended mainstream schooling and struggled to fit in to the schooling system. Being taught predominantly western subjects caused confusion and identity issues for whānau participants. It has been later in whānau participant's lives that they have sought their Māori cultural heritage and identity and realised the importance of being Māori.

Together Christianity and education would infiltrate the pre existing teachings, beliefs and knowledge base of whānau, hapū and iwi entrenched at the arrival of

missionaries (Penetito, 2008). Christianity achieved a rapid conversion of Māori society over the period 1814-1846 and led to further erosion of Māori culture and power (Walker et al, 1990).

We have overcome barriers, evolved and continue to be innovative to find healing first within, then ensuring that future generations know that Māori can live and thrive in contemporary and urban spaces. Our stories indicate that the concept of whānau continues to change and evolve over time and that whānau remains strong and relevant today as it was in the past. What will ensure whānau unison and strength will be how we live our lifestyles to remain healthy.

## **2.2 Māori health: *Māori Hauora***

It is difficult to understand Māori health status without understanding our colonial history (Reid & Robson, 2007). Furthermore unless we recognise colonisation as a deliberate and continuous process, it is easy to assume that colonising events are accidental, inevitable and over. We must never assume that colonisation is something confined to our past. The lived experiences of our whānau demonstrate the trauma and challenges that each member has endured because of the changes to Māori society and the move towards urban lifestyles. The results will demonstrate that the effects of these changes continue to be felt and as consequences we firmly believe are a factor in our collective struggle to maintain mental wellness.

Colonisation of Māori people is not significantly different from other indigenous peoples (Durie, et al 2003). Loss of political authority coupled with loss of resources has led to cultural alienation and loss of heart. Furthermore Durie (2003) adds colonial journeys may have led to innovation and adaption but they also created pain and suffering from which full recovery has yet to occur.

Today, Māori mental health is an area of high priority as although mental health varies across ethnic groups Māori and Pacific adults continue to have higher rates of psychological distress than other adults, with one in ten being affected (Health, 2013). Māori have poorer health and more unmet need for health care with higher rates of most health conditions and statistics continuing to show a decline in Māori health and mental health (Health, et al 2013). A strong determinant of mental health is socioeconomic position. Unfortunately Māori are disproportionately represented with one in every three to four people in deciles<sup>1</sup> nine to ten (Baxter, 2008). Māori therefore bear a disproportionate burden of risk for ill health. Economic and social impacts on whānau as a consequence of our colonial past and the current recessions collide to produce a situation where a reality for many is that poor health is severe and intergenerational (Lawson, 2010). The impact on whānau is seen in job losses, food security, and poor mental health and housing statistics, and is heard in the voices of the whānau affected by job closure, articulating the personal impact, the feelings of hopelessness and despair. These impacts are present in my whānau journeys and although the disparities have not been eradicated, whānau have learnt to deal with these pressures to bring themselves to a place of wellness, understanding and acceptance.

Rupene spoke often of coming from a very poor whānau. Their main source of income was from gum digging. Added extra's to survive were from growing their own gardens for vegetables, raising animals as their source of having meat, gathering food from the sea or doing extra work in the community or the exchanging of items

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<sup>1</sup>**Socio-economic decile** (also known as **Socio-economic decile band** or simply **decile**) is a widely used measure of socioeconomic status in New Zealand education, primarily used to target funding and support to more needy schools.

with your neighbours if you ran out of something. Rupene said life was hard back in the day.

Rupene also disclosed that mental illness was a normal part of his life. He could see dead people from a very young age. This conflicted with his western beliefs, in particular his religious beliefs. From a Māori world view, it was considered normal for some people to experience either auditory or visual communications from deceased relatives, or others from time to time (Hemara, 2000) . Māori society had developed systems and specialists for dealing with this reality. For example tohunga were recognised as ritual experts whose functions directly or indirectly influenced political, social and economic affairs of whānau including dealing with instances of porangi (Tau, 2009) . A tohunga performed the duty as a priest or a doctor. Rupene did not have this support available to him due to the whānau turning to Christianity.

Some mental and behavioural states experienced by Māori cannot be explained by mainstream medical classifications (BPJ, 2010). Traditional Māori explanations for poor health can be quite different from those based on western beliefs. Furthermore health professionals should be aware that these specific cultural syndromes occur in Māori. It is important that health professionals seek expert cultural assistance if these situations arise when working with Māori.

In the New Zealand health sector it is acknowledged that Māori have a different way of conceptualising health and wellbeing and this has important implications for health delivery. Te Wheke, Te Whare Tapa Wha,<sup>2</sup>Te Pae Mahutonga<sup>3</sup> are some examples

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<sup>2</sup> Te Whare Tapa Wha introduced by Mason Durie in 1982 describes the four cornerstones (or sides) of Māori health are whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health).

<sup>3</sup> Te Pae Mahutonga also developed by Mason in 1999 uses the (Southern Cross Star Constellation) bringing together elements of modern health promotion.

of models for conceptualising Māori health and delivering health services to meet the physical, spiritual, mental and environmental needs of Māori clients.

### **2.3 Conclusion: *Mutunga***

This section provides an overview of changes to the forms and function of whānau and the impact on Māori wellness.

Colonisation, assimilation and urbanisation have been key factors for the changes in Māori social structures and the deterioration of Māori health and wellbeing. The lived experiences of the whānau participating in this study provide examples of the impact of these changes on whānau realities. Despite these changes it is proposed that functioning whānau can facilitate wellness and this will be demonstrated in later chapters.

## CHAPTER THREE – METHODOLOGY

*Whāia te matauranga hei oranga mō koutou*

*Seek after learning for the sake of your wellbeing*

### **3.1 Introduction: *Tīmata***

This chapter outlines the methodology and methods used in this project. It was difficult to find a research question that had meaning and depth that would actually address the issues I wanted to explore. I finally settled on the following research question: ‘What healing strategies do whānau with mental illness use to find wellness?’

### **3.2 Theoretical Underpinnings: *Niu ariā***

What differentiates this research from others is that mental unwellness in our whānau is a normative part of our life. Such a foundation requires the development of a research approach that reflects this worldview and supports whānau aspirations for the future. A kaupapa Māori methodology that adopted a pūrākau approach was used. A kaupapa Māori approach ensures that Māori culture, cultural knowledge and practices, such as pūrākau, underpin the research design and research practices.

Pūrākau is a traditional form of Māori narrative that contains “philosophical thought, epistemological constructs, cultural codes, and worldviews that are fundamental to their identity” (Lee et al, 2009). Pūrākau therefore contain a Māori worldview. A worldview represents the distinctive way in which people make sense of their world furthermore it ties them to their environment and to one another within a framework of shared beliefs and understanding about the way in which the universe is ordered (Mikaere & Te Wāananga-o-Raukawa., 2011). Māori have a long tradition of

storytelling to help understand the world around us and appropriate ways of interacting with the environment and each other.

Māori tell stories through mihimihi, carvings, weavings, tukutuku and each mark or print made defines the moment and the story surrounding it. Stories are shared from our grandparents, parents, and whānau. Stories define our obligations, responsibilities and self-determination. Furthermore, Moana Jackson describes stories as an 'imaginary place'<sup>4</sup>Tiakina Te Pa Harakeke Symposium. An imaginary place is a place where we can contemplate how we want our future to look like; it nurtures hope.

Mehl-Madrona, a native American psychiatrist and author who specialises in storytelling, said that the sharing of stories assists us in developing empathy by helping us to see the world from another's perspective (Mehl-Madrona, 2010). Furthermore he adds that stories enhance our creativity and help us to think beyond the here and now. Mehl-Madrona (2010) also argues that everything is story, including our identities, us, our meanings and purposes, our theories about the world. This has implications for wellbeing with Mehl-Madrona (2010) acknowledging that cultural ceremonies as part of the story are important to open the doorway for spirits to enter the ordinary world, to fix and heal people.

Māori tell story through whakapapa. I was reminded of this when I attended the 'Tiakina Te Pa Harakeke: Māori Childrearing Symposium, the conference explored pūrākau (story telling) as a process in life, where changes can be developed and learning evolved. Keynote speaker Moana Jackson described whakapapa as 'mokopuna' and argued that if we had no mokopuna we would have no whakapapa,

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<sup>4</sup> 'Tiakina Te Pa Harakeke: Māori Childrearing in the context of Whānau ora Symposium on the 10<sup>th</sup>-11 February 2014 at the Waikato-Tainui College for Research & Development, Ngaruawāhia.' <http://whānauoraresearch.co.nz/events/>

and it is through whakapapa that stories evolve and are passed down through the generations.

The stories shared in this research were all told with love and build on the tradition of pūrākau. Participant stories and journeys give insight into their personal lives and who they are as individuals. Their stories show their vulnerability but more importantly their strength and courage and how they continue to overcome their unwellness. The stories told by my whānau are their experiences of how they have lived with a western diagnosed illness for much of their lives yet from a Māori perspective they saw the unwellness as a normal process in life, one that everyone experiences during difficult times of their lives. Given the strong focus in this thesis on stories I have also chosen to adopt a pūrākau approach to telling my research journey and writing the thesis.

### **3.3 Kaupapa Māori Research: *Rangahau Māori***

Kaupapa Māori research is related to being Māori and is grounded in Māori worldview, philosophy and practices (Smith, 1997). Adoption of a pūrākau approach in this research acknowledges Māori culture as a way of knowing and understanding. An important feature of Kaupapa Māori research is practices and outputs that empower, that will have positive outcomes for Māori (L. T. Smith, 1999). This research collects participant's stories about living with mental unwellness to enhance understanding of our realities and assist others in this situation. All participants are of Māori descent including the researcher. Some participants, although not fluent in Te Reo or Tikanga Māori know their whakapapa and where they come from. That alone was not the only reason to use a kaupapa Māori approach. Kaupapa Māori was chosen as it acknowledges how participants viewed their world and their unwellness. Although diagnosed from a western perspective all participants concluded that the

road to wellness commenced with acknowledging and searching for their identity in a Māori world they never knew. For some participants it meant moving back to their tūrangawaewae and for others although surrounded with snippets of their Māori culture it was not of relevance until unwellness occurred.

There were a number of kaupapa Māori processes used in this research. A brief summary is provided here and more detail given later in the chapter. Kōrero through whānaungatanga was a feature of the research processes.

There was over two years of nurturing 'manaakitanga' through formal and informal gatherings with whānau before a point was reached where all participants were ready to commit to the project. The researcher and the participants all believed in the research topic and that their stories were important for their own healing and that of future generations.

Tika and Pono were important aspects to engagement between researcher and the whānau participants. This meant being transparent and communicative constantly with participants involved. The principles of tika to mean 'right' or 'correct' and pono to mean 'true' or 'genuine' (Mead, 2003).

Maintaining the 'mana' and 'wairua' of each person participating in this research was imperative to ensure that no harm would come to them. This was achieved through the participants knowing that they had control over the interviews and that at any time the interviews could be ceased. They had support people present of their choosing and there were support agencies available with contact details should they need professional support or advice. Kaumātua and Kuia within the whānau were also available to support the participants. Also, the researcher was in constant dialogue with participants ensuring all participants were aware of the research intent

and all information was true, genuine and relevant to the research. Participants were in control of their stories and there were several drafts sent through to them ensuring that the stories were true and in the context they wished to see it written.

Tikanga were a regular feature of the research process. For example, karakia was a normal part of the process and used in many situations such as before and after the interviews and during informal whānau gatherings. Karakia in this whānau is a normal valued part of their daily rituals. Also, the researcher blessed and cleansed herself with water known as 'noa' regularly to maintain balance and clarity as she journeyed with the whānau through their story telling to aid in the emotions that were shared and felt.

### **3.4 The Research Plan: *Rangahau mahere***

Qualitative research approaches have been used for this research. Qualitative research was required for this research as whānau participants wanted to share their stories and lived experiences that could only be justified through kanohi kite kanohi (face to face) interviews. The research involved interviewing four members of my whānau living with a mental illness to explore how healing has been achieved and maintained.

A pūrākau approach has been used in writing this thesis to give substance to the stories lived, shared and told by whānau participants.

### **3.5 Ethics Process: *Matatika tukanga***

An <sup>5</sup>Ethics application was submitted to the Massey University Ethics committee before any research was undertaken. Completing the application provided an

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<sup>5</sup> Massey Ethics Application form: Appendices 2. Page 77-89

opportunity to identify ethical issues that would be raised by the research and to identify strategies for addressing these issues. Two key ethical issues needed to be resolved before research could begin. I was interviewing whānau members all of whom lived with mental illness. I needed to ensure my role as researcher and whānau member was distinct and that there was minimal risk of the research process triggering unwellness. Participation had implications for wider whānau who are connected to the whānau participants. Key ethical issues of concern were being identified in their connection to whānau members with unwellness. It was important to discuss this research in-depth and raise awareness of the implications for future generations if this research was not to go ahead. Examples of implications were the continuation of stigma and discrimination, stereotyping, disconnection from whānau and isolation. Cultural implications were also another factor in that diagnosis of a mental illness would come more from a western perspective than to be seen from a Māori perspective. Extended whānau soon realised that the stories and experiences shared would create another healing process not only for the whānau participant but for whānau, hapū, iwi overall. Any extended whānau member's mentioned in this research their name has been changed for confidentiality. Extended whānau of the participants were very supportive of this kaupapa and were informed like whānau participants of how confidentiality although not finite would be an integral part of this research.

### **3.6 Research with Whānau: *Whānau Rangahau***

The researcher is a bipolar sufferer, and it is this personal and whānau knowledge that has driven the interest in this topic. This insider knowledge has enabled an understanding and compassion for what whānau members participating in this research have experienced.

The idea to research this topic came about through formal and informal whānau gatherings. The eldest participant and kaumātua for the whānau expressed the importance of whānau members with an unwellness to share their experiences and how their stories might support others, more importantly mokopuna that may present with similar experiences in the future.

Following further whānau discussions on wellness (including mental wellness), the researcher in consultation with her kaumātua developed a pilot study for an assignment in a Massey University Postgraduate Diploma in Whānau Development programme. This led to presentations at conferences, e.g. “Like Minds Like Mine” and to Health providers in the far north. The presentations shared at the Like Minds Like Mine and health services hui were case studies on our whānau. Photographs of whānau participants highlighted the reality of unwellness to those so close to home. Extended whānau and health providers in the far north were taken back by the honesty, openness of our whānau sharing their unwellness. It brought many people to tears and feedback was that this is our whānau too. Others commented that it takes great courage for a whānau to come out openly and talk about their unwellness. It was these comments that motivated the researcher and her kaumātua to kōrero on taking this kaupapa further with other whānau members.

It highlighted the need to research whānau further in depth in particular Māori whānau. It was necessary to share lived experiences rather than be shamed from having unwellness especially from a Māori perspective. Support therefore was greatly received from the whānau and far north community.

The researcher while designing the research process was in constant kōrero with her kaumātua and kuia discussing ethical considerations. The researcher knew in her

role she had to step back from her role as a whānau member. The researcher's kaumātua did not see any ethical dilemma as he believed all processes would be followed according to tikanga.

For the researcher to continue the research project according to the Ethics Committee, building mechanisms to ensure the safety for the researcher and the whānau members was a critical part of the research design. The strategies and plans were actioned to ensure the safety and wellbeing for all concerned. These will be explained in detail throughout this chapter.

### **3.7 Recruitment: *Kimi***

My whānau were supportive of this research project so finding whānau to participate was not difficult. Once whānau members were identified a <sup>6</sup>letter of participation accompanied with an <sup>7</sup>information letter outlining the research and an interview schedule was given to participants. Confirmation of their participation included contacting the researcher's supervisor via email indicating their intent to participate. This was one strategy used to ensure my position in the whānau as maatamua did not influence decisions to participate.

Whānau participants ranged from 25 years up to 75 years of age, from three generations. The participants are representative of different generations, and therefore will bring forth considerable knowledge and healing through their personal journeys including any exploration of historical similarities or differences. It was my kaumātua who recommended this approach.

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<sup>6</sup> Letter of participation form: Appendices 7: Page 94

<sup>7</sup> Information Sheet: Appendices 3: Page 90

All whānau participants have given permission to use their real names however I have chosen to use their Māori equivalent identity so as to give some form of confidentiality. Our kaumātua insisted that his real name be used. The researcher discussed in depth with whānau participants and their immediate whānau the repercussions that might flow from using their real names however they were still approved with this to continue.

Whānau participant names except the kaumātua have been changed to protect their integrity however it is likely that extended whānau members may recognise participants. Whānau participants still gave permission for this research to go ahead with the likelihood that they may be recognised.

I was fortunate to have a balance of genders to participate with ages that varied. Some participants were rural living in the far north and others lived in urban Auckland.

Two whānau participants' asked if their partners could sit in on the interviewing process. They explained that having their partner sit in on the interviews would manaaki (care), tautoko (support) and awhi (comfort) them should any parts of the interviews become too emotional for them. They also felt that it would give their partners insight into learning more about them as a person, their unwellness and how their perceptions contribute to their unwellness or wellness. In conversation with the researcher's lecturer that a <sup>8</sup>Support Person Confidentiality Agreement was formulated highlighting privacy and confidentiality to support person's according to Massey University Code of Ethics privacy and confidentiality clause.

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<sup>8</sup> Support Person Confidentiality Agreement Form: Appendices 6. Page 93

### **3.8 Interviews: *Uiuinga***

It was envisioned that interviews would take approximately two to three hours to complete. The researcher formulated a <sup>9</sup>set of sample questions that all whānau participants were asked. These questions formulated topics the researcher hoped to cover in the research. The questionnaire topics were to draw attention to the following themes; ‘unwellness’, ‘feelings’, ‘perceptions’, ‘triggers’, ‘healing strategies’ and ‘whānau awareness’.

Before the interviewing process commenced, participants were sent an Information sheet highlighting the purpose of the research a letter of Participation and a list of questions. The participants were given a month to go through the Information sheet and questionnaire and respond if there were any concerns. If there was no response the researcher would follow up with a phone call or meeting to arrange interview dates and times.

Before each interview commenced the research went through the Information Sheet that was sent to participants, the <sup>10</sup>Participant Consent Form; <sup>11</sup>Authority for the Release of Transcripts Form and Support Person Confidentiality Agreement Form. All forms were signed before commencement of interviews. Given the personal and emotion nature of the kaupapa and the potential for revisiting challenging moments in people’s lives it was necessary to develop a series of strategies for supporting and caring for whānau and in terms of universal ethics and minimising harm to participants. The researcher compiled a list of professional services from each area where the whānau participants resided. The participants were made aware of this

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<sup>9</sup> Sample questionnaire: Appendices 1. Page 78

<sup>10</sup> Participant consent form: Appendices 4. Page 91

<sup>11</sup> Authority for the Release of Transcripts Form: Appendices 5. Page 92

and were offered access to these service's should it be required. The researcher also had a support person, including access to her supervisor, if deemed necessary. The support person was my husband. He is a Māori speaker and respected by all whānau participants of this research. Permission was sought from whānau participants for him to be present.

Each interview commenced with a karakia followed by a mihi to acknowledge the whānau member and their support person. Kawa or Ture (rules) were discussed in conjunction with the whānau participant and their support person to ensure a safe space to kōrero without disruption or distraction. All interviews were recorded with a Dictaphone, with the permission of the whānau members. Whānau members were given all the time needed to answer the questions and could cease the interview at any time. Karakia also closed the interviews. There were varied moments of emotions ranging from tears to moments of sadness, frustration, anger and where necessary interviews were stopped while participants and the researcher gathered themselves. Once this was achieved the interviews recommenced. Other strategies used were tea breaks and the researcher intermittently asked participants if they were doing okay or needed to take a break.

As the researcher it was important to identify boundaries for ethical and professional reasons. The researcher is a member of the whānau, being a daughter, sister and mother to whānau participants. The researcher also, as already outlined, suffers from bipolar and manages her unwellness.

The researcher made herself 'noa' by cleansing herself with water before commencing and concluding all interviews. The researcher was able to debrief with husband, kaumātua and kūia and had open access to contact her research lecturer.

A cup of tea was provided at the conclusion of all interviews providing time and space for whānau participants to debrief and to calm any emotions that emerged during the interview process. Māori define cup of tea or any other form of drink as a form of 'noa' or cleansing.

### **3.9 Data Analysis: *Tātari raraunga***

Once all the interviews were completed, transcribed drafts and copies of pūrākau provided in the following chapter were sent off to whānau participants for checking to ensure the stories were written in their words. It was important that the stories articulated their voice and experience.

The transcripts were analysed thematically. Thematic analysis is a widely-used qualitative analytical method used within psychology to analyse qualitative data (Braun & Clarke, 2006). Thematic analysis is the search for themes or patterns, and in relation to different epistemological and ontological positions.

Each interview was coded and emerging themes identified. Commonalities and differences were also emphasised. The data was used to develop a whānau healing cycle which will be explained more detail in chapter five.

### **3.10 Conclusion: *Mutungā***

As a novice researcher the methodology process and planning for this research topic was lengthy and timely yet provided much insight into the western and Māori perceptions of research and storytelling.

The methodology was kept as close to kaupapa Māori practice as practicable for the researcher who although not fluent in te reo has a basic knowledge of tikanga Māori. The methodology was kept "tika" and "pono" to ensure that the stories told would be read as if the whānau participants were talking their stories to the reader. The

researcher at all times kept in contact with her kaumātua to ensure validity and correctness and to ensure that the 'mana' of all participants remained intact.

## CHAPTER FOUR – WHĀNAU STORIES

*Na te Whānau I whangaia i te tamaiti*

*It takes a whānau to raise a child*

### **4.1 Introduction: *Tīmata***

In this chapter my whānau share their experiences of living with a mental illness. It was in korero with whānau members over the years that this thesis came into fruition. All whānau members that have participated in this thesis agree that the sharing of their experiences would open the door to healing for other individuals and whānau. Whānau is the basic social institution of Māori society (Metge et al, 1995). It is through whānau that certain beliefs, values and norms are fostered enabling whānau members to be socialised into wider society. This certainly was the case for my whānau. The healing stories of my whānau are provided here to assist other whānau to understand mental illness in the hope that others will not suffer silently. My whānau strength, resilience and honesty are attributes that I will treasure always. The interviews were very emotional, a healing process that gave me insight into the holistic views of my whānau. Our whānau firmly believe that if mental illness was seen from a Māori perspective there would be no stigma and discrimination.

### **4.2 The Whānau: *Te whānau***

For this thesis I interviewed four whānau members from three generations ages ranging from 25 through to 74 years of age. It seemed appropriate that I support my whānau through sharing my own story of unwellness. This collection of journeys shows the breadth and fullness of this topic to our whānau. All whānau members excluding myself have been diagnosed with a mental illness and are in various stages of wellness and healing.

### **4.3 The journeys: *Te haerenga***

Following are five narratives as written and described by my whānau members. I begin with my father's story. He has endured much sorrow and sadness in his life and suffered silently and alone only deciding to share his story as our whānau grows and with the knowledge that his mokopuna may also endure some form of mental illness. My father was so passionate about his experience with mental illness that he was approached by Waka Huia TVNZ to do a documentary on his life living with a mental illness. This was televised Sunday 28<sup>th</sup> July 2013 under the heading Waka Huia profiles Rupene Mare. Magnificently televised with information condensed to a half hour program, Rupene goes into more detail in his story that follows. Stories to follow Rupene are the pōtiki of my siblings Hone, followed by my story then my eldest and youngest daughters Terēhia and Te Rangimarie, all of who suffer with a mental illness. Each story interweaves into each other showing the connectedness of each whānau member. Their courage I cannot find words to describe.

### **4.4 Rupene**

Growing up as a child in Te Kao wasn't easy for me. I was born into a very poor whānau. My upbringing wasn't easy; we lived mainly in the gum fields and moved around the far north. My parents separated when I was about five years old with my father moving to Auckland with my older siblings mainly for work. I was left at home to look after my younger sister, my mother who had suffered a stroke and an older brother who was an epileptic. We also had my nephew living with us who was closer to my age so we kind of grew up as brothers.

I was angry that we were left to fend for ourselves and I was relied on to milk the cows, look after our mother bath her give her meals, medication and watch out for

my older brother who at any time could have a seizure including ensuring my younger sister was okay. I would also go into the gum fields because this was a way of helping to get money for extra food. When my mother passed away I felt my whole world had come to a standstill. It was about this time of my life that I knew something wasn't right and perhaps even when my mental illness started.

I was fifteen years old at that time, and then I had to leave my home and move to Auckland, to live with my father and older brothers and sisters. Their lifestyle however was something I wasn't accustomed too as I had been raised by our mother as a Seventh Day Adventist and I had not been subject to the alcohol and partying lifestyle which my older siblings and my father were living. I became the run around person for everyone and when they drank too much, fights would start and I would become their punching bag.

At the age of sixteen I decided to get into body building for strength, as I was a slim built young man, and wanted to gain muscle as I thought this would help me defend myself. I was also tired of getting beatings from everyone and felt if I was strong enough then the beatings would stop.

I married my first wife who although we grew up together she had moved to Auckland with her family. We had three children, a daughter and two sons. Before too long I found myself becoming entrenched in the life of alcohol and violence. Our married life was plagued with whānau members coming and going, parties,' constant arguments and violence.

At the age of seventeen and a half I tried to take my life by drinking a purple coloured substance in the bathroom cabinet. My father and older brother took me straight to Oakley hospital. They spoke with the doctor there and left. I didn't know what was

going on or why I was here. I was never diagnosed with a mental illness but was subject to shock treatment. I soon learnt that I could either go one of two ways; I could prove to them that I didn't belong here or I could easily become one of the patients. I started picking up rubbish in the rooms, clearing dishes and sweeping floors. This was noticed by an orderly who became a friend and helped me cope with my stay at Oakley hospital. I spent two years there in Oakley hospital while my wife was looking after our children.

Before too long my first wife left and I refused to allow her to take our three children. My daughter at the time was five years old and she stepped into the role of mother not only to her younger brothers but also her father. I was in and out of relationships and other children started coming into the picture. My violence, anger and frustrations continued and were enhanced with the consumption of alcohol.

I then had a relationship and another three children, which did not work out, and she also left me taking our three children.

I became involved in a relationship with two women at one time resulting in both becoming pregnant. I was not aware at the time that both women were pregnant. To one of them I had a son who was raised by his maternal grandparents.

The other became my second wife and we had a daughter and a few years later a son. My behaviours did not diminish in fact the anger, violence increased. I did however give up drinking knowing that it was increasing my violence. Before too long my second wife had a breakdown and left me. I was still unaware of the impact my behaviours were having on other people. In a bid to try and get my wife back I attempted to take my life by shooting myself. I was not successful in my attempt and the recovery was long both mentally and physically. My eldest daughter looked after

me and when I was feeling well enough I decided to move to Australia with my son as the pain of my wife's departure was still fresh in my mind and there were too many memories that I couldn't erase.

My mental and physical recovery was very slow and I decided to totally commit my life to God. I felt the only person that could heal me would be my faith in God which had diminished over the years. This was not an easy road as I was still in the blame game blaming everyone for what I had become. It was during this time that I met my current wife who was a member of the church I was going too. I wasn't diagnosed with a mental illness till very late in life. This came about through a visit to a doctor friend and when I shared my experiences with him he told me what I had. I was on medication for a while and found it helped for a while. The call from home (New Zealand) was great and eventually my wife and I returned home.

I have done many things in my life; Mr Auckland in the nineteen sixties. I was skilful at unarmed combat resulting in training SAS soldiers. I was the first Māori to hold a publican licence to run a pub and club running the Bridge way Tavern at the bottom of Auckland city and the Peacemakers club in Symond Street, Auckland through the late sixties and early seventies. I had my own security business and was privy to being security to famous pop stars. I have owned and operated three gyms in a bid to teach people how to look after their bodies. Physical fitness has been a constant part of my life. Physical pain is nothing compared to mental pain. Physical pain I can handle but mental pain I struggle with. I am head of the bipolar support group in the far north and co-presented with my daughter in the 'Like Minds, Like Mine National Conferences for the past two years.

In 2008 I completed the Diploma Level 5 &6 for the NAEC, and the 4098 work assessment certificate, a feat I would never have thought possible due to my limited education. This has enabled me to teach adults in Tikanga something that is very dear to me as it has also been part of my healing.

2009 I was one of the founding members of the One Heart Many Lives program with Dr Lance O'Sullivan, mentoring other men in the thirty to forty year age group.

In 2010 I was asked to do a documentary on health & fitness in light of my work in the community, and other places in New Zealand, as well as teaching level 3 & 4 Health & Fitness for Te Wananga o Aotearoa. This enabled me to motivate Māori men to a better way of life through health.

In 2011 I graciously accepted the Queen's Services Medal for services to Kaumātua/Kūia, to the disabled & mentally unwell living in the far north.

July, 2013 saw the airing of a documentary called Waka Huia profiles Rupene Mare. The documentary focused on my journey through life living with a mental illness. This documentary was a year in the making. It consisted of my earliest experience of mental illness as a seventeen year old being left in what was called Oakley Hospital at Point Chevalier, the impact this had on my life and how it has brought me to where I am today. In the documentary I shared my experiences of shock treatment, failed suicide attempt, marriage breakdowns, drug abuse not excluding the different emotions from anger to rage, blame, guilt and the impact my unwellness had on those around me. This documentary was grasped by many people and I was often called, stopped in the street by people with similar experiences. I decided then that I wanted to share these experiences further to help others who felt ashamed to talk about their illness openly.

Following Waka Huia's documentary was another documentary by Māori television named Ngā Pari Kārangaranga, He Kuaka Marangaranga: Series one, episode 2. This was re-aired on the 28<sup>th</sup> October 2014. These documentaries were a series on kaumātua, kuia and their lived experiences within their iwi. In this documentary I shared my experience of running a gym and my passion for helping others that suffer with mental illness. I believe we can help ourselves to overcome mental illness through physical activity. My motto is strengthening the body, heals the mind.

February, 2014 saw the Waka Huia profile's Rupene Mare documentary chosen to be screened at the FIFO film festival in Papeete, Tahiti. The documentaries presented at FIFO film festival look at all aspects of Oceania and the Pacific islands: social, economic, ethnological, cultural and environmental and they should last between 15 and 90 minutes. I attended this event and was humbled to be a part of a prestige event amidst amazing people who produced documentaries on people from all over the world. I was also approached by people of different ethnicities who could relate to my experiences.

Do I see these as achievements 'No'. Not in the sense that I purposefully set out to do these things, however, I look back now and can see where I have improved my life despite having this illness. I have done what I have done plagued with mental illness struggling to survive. I have been a loner all my life not having any support or positive role models in my life. Being part of a whānau has not been a big part of my life. It has been through my children that I realise the importance of whānau and sharing the knowledge of what I have and been through so that they know that yes, there is a light at the end of the tunnel, and that this too can then be passed on down to my mokopuna. Participating in this thesis has given me the opportunity to share my stories; it is hoped that it will create healing for others.

My greatest wish before I die is that all my whānau especially those suffering with some form of unwellness come together and talk about each other's experiences. We mustn't be afraid to talk about our illness for those of us in my whānau that suffer and have accepted our unwellness; we see it as a 'normal' process in life. Everyone has moments of unwellness no matter what race or creed you are. Only through talking about it are we then able to find solutions, common sense solutions. I am also conscious of the impact our unwellness has on our partners so it is important to listen to them for they are a part of our healing and without them our healing can regress.

My greatest healing comes from God for without whom I probably wouldn't be here today. He has continued to love and forgive me unconditionally even when I have struggled to forgive myself and turned my back on him. My faith grows stronger every day.

There is a Māori word 'Po' it can be seen by some people as a derogative word. My whakaaro is this, if you split the word up 'Po' and 'Rangi'. Po is darkness and you know for those of us that suffer with a mental illness it's like being in a dark place when you hit rock bottom. Rangi is the sky the light of day. Therefore 'Po' for us is coming from out of the darkness into the light.

#### **4.5 Hone**

I was born in Auckland the pōtiki (youngest) to an older sister. Our family situation was confusing for me growing up as our father had children in other relationships and I struggled to come to terms with older brothers and sisters who were not from the same parents. My father is Māori and my mother is English having immigrated to New Zealand in her youth. I always felt that I was different growing up and I saw

unpleasant things happen in our family. My father was a violent man and my mother was subject to this. My sister and I were subject to seeing and hearing the arguments and fights constantly. I spent my early childhood living in Auckland then we moved up to Te Kao to live. I don't know whether the move up north was to make our home life better but that is where my father is from. We lived in a caravan at an uncle's place then lived in a double garage on our land that dad converted into a cottage while we awaited our house to be built.

Shortly after the move into our house my parents separated. It was not a pleasant situation as my mother had a nervous breakdown and my father tried to shoot himself through the separation. My mother and father never got back together again resulting in my sister living with our mother and I living with my father. I was 12 at the time and I witnessed my father try to hang himself, this, I feel, was the starting point of my unwellness. My father's recovery after trying to take his life was lengthy and resulted in us moving to Sydney, Australia to live. My father was soon in another relationship. I also found myself in a relationship. This relationship resulted in the birth of my eldest daughter however the relationship did not last. I felt as though my family and extended family didn't support me though my decisions (whether good or bad), I felt as though I was a disappointment to them as they weren't there for me when I needed them. I was soon on a whirlwind to destruction.

I was soon in another relationship where I found myself doing exactly what my father subjected my mother, sister and I too. I was subjecting my new partner and children to arguments and fights and violence. I was drinking excessively and experimenting with drugs. I was also self-harming cutting my arms, wrists. I found I was not only harming my family but extended whānau. This relationship resulted in three children, a daughter who was born Down syndrome and two sons. It became too much for my

partner and she eventually moved to Queensland by her family to raise our children. I felt that my family and extended family didn't understand me; they didn't try to understand. I felt like they looked down on me and made me feel that I didn't deserve what I had worked hard for. My life continued to spiral out of control and I got into trouble with the law and I went into several Australian prisons. My anger fuelled as I longed to see my children, but was unable too. Thankfully my father and his new wife visited me for support and companionship.

My father soon moved back to New Zealand with his new wife. I decided to move back too. I knew if I went back to New Zealand I would never be allowed back into Australia and I was leaving behind all my children including my eldest daughter who was also living in Australia with her mother. This was a very hard decision for me.

My return to New Zealand was not plain sailing and I continued to be out of control, it was at this time that I went under the mental health system and was diagnosed with bipolar. I loved helping people through fitness and trying to live healthy. It was here that I got a torn meniscus. Doctors misdiagnosed me and I became bedridden as the swelling poisoned my body and I could not move. I developed a physical sickness called Polyarthritis. I often fell into very deep depressed states. I soon realised who cared about me, who my true friends were. Several times I wanted to commit suicide; several times I wanted to hurt those that hurt me (including my family). I was alone yet in a household of 4 and surrounded by extended family. The pain was unbearable as my mobility became next to nothing (dressing, walking, sitting, and eating). My road to recovery has been an arduous journey but I feel it has somewhat aided me in my wellness, knowing that I have the strength to carry on and know that I am worthy. I feel I have been given a second chance in life.

I am happily married to someone who supports my unwellness and I have a new son that for the first time I can be around to watch grow up. My son inspires me to be well and to do my best for him. I am a grandfather now with four grandchildren however they live in Australia and I don't get to see them as often as I would like. Technology however is a wonderful thing and I am able to keep in touch with them through social network or Skype.

What helps my recovery is helping others and you would be surprised at the amount of people who suffer with some form of unwellness. I share my own experiences and tell them 'you can't be happy without being sad' it's like 'yin and yang', 'positive and negative'. I also like to karakia each day with my father that helps me through the day.

I love physical pain as it pushes me through the mental pain. I work out every day to keep my body fit and mobile. I have abstained from alcohol and drugs knowing the impact it has on my body my mind and my family. I'm in a good place right now.

#### **4.6 Rangī**

I am the maatamua (first born) of a blended whānau of twenty two brothers and sisters. I am a first generation urban Māori. My parents and grandparent were part of the urban migration during the 1940's. At the age of 3 years our parents moved into a new Māori Affairs home in West Auckland after spending a period of time living with extended whānau members. Shortly after the move into our new home our parents' marriage ended. I was five, my brother's 4 and 18 months old. I took on the role as mother to my two younger brothers and our father.

As other women came into our father's life more children were born and I was relied upon to take care of them, so most of my life was looking after children perhaps a

reason why today I have an affinity for children and have worked in the social services for thirty years. One of my father's women took her frustrations out on me and I endured many a years of beatings, being locked out of the house, not given food and being told that I was no good and would come to nothing. This was upon reflection when my unwellness started coming to fruition. Eventually this relationship broke down and my brother's and I were moved once again between whānau members.

We had a lot of interaction with extended whānau being moved around. I remember these times however lonely with fond memories for many of the uncles and aunties have since passed away. Our mother was intermittent in our lives as she had started a new whānau but where possible holiday's times were spent with her.

Schooling was erratic coming and going to different schools and shortly after commencing fifth form I left school against my father's wishes. I did enjoy school however with all that was going on at home it was not deemed a priority. Education however has been a big part of my life since with my greatest educational achievement to date being the completion of this thesis. I would never have dreamed I would go to University in my fifties for five years.

While being of Māori descent we were not subject to Māori things in our lives for our father believed that it was of no importance or value to us and learning Māori would do us no good in the future. We were later to find out that this was his way of protecting us from the impact colonisation had affected him going to a native school and the chastising they received for speaking Māori in school. Our father spoke often of the chastising for speaking Te Reo in school and he had experienced the dark

side of Māoridom therefore he was adamant that his children would not be exposed to this for fear of reprisal.

Our paternal grandfather played a big part in my life; he was a devout Seventh Day Adventist having given up his tainted ways and his vision was to expose as many of his children, grandchildren and great grandchildren to God teachings. We were raised as strict Seventh Day Adventist's and it is through this that my faith in God is still strong today and like other members of my whānau have found solace and comfort knowing that he is always there for us. God has been a great healer in my life.

At the age of thirteen I started experimenting with alcohol and cigarettes that was to remain a large part of my life.

At the age of fourteen I was raped, my first sexual experience. It took me many years to come to terms with what had happened. This trauma shadowed the early years of my marriage for I blamed myself for what had happened.

Although meeting my husband at the age of thirteen we did not become involved till at the age of fifteen when he asked me to marry him. I married at the age of 16 years; this was my escape from what was happening at home. We grew up subjected to a lot of violence, neglect and abuse in various forms.

I had our first child at the age of sixteen again at seventeen. While I was mothering our children my husband was working hard and drinking excessively leaving me to raise our children alone. I had our third child at the age of twenty two. By the age of twenty I was having intermittent dark episodes of depression to the point of suicide. My husband and I were able to buy our own home before I was twenty one. Shortly

after we moved into our new home my husband was hit by a car with head injuries and was unable to work. This put pressure on me to work full time or we would lose our home. It took my husband over a year to recover and eventually go back to work.

Although I had given up drinking while carrying both our son's I took it up with a vengeance during the pregnancy of our first daughter. I loved physical sports; I found it stimulating both in the mental and physical sense however there was always alcohol to follow. It probably didn't help that our parents, aunties and uncles all drank so it became an accepted part of our lifestyle.

Alcohol encompassed with unwellness does not mix and my emotions were everywhere. There seemed to be a void that could not be filled so I drank more thinking it would fill my void. The constant consuming of alcohol affected my boys who were subject to watching and listening to constant fighting between their father and I; I knew I had to make some changes. Playing sports was great but there was always a function where alcohol would be present so I decided to give up playing sports. I decided to join a kapa haka group and it was at this point that the void was filled. It was like a calmness had overcome me and I realised the importance of being Māori. It was at this point that I continued into various aspects of Māori learning against my kaumātua/Kūia wishes including my father.

In the early eighties my father tried to kill himself through the breakup of his marriage. This was not the first time I had seen my father try to take his life. I uplifted my children and moved back to Te Kao to look after him. This was really hard on our family as my husband remained in Auckland to work to keep us all. He would travel up north fortnightly to bring us food, I missed him terribly.

In the late 1980's we uplifted our whānau and moved to Sydney, Australia. There were many reasons for this move; a lifestyle change and growth for my husband and I. Our life change did not happen immediately and we fell back into the alcohol trap. I also fell pregnant for this was something I was not prepared for. This sent me into a tailspin however our second daughter was born; our fourth child who in many ways was the calm that we needed.

Shortly after the birth of our fourth child my husband was laid off work and because of his age found it difficult to find work. We decided that I would find full time and my husband would stay home, look after our daughter and be a housemother. He used this time to become involved with starting up a kohanga reo and getting involved with kapa haka and other Māori activities for our children to retain their Māoriness. It was not easy however living off one income and raising four children but we managed.

I have worked my entire life to provide a better lifestyle for my whānau however this may have impacted on our children not having me around. I was able to conceal my unwellness with busyness. Busyness enabled me to not think about my unwellness but there were many occasions that I worked so much that I crashed into darkness with exhaustion and tiredness bringing on my unwellness. These were not pleasant times and each time I became unwell my husband through lack of understanding my illness, instead of supporting me he would go into isolation for fear of making me worse. This in many ways lengthened the recovery.

In 2003 our eldest daughter suffering with deep depression handed over her three boys to us to look after. Our youngest daughter at the time was just entering high school and she struggled having her nephews living with us. We were a point of looking at returning back to New Zealand. The move was postponed in a bid to give

our grandson's parents time to reconcile or go separate ways. This time was very difficult trying to meet everyone's needs was physically and emotionally draining. We had three grandsons suffering trauma from the separation of their parents; our youngest daughter was feeling like she had lost her parents at a time she needed us the most; a son who was traumatised by the loss of his one and only child and a daughter who through giving up her sons had entered another relationship on the boundary was suffering a mental breakdown including our sons wife who was going through an unwellness of her own. I felt I had to be superwoman to cope with all that was going on; I could not afford to show any weaknesses for there was too much at stake.

In 2005 my husband and I returned back to New Zealand to live with three grandchildren in tow. The need to move back to Te Kao where my tupuna had come from was strong and there was a sense of needing to be accepted back by my whānau, hapū, iwi. I also felt that this would be a wonderful healing process for our mokopuna and self. It was during this time that I realised how unwell I had been and had accepted it as a normal part of my life.

For many years I had been taking a natural product called St John's Wart to help me through the anxious times. My husband called these my 'happy pills' saying that while on these tablets I was bearable to be around. By taking these tablets before the onset of my unwellness it stopped me from hitting rock bottom.

I believe that due to being involved in Māori activities most of my life, karakia has been an important aspect of my life coupled with whakanoa or cleansing with water these have been healing qualities for me. I have had the privilege to be mentored by a Kūia from Tainui who came into my life in my early forties. She influenced and

sealed everything Māori for me. She was a matakite and has since passed away. Her teachings reinforced the importance of one's mana and how easy it can be damaged. Mana is our birth right and is the essence of who we are. Nurtured right creates powerful changes.

Although not formally diagnosed with a mental illness my father a diagnosed bipolar sufferer has always commented to me that I had the same as he, meaning I had a mental illness similar to his. Not totally understanding his meaning I would go into denial. I accepted my unwellness late in life; understand the triggers that might set my unwellness in motion and have many strategies that help me remain well. I feel blessed to be where I am today with such a loving and supportive whānau. For those that do not understand us and many don't we have been judged, discriminated against all in the name of ignorance? What our whānau is saying by sharing our stories and experiences is that we are normal and everyone has moments of unwellness.

#### **4.7 Terēhia**

I am thirty five years old a mother of three sons.' I became a grandmother November 5th 2013. I am the third child in a whānau of four children. I have two older brothers and a younger sister. Both my parents are Māori. At the age of nine years our whānau moved to Sydney, Australia to live. It was about this time in my life that I felt something wasn't quite right. I felt different in the sense of belonging. My schooling was erratic and I never really settled down. My problems started at high school where I was bullied and through this truanted school and started experimenting in drugs and alcohol. I was about 14 years old. My parents eventually pulled me out of school having exhausted all avenues to keep me there. My parents were involved in starting up a Māori pre-school which started in a garage in our back yard. The

garage became too small and they searched for other avenues eventually they were given a prefab building on the grounds of a Primary school. As I was legally supposed to be attending school my parents in consultation with the school decided it was best for me to remain at home where they could keep an eye on me. My parents decided that I would use my time wisely and I was to attend Kohanga reo with my youngest sister who was attending at the time. My work in the kohanga was varied but it helped to settle me down. My parents were heavily involved in Māori community so Māori activities were a big part of our upbringing.

I stayed helping out at the kohanga reo until I turned 15 years then I wanted to work and earn my own money. My first job was making furniture. I loved working and having my own independence it was also where I met my children's father. He was of Philippine descent and with his brother we all worked in the same factory. They had limited English skills but I soon learnt to understand them and in turn taught them how to speak English. Before too long James and I were in a relationship and I was pregnant with our first son. It was a sad pregnancy as James was not ready to be a father and denied it was his child. Throughout my pregnancy I saw little of my baby's father and started to delve into depression. I was fortunate to be still living with my parents who were my greatest support. At the birth of my eldest son James and his family came to the hospital to see the baby. It was evident he was the father. James still would not commit to our relationship but supported our son who had breathing difficulties resulting in asthma up to the age of ten years old.

Shortly after our first son was born I fell pregnant again however my relationship with my partner was still evolving and I decided to terminate the pregnancy. It was one of the hardest decisions I have had to make in my life. At the time I felt I had made the right choice the aftermath sent me into a tail spin and I fell into deep depression. I

couldn't cope with what I had done and fell pregnant again with my second son. I berated myself for a long time and to help me overcome my inadequacies I fell back to using marijuana to deal with the pain. My mother recognised something was amiss and took me to seek medical help. It was then that I was diagnosed with bipolar. The use of marijuana was not helping my situation contrary to thinking it was.

Marijuana became a big part of my life even into the birth of my third son. My relationship although moments of happiness continued to be volatile with my partner not understanding my mental state of mind encompassed with the use of marijuana started to see me as a 'junkie'. My partners coping mechanism when things weren't going well was to walk out and leave me and the children. He would disappear for days and I never knew if he was coming back. At a time when I was feeling vulnerable I never coped with his departures and I would delve deeper and deeper into depression. I couldn't even cope with looking after our sons. I was prescribed medication by my doctor to help but I did not like the affects it had on me and often it would just make me sleep while my boys were left to fend for themselves. I actually believed that if I took pills everything would be 'okay'. I tried several times to come off the marijuana but each time a situation arose I couldn't cope and fell back to using again.

My son's suffered greatly from my depression and marijuana use fortunately my parents were always around to pick up the pieces. When our third son was two years old I decided things needed to change and separated from their father realising the problem was with me. I then hit rock bottom and again marijuana dominated my life. I was not aware that drug use could increase my mental instability.

My sons were starting to display behaviours or maybe they were already there and I didn't see them. My eldest son was becoming angry and aggressive in turn setting off his asthma. My second son started becoming withdrawn while my youngest displayed every imaginable behaviour, spitting, swearing, anger, frustration. I knew this was all a result of my own actions.

Despite my efforts in trying to assert change my children were struggling and I knew they didn't deserve to suffer at my expense so I reached out to my parents to take my boys. This was the hardest thing I have ever had to do in my life but it was the only way I knew my sons would be safe and looked after. My parents told me how courageous I was to put their wellbeing first but I felt like a failure but knew I had to get my own life back on track. Healing for me was a long journey. I found it the hardest to control my emotions which were constantly out of control and the giving up of marijuana was difficult. Like alcoholics I go day by day. I have learnt to control my emotions and I have been off any medication for some nine years now. I found it the hardest to forgive myself but found solace in God. I became a Christian through my eldest son who also found peace in God.

My eldest son married in October, 2013 and my second son although young is to become a father. I know that he will be a great father. My youngest son remains with his grandparents till such a time as he is ready to move on. My son's through all that they have prevailed are grounded sensible young men with many contributing factors to their success. Life has not been easy but each day is a blessing. My journey has been long trying to find myself but now realise that I have to trust God, and leave it in his hands.

#### **4.8 Te Rangimarie**

I am a mother of four children aged five, four, two years and I have a 6 month old. I am married to an Australian man. I was born in Sydney, Australia therefore most of my childhood was spent growing up in Australia. I did however have strong ties to New Zealand as my parents travelled home frequently. I was also raised around Māori activities going to kohanga in Sydney and participating in kapa haka groups so Māori was a big part of my life. I am also the pōtiki (youngest) of my whānau with an older sister and two older brothers. I grew up with a feeling of something not being quite right about myself but as our whānau were so active I did not go anywhere with it or stop and think any more about it.

I struggled with my mother working a lot and not having her around, which resulting in close relationships with my older siblings. Although my father was around all the time to take care of me something was still amiss. I started experimenting with drugs and alcohol at the age of twelve years. In Year eight and nine it hit a peak, when my nephews moved in to live with us full time. I struggled with my sister's children moving in with us. My unwellness came to a peak when I was told we were moving back to New Zealand.

My schooling years were good up until I went to high school where I become involved with not very positive peers. They were a big influence on me and I delved into areas that were upon reflection to start me down a path of self-destruction. I met my husband at the peak of my depression. My education suffered resulting in leaving school early. It was through this period that my unwellness surfaced with a roar.

My parents moved back to New Zealand when I was sixteen. They wanted me to return back with them but I decided to remain in Sydney with my partner and older

siblings. Prior to my parent's leaving I suffered a miscarriage. It was at this time that it fully hit me that something was terribly, terribly wrong. I was starting to hurt myself by cutting myself, punching myself in the head, throwing myself against walls. I was constantly sad and mad but didn't know why. There were even thoughts of suicide. My parents concerned for my wellbeing took me to a doctor who diagnosed me with depression and I was given antidepressants'. I did not like the affects the medication had on me. My first experience of being on antidepressants' was like being on 'crack'. I remember the first day I took my medication my husband and I was crossing the road. I couldn't see the cars they were going so fast and I had to literally get my husband to walk me across the road. My mind was just buzzing; it was like an out of body experience.

I suffered a second miscarriage when my parents moved back to New Zealand and I struggled to keep my emotions together. My older siblings were close by but it wasn't enough, they had their own lives and our closeness was growing further apart. Not having my parents to support me through this time was extremely hard and my now husband was struggling with my emotions. I then decided after my eighteenth birthday to return with my partner back to New Zealand to be by my parents.

Unbeknown at the time I was pregnant yet again. After the birth of my son I was diagnosed with Postpartum Psychosis. I was hearing voices, people talking to me, telling me bad things about myself, my husband and my son. There was a constant voice in my head making me doubt myself. My moods had been erratic since my first miscarriage and although I knew something wasn't right I refused to accept and be told something was wrong. My husband feeling helpless and useless told me I needed to seek help or he was going to leave.

When I sought medical help and was diagnosed, I felt relieved that someone understood what I was going through and that it was in a sense 'normal'. I was aware that my family knew I was unwell but to hear it from an outsider made a difference. I am not sure why. I have four beautiful children that keep me on track and I find that comforting. My husband gives me the space I need when I feel myself falling back.

Because I am a mother and wife I don't focus too much on my unwellness but what I do know is that when I feel it coming on, I need to take myself away for a short time, recoup and get on with it. I find removing myself from the situation helps but I'm also conscious that if I am away too long I can dwell on it, so I keep my time limited. If my unwellness becomes too unbearable I will seek medical help and take medication. I've had to seek medical help for numerous things including a termination and more recently after the birth of my daughter. Now that I have accepted my illness, I recognise there are small things that can set me back and there are things that can help me back to wellness. I feel more in control of what I have and have strategies that help me to maintain my wellness. My mental health is always an issue and healing is on-going but in the end it's up to me to maintain my wellness.

#### **4.9 Reflections: Whakaaroaro**

These stories are but a peek through a window of what each whānau member has endured. It by no means does justice to the depth of pain each have experienced. Listening to the korero and then writing it with each whānau member was very emotional and I shed many a tear. Whānau members that are diagnosed by western methods perceive their unwellness to be the 'norm' and are accepted as a normal part of life. Healing ourselves and learning to live with moments of unwellness is just part of the journey. These stories show the resilience and endurance of our whānau

and the strength it has taken to overcome adversity. Durie (as cited in Te Puni Kokiri, 2009a) argues that Māori endurance is about resilience in relation to time. Māori cultural endurance, like resilience, is having the capacity to respond to, cope with and persevere through adverse conditions and continuing to cope with each subsequent difficulty. Such are the journeys of our whānau.

## CHAPTER FIVE – INTERGENERATIONAL HEALING

*I te wa e māuiui ana, ko wai te whaka awhi I ahau?*

*And when I am unwell, who will be there for me*

### **5.1 Introduction: *Tīmata***

In this chapter key themes emerged from whānau stories shared in the previous chapter are identified and used to provide an understanding of intergenerational healing based on the lived experiences of my whānau. It also highlights through my whānau the similarities and differences of mental illness and how each whānau member perceived their unwellness and healing process.

The key themes that emerged while collating the whānau interviews were wellness; behaviours and healing. Enveloped under these three themes are subthemes that all interweave into each other creating the healing desired. A whānau cycle of healing also come out of the data that showed at various stages what whānau participants went through to achieve wellness and healing.

### **5.2 Wellness: *Te Oranga***

Wellness as identified by whānau participants is a journey of self discovery where participant's have accepted their unwellness, seek different strategies and incorporate the right supports to stay in a place of wellness. The subthemes under each key theme were identified as fundamental segments to a holistic approach of remaining well.

### 5.2.1 Whānau: *Te Whānau*

Māori have a distinct way of conceptualising illness and wellbeing. The western scientific model of disease focuses on the signs and symptoms of a disorder rather than the individual's capacity to function in a dignified and meaningful manner (Rossouw, 2008). A Māori model of wellbeing differs from this as it deals holistically with a person's body, mind, spirit and more importantly the role of whānau and other external supports.

Rossouw (2008) further explains that for Māori, the meaning of wellness does not mean the removal of symptoms; being well means living a meaningful life with or without symptoms. Wellness for our whānau is seen in a positive context and as highlighted by all participants' whānau is an integral part of wellness, healing and recovery.

Te Rangimarie commented '*wellness is my whānau, they keep me on track*'. She reiterated the importance of her husband, children and extended whānau and their presence during moments of unwellness. She stated they did not have to do anything but be there without judgement or stigma. She also noted that there were times when she needed to isolate herself from whānau to put her mind into perspective because she said there are times when she feels her head *is 'full of bees'* or it *feels like my mind is popping out everywhere*'. Te Rangimarie stated that whānau presence motivated her wellness and recovery. Te Rangimarie was able to identify that when her mental state of mind deteriorated so did her physical body. Te Rangimarie commented that *'just getting out of bed some days is hard and I sometimes lose my appetite to eat, but worst are times when I struggle to look after*

*my whānau. I am lucky that my mother senses my unwellness and intervenes to help till I get back on track’.*

Rupene commented that *‘wellness is about whānau support’* even though whānau supports were not present for him during his many years of unwellness. Hone commented that his new whānau gave him a second chance at life. He also acknowledged that whānau can make you feel different through not understanding mental illness. He also recognised that although whānau support is around during times of unwellness it is easy to push that help away through misunderstanding their intentions. Terēhia acknowledged the importance of whānau and spoke of how her three sons were her motivation to get well. Terēhia also confessed it was hard to ask for help from whānau and even harder to accept help when offered.

Whānau participants agreed that accepting help from extended whānau members was difficult for fear of being judged and discriminated against. They acknowledged that their own bad behaviours displayed during times of unwellness got in the way of other whānau members supporting them. Hone commented *that ‘I was hurting my whānau through my behaviours’* and that he would push away the ones he loved most because he was ashamed of his behaviours. Te Rangimarie and Hone during moments of unwellness stated that they would go into isolation and shut themselves off from whānau and the world. They felt this was the safest option at times. Te Rangimarie acknowledged that isolation for too long was not healthy and could contribute to hindering recovery or healing.

### **5.2.2 Communications: *Korero***

Whānau acknowledged the importance of communication. Lack of communication with whānau was highlighted as hindering positive whānau supports. Whānau felt it

easier to communicate when they had come to terms with their unwellness. Rupene highlighted the importance of communication by *saying 'don't be afraid to talk about your illnesses for by doing so it creates an environment where unwellness becomes accepted and seen as a normal everyday part of life'*. Rupene used his experience of mental illness to advocate on behalf of others who were whakama (shy) to speak about their illness. Whānau agreed that if mental illness was discussed more openly it would be seen as more the 'norm' than a sickness.

### **5.2.3 Environment: *Taiao***

All whānau acknowledged that their environment impacted on their wellness. Te Rangimarie noted that everyone had moments of unwellness but healing and recovery depended on the individual and their capacity to cope including surrounding supports. Rupene talked about being raised with strong Christian beliefs and moving from rural to urban living and becoming exposed to alcohol and drugs. He felt it necessary to fit into his environment by partaking of alcohol and drugs to later realise that this contributed to his unwellness. Te Rangimarie felt strongly that the negative company she kept in her teens resulted in experimenting with alcohol and drugs contributing to her unwellness. Hone said that hearing the arguments and watching the violence between his parents impacted on him and perhaps was the beginning of his own unwellness. Hone explained that although he had an older sister he often felt alone and different. Terēhia was raised in an environment where alcohol was deemed the 'norm'. It was during these times that she was introduced to 'marijuana' at a young age, this encompassed with sudden changes in her life were contributors to her unwellness.

All whānau members recognised there were negative and positive environments with negative environments hindering their wellbeing. Whānau acknowledged that to be in a good place required lifestyle changes. Positive changes were giving up alcohol and drugs, changing the company they kept and being around more positive people; exercise and good eating habits, participants said lifestyle change wasn't easy. All whānau agreed that healing and recovery is on-going.

#### **5.2.4 Awareness: *Mōhio***

Whānau members had varied degrees of awareness around their unwellness. What was common in all was that they sensed a difference about themselves as early as in their childhood.

Te Rangimarie explained it in an array of ways *'I was consciously aware that something wasn't quite right', 'I realised it wasn't a good thing', 'something was truly wrong', 'I couldn't get rid of the feeling'* and *'it just didn't seem to go away'*. Rupene likened it to *'grief and loss'* adding *'I knew there was a problem it was like unwellness in a dark place and I couldn't control it'*. Hone said *'I felt I was different and the family made me feel different', 'it was like strangeness to me'* and *'the scariest thing is thinking that I had become a different person'*. Terēhia recognised there is a problem and likened it to being on roller coaster.

Awareness was not only about recognising something was wrong. Once recognising and accepting the unwellness there is an ongoing raised awareness to monitor and maintain wellness.

### **5.2.5 Causes: *Take***

Whānau did not talk a lot about triggers yet recognised that there were situations that could set their unwellness off. Te Rangimarie felt that nothing caused her unwellness; *'it just kind of crept up on me'*. Te Rangimarie recognised that depending on her state of mind she could be doing the same thing every day but one day I wouldn't be happy and this could be what sets everything in motion. Te Rangimarie said *'what I think is what I feel'*. Hone commented that it depended on how I felt about myself and the environment I am in at the time. *'If I feel good about myself and I'm in a good environment then everything is fine but if I feel negative and the environment I'm in is the same then things can quickly spiral out of control'*. Terēhia acknowledged that she had triggers and was able to recognise these and do something about it before things got bad. Rupene said that communication was imperative for his wellness and if he is able to talk to someone beforehand about what is going on for him then it was likely he would be okay but if no one listened then his mental state of mind would take over and he could easily revert back to unwellness.

### **5.2.6 Trauma: *Whētuki***

It was evident interviewing whānau members that each had experienced some form of trauma possibly initiating mental unwellness.

Rupene's first trauma started at a young age through the separation of his parents, and then the death of his sick mother who was his only stability. This was the beginning of a long history of ordeals to follow. With no positive role models in his life he was therefore unequipped to deal with trauma leading him down a path of destruction and suicide attempts. Rupene interpreted suicide as *'near death releases*

*the pressure in your mind*'. Rupene further elaborated by saying that *'death for some is a healing, I was not afraid of death'*. Plagued most of his life with trauma Rupene was not diagnosed with a mental illness till in his sixties although he acknowledged he had a problem of some kind but never sought medical help for it.

Te Rangimarie said that her parents taking on the caring role of her three nephews impacted on her. She said she was at a vulnerable age in her life and it was a sense of loss *'losing my parents'* to my nephews. She later experienced the loss of two pregnancies that sent her into depression. Te Rangimarie acknowledged that it was not till after the birth of her first son that she truly realised something was wrong and that was when I was then diagnosed with Postpartum Psychosis. Te Rangimarie said *'being diagnosed helped me to accept my unwellness and do something about it'*. My husband helped me to see its okay to ask and accept help'.

Hone witnessed the verbal and physical abuse from his father towards his mother at a young age then in his teens witnessed his father trying to commit suicide. It seemed from this point Hone's life spiralled out of control also with attempts of suicide. Hone said that *'being close to death makes you feel alive'*. Hone was not diagnosed with bipolar in his thirties.

Terēhia said that her move from New Zealand to Australia at the age of nine years brought about a sense of instability for her. She didn't cope well with the move and soon she was displaying destructive behaviours. Added was the termination of a pregnancy after the birth of her first son that soon turned to guilt and to conceal the pain turned to marijuana use to the point of addiction. Followed was that of giving up her three sons' to her parents. Terēhia was diagnosed with bipolar in her twenties.

Trauma impacts on people in various ways but it is the resilience of a person that determines how they deal with their unwellness.

### **5.3 Behaviours: *Whanonga***

Behaviours that whānau participants experienced was breaking ground to admitting something was amiss and taking the next step or remaining in denial hindering one's wellness. Whānau participants gave insight into how certain behaviours affect their bodies holistically and what strategies they used to keep in a state of wellness.

#### **5.3.1 Emotional: *Aronganui***

Whānau said they felt a range of emotions; Terēhia likened it to being on a roller coaster. There was a cycle of emotions that affected all whānau members and they are described in the following context. Whānau highlighted an intense feeling of 'sadness' and for some it was overwhelming. Hone described it as *'darkness like nothing matters or a hole that you can't get out of'*. Rupene and Hone also described it as *'being close to death'*. Whānau described a *'loneliness or feeling alone'*. Terēhia said *'it was like you're in there all on your own'*. Followed was a feeling of 'anger'. Te Rangimarie said that her anger drove her to self-harm. Te Rangimarie described hurting herself as a release or a way to stop the sad thoughts. Rupene explained that he had an innate hatred for his father for leaving his mother. Rupene's father also put Rupene into Oakley hospital at the age of seventeen years for reason's Rupene did not understand. Rupene became angry at a young age and carried this anger throughout his life. Rupene explained that his anger resulted in attempts to take his life on many occasions. Rupene said *'being near to death helped to release the pressure in my mind'*. Hone also carried a lot of anger that he learnt at a young age from witnessing the abuse his father inflicted upon his mother. Hone carried this

anger into his own relationships and in turn turned the anger inward and also made attempts to take his own life. Hone said '*being close to death makes you feel alive*'. Terēhia said '*I thought if I popped a pill everything would be okay*', I didn't realise that I had to find other ways to deal with my emotions.

### **5.3.2 Physical: Tinana**

Physical behaviours played a big part for all whānau members be it in negative and positive form. Whānau members described good and bad physical pains. Unhealthy physical pain was when one self-harmed or attempted to take their life. Te

Rangimarie said '*when my mental state became so bad I would punch myself in the head, throw myself against the wall even cut myself anything to stop the pain in my head*' Te Rangimarie added '*I felt like my mind was popping out everywhere*'.

Rupene said when the mental pain became too much for him he felt that death would relieve the pain. Rupene said he did not fear death. Hone had similar comments to Rupene in that when the pain in his head became too much '*I just wanted to die or kill myself*'.

Healthy physical pain as described by Rupene and Hone was working out in the gym or pushing your body to the extreme where you felt good about yourself. Hone described '*physical pain as nothing compared to the mental pain*'. Rupene and Hone also stated that working out in the gym was an opportunity to meet and speak with other people of like mindedness. Rupene and Hone enjoyed helping and sharing their own experiences with other people for them it helped to keep things in perspective. It also made them feel good about themselves by helping others. This contributed greatly to their wellbeing.

In July 2013 Rupene was approached by Waka Huia of Māori Television to do a documentary on his life with the focus being on what it is like to live with a mental illness. The decision to do the documentary was not difficult for Rupene was passionate about mental health however he worried about how the documentary might reflect back on him. Rupene said he didn't want whānau labelling him and saying he was crazy or nuts. Rupene consulted with those of his whānau he knew would support his kaupapa and he agreed to do the documentary. Rupene said he wanted to do the documentary to show Māori that there was no shame in having a mental illness. He said if he was able to talk about mental illness publicly he hoped it would open the door for other's to do the same. Rupene said talking about mental illness should be normal and if it was discussed more openly there would not be the stigma and discrimination attached to having a mental illness. Rupene said after the televising of his documentary he was pleased that he had done the documentary and has received nothing but positive comments.

Rupene and his wife hosted the 2010 Like Minds Like Mine National conference in Kaitaia. At the time of the conference I was studying 'Whānau Development' focusing on the impact mental illness had on our whānau. Rupene asked if I would co-present with him around the topic, it was also when I publicly acknowledged my own unwellness. At the conclusion of the presentation there was not a dry eye in the Marae and several people came forth saying they could relate to our presentation and how courageous we were to share openly our whānau experiences. 2011 saw another presentation at the Like Minds Like Mine Conference held in Whakatane. We will continue to advocate on behalf of those suffering with a mental illness.

Our stories are not unlike anyone else suffering with a mental illness, what is different is that we are prepared to talk publicly about what it feels like to have a

mental illness and share our experiences from a Māori perspective. We believe the more mental illness is talked about openly, stigmas and discrimination will be reduced.

It has been Rupene's passion and our whānau experiences that have been the drive behind writing this thesis. Rupene is passionate that any knowledge he holds should be passed on to future generations. He commented to me one day saying *'when I die I want my mind to be empty'*.

In summary whānau members believed that the mental and the physical states are interrelated.

### **5.3.3 Denial: *Whākorekore***

Whānau went through stages of denial and used various techniques to disguise their unwellness. All whānau used alcohol or drugs to hide their illness until it reached a point where they were aware of the impact this was having on their wellbeing.

Alcohol and drugs initially were used as a relaxant however later realised that it was enhancing their unwellness to the point of risk taking and damaging their health.

Rupene and Hone admitted that alcohol and drugs made them feel 'bullet proof' but it also made them 'violent' towards themselves and others they cared about. Te

Rangimarie said that she knew something was wrong but didn't want to admit it until her husband told her that she had to do something about her behaviours or he would leave her. Terēhia admitted that she knew something was wrong but did not want to admit it.

#### 5.3.4 Acceptance: *Whakaaetanga*

Reaching the point of accepting you are unwell is a journey on its own. Te Rangimarie said that knowing what was wrong and being diagnosed helped me to accept my unwellness and do something about it. Furthermore according to Te Rangimarie being assured that it's okay to have these feelings and emotions bought a sense of relief. My husband helped me to see that it's okay to accept and ask for help. I realise that any support is helpful and accept it willingly.

Rupene said that being diagnosed helped him to accept and deal with his unwellness. Rupene added that it was hard to accept help from family because they were never there but I realise now they are an important part of my wellness. Hone said *'I realise that I might have a mental illness and was relieved when I was diagnosed'*. Accepting his illness helped him to understand a lot of the unknowing things. I was aware that it was okay to have these emotions and that eventually everything would be alright. I had to find ways to deal with my unwellness. *'I realised that it was okay to feel sad it's a part of life'*. Terēhia said that when she accepted her unwellness *'I wanted to do anything to make myself better'*. She further added that accepting her illness helped me to start healing and that my unwellness will be on-going. Terēhia acknowledged feeling comforted knowing there were others in her whānau that were like me.

In all, acceptance for whānau members was about taking responsibility for their own unwellness, recognising the triggers, not blaming others and finding ways to work toward healing.

## **5.4 Healing: *Whakaora***

Healing for the whānau participants came in a variety of ways and each recognises that the process is ongoing. Each whānau participant had different strategies to get them to a point of wellness and all admitted that healing never stops it is a work in progress.

### **5.4.1 Identity: *Tuakiri***

Whānau acknowledge that self-esteem and knowing who we are is vital for wellness. For the younger generation who did not have a strong sense of cultural identity or belonging being able to feel good and believing in one-self was a priority.

Rupene said *'it was important to believe in you and accept that we are different'*. Te Rangimarie said *'it was important to know what you want and to go for it'*. Rupene also said *'other people's attitudes can make you feel bad I've learnt to just get up and walk away and that people are entitled to their opinions, it doesn't mean it applies to me'*. Hone accredited having a positive outlook on life helped him feel good about himself. Terēhia said *'it was important to not give up no matter what others say'*.

Although whānau members were all of Māori descent not all are proficient in their Māori world view. The senior whānau member participating in this thesis is fluent in all aspects of tikanga and te reo Māori however this was not passed on to following generations for fear of his children being chastised as he was for speaking Te Reo Māori in school. Younger whānau members however are becoming more involved in aspects of their tikanga Māori; Te Rangimarie learning her Te Reo through her tamariki kohanga reo. Terēhia is studying Mahi Ora through Te Wananga O

Aotearoa and Hone lives on his papakainga surrounded by kaumātua and kūia. This resurgence in regaining their Māori heritage is enhancing their sense of identity and belonging. This in turn contributes greatly to their healing processes.

#### **5.4.2 Support: *Tautoko***

Support from extended whānau, community or health services was important.

Whānau participants acknowledged that it was important for extended whānau to accept their unwellness and provide the necessary support to help them maintain their wellness. Just being present to listen and talk about their unwellness without judgement was important as part of their healing process. Rupene said that being able to access the mental health helpline helped him through moments of unwellness. Te Rangimarie said the hardest thing was accepting help from her whānau as she just wanted to get on with her life but now appreciates there are times when she needs their support. Te Rangimarie and Terēhia both acknowledged their children as being motivators to wellness. Whānau participants were all animal lovers and acknowledged the animal's unconditional love. They said animals played an integral part in their healing.

#### **5.4.3 Environment: *Taiao***

Whānau participants identified that their environment impacted greatly on their healing and how easy they could revert back to unwellness simply by the environment they were in. Whānau acknowledged that the physical and spiritual environment interwove into each other. Te Rangimarie acknowledged that when in a good space things went well. She said that some strategies for her healing were simple things like 'feeling happy and comfortable in the moment', '*being relaxed and just going with the flow*' and what made any of these happen were things like

'blinking the mind of no thoughts or emotions'. Rupene and Hone are passionate about working out in a gym environment and said this not only keeps them physically fit it helps to maintain their overall wellness and it gives them the opportunity to meet others of like mindedness and share their own experiences a very powerful healing process.

#### **5.4.4 Spiritual: *Wairua***

Rupene and Terēhia extend their healing into their faith in God and how attendance to church and being in God's presence assisted in their on-going healing. Hone although not a church attendee believed in the power of prayer and acknowledges his day never starts without 'karakia'. Te Rangimarie acknowledges the influence of 'Atua' and 'karakia' that she learns and shares through her children.

#### **5.4.5 Communication: *Korero***

Whānau participants acknowledged the importance of communication and that often they just needed to talk to someone and be listened too without judgement. Rupene said it was important just to listen, we don't need advice we know what we are feeling we just want to talk about it and it's important for others to understand.

Unless you have gone through what we have gone through then you don't understand what people like us go through. We don't want pity we just want everyone to know that this is our normality some people cope with things differently.

#### **5.4.6 Difference: *Rerekē***

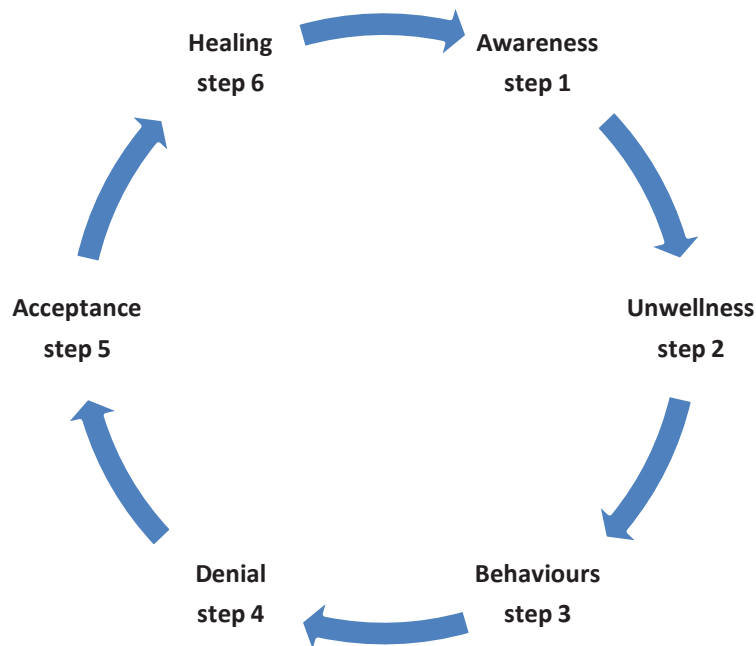
What was different? Whānau participants saw their unwellness through different lenses. Rupene and Hone accepted the stigma of mental illness from a colonised point of view having been through the mental health systems. Initially they believed

that diagnosis and medicine was the accepted 'norm'. Rupene and Hone relied on their medication for some years before finding different strategies in which to deal with their unwellness. Terēhia and Te Rangimarie saw mental illness from the perspective of normality in that everyone experiences the emotions and feelings that those with a mental illness experience. They did not set themselves aside as being different from anyone else except that they may not have learnt the coping strategies to deal with situations that resulted in their unwellness. Terēhia and Te Rangimarie saw medication as a temporary solution learning more strategic ways in which to maintain their wellness and healing.

As our whānau have become more aware of their own unwellness and shared their experiences with each other it has been noticeable that all whānau members are now linked in their thinking about mental illness and the varied ways in which each copes and manages their unwellness. Whānau participants no longer use western medicines feeling that they are better equipped to deal with their unwellness.

Whānau members will only use western medication for temporary measure under extreme circumstances.

### ***Our whānau cycle of healing:***



The whānau cycle of healing came out of the findings through the stories told by whānau participants. The cycle shows a whānau pattern from commencement of unwellness to healing. The cycle begins with awareness in the sense that something is amiss to a heightened awareness in monitoring one's unwellness. Unwellness is the diagnosis with added influences that impair the unwellness. Behaviours are physical and mental and the bridge between ongoing denial and accepting ones unwellness. Denial will hinder unwellness and a person can remain at that point until the acceptance of their unwellness. Acceptance is the step to healing and recovery. All participants acknowledged that healing is ongoing and to remain in a state of wellness this varied for each whānau participant.

## **5.5 Conclusion: *Mutungu***

It has been an arduous journey collating the information and condensing it to make sense of my whānau and their healing journeys. The themes and subthemes as identified by whānau participants describe in their words the journey of unwellness to where they place themselves today.

Wellness identified as a main theme integrated the following subthemes; whānau, communication, environment, awareness, causes and trauma. Whānau identified these subthemes as vital parts of a jigsaw. Once each part was identified, understand, overcome, practiced and put together, participants were able to find holistic ways in their new lifestyle to stay in a place of wellness.

Under the behaviours themes key subthemes included; emotional, physical, denial and acceptance. Participants claimed this was the critical and turning point to wellness. Emotional and physical interweaved with each other and could play havoc on the physical body and vice versa. All whānau participants recognise that physical not only had negative connotations it also had positive outcomes for wellness as described in whānau stories. Denial was the hardest behaviour to overcome as it meant having to admit you were unwell. For some admitting you were unwell came with repercussions such as stigma, discrimination, being called 'mad' are examples therefore hindering the healing process.

Healing was the final theme. Healing was the place of wellbeing where everything fell into place. It is a place of wholeness where one feels grounded and good. The saying "All is well in my world" identifies the sense one feels when healing is ongoing.

It would be premature to think that healing was unyielding because all participants identified falling back into the place of unwellness from time to time but healing was always the place that one felt a sense of wholeness and contentedness.

In collating the information from each whānau participant it was evident to see that there were patterns of similarities in how individuals saw their healing. Does this then mean that because they are whānau their techniques for healing are learnt behaviours therefore making the healing intergenerational? What was evident was that each theme was a healing step in their journey to wellness.

All participants identified that healing never stopped but what helped to keep one in a state of wellness ultimately was whānau support inclusive of all the themes outlined in this research.

## CHAPTER SIX – CONCLUDING THOUGHTS

*'E tipu, e reā, mō ngā ra o tōu ao; ko tō ringa ki ngā rakau a te Pākehā hei ara mo tō tinana, ko tō ngākau ki ngā tāonga a ō tupuna Māori he tikitiki mō tō māhuna; ko tō wairua ki tō atua, nāna nei ngā mea katoa'*

*Grow up and thrive for the days destined to you, your hand to the tools of the Pākehā to provide physical sustenance, your heart to the treasures of your Māori ancestors as a diadem for your brow, your soul to your God, to whom all things belong.*

*(Sir Apirana Ngata)*

### **6.1 Introduction: *Tīmata***

Four whānau members from different generations gave insight into their lives and what it is like living with mental unwellness diagnosed from a western perspective. Three generations describe their experiences of being Māori and growing up in a western dominated environment and being torn between two worlds. Although they describe feelings of disempowerment and having no control over their unwellness they have each reached a point in their lives where they have found healing and a confidence in their identity as Māori.

### **6.2 Reflections: *Whakaaro huritao***

The planning and preparing for this thesis was a challenging yet rewarding experience. I learnt more about myself and my whānau through this process, and I thought I already knew them well. No amount of preparedness could prepare me more for the process of interviewing my own whānau. The mixed emotions I felt within myself and for each participant was daunting and overwhelming.

Keeping my boundaries as the researcher was difficult at times as I wanted to delve deeper into participant's korero. Fortunately my patience and listening skills paid off with the participants opening up and talking freely about their experiences.

The whānau participant's stories stirred a whirlwind of emotions for me, the participants and support people during the data collection processes, data analysis and writing of their stories. Hearing the traumatic events that occurred with each participant and constantly reading their stories inflicted a deep sense of sadness for what they had endured. I wonder in the bigger picture whether the trauma's experienced were the initial triggers to each one's unwellness followed by an accumulation of other negative experiences.

Listening to whānau share their lived experiences and their healing journeys creates hope for others. The intent of sharing their stories is to encourage others in similar situations to seek their own healing strategies to maintain their own wellness. My whānau have shown that as Māori still enduring the impacts of colonisation, assimilation and urbanisation in a modern context, we are able to change according to the environment and situations that are placed before us.

### **6.3 Words of Wisdom from participants: *Kupu o te whakaaro nui I te whai wahi***

Advice that came out of this research as described by the whānau participants;

- Get to know me, know what my interests and strengths are. Encourage me to utilise my strengths and interests to take me into a better place. Sometimes I may need to be taken by the hand as the first step but don't give up on me.
- Listen to my stories not with sympathy but with compassion and understanding.

- When we display moments of unwellness don't judge me, look past the behaviour, take me away from the situation or listen to what I am feeling sometimes all you might get is SILENCE but just BE THERE.
- Don't assume to know what we have been through. Although there are similarities in living with unwellness as individuals we find ways that fit for us but we may need your support to maintain wellness from time to time.
- When we are unwell don't assume to know what we need or that we even need an answer to our situation just BE THERE.
- BEING THERE might mean ringing me from time to time, popping in to have a visit with me, not just when I am unwell but also when I am well. Invite me to participate in wider whānau activities it helps to keep me connected to you all more importantly I feel like I belong.
- Remember that we are whānau and that we are all capable of falling into moments of unwellness. I need to know that I can rely on my whānau to be there for me.
- My unwellness not only affects me it affects others close to me, my partner, children, my extended whānau. Be there for them and each other.
- There will be periods that will challenge us as a whānau, we need to be able to talk about it openly and even laugh at the situations that arose this is all part of the healing processes for us.
- BUSYNESS in our whānau is what contributes to our wellness. Some of us enjoy health and fitness activities, other's through their work and study. Remaining active was an important component of remaining well.

#### **6.4 Future Research: *Rangahau i mua nei***

When I began this project I struggled to find information related to Māori whānau sharing their experiences of unwellness. It is hoped that the lived experiences shared by my whānau fills this gap and encourages others to search for wellness or healing. For my whānau mental unwellness is 'normal,' and stigma and discrimination comes from those that lack context and understanding around mental unwellness.

#### **6.5 Insights from the research: *Ngāhi whakakaukau i te rangahau***

As a researcher interviewing my own whānau I felt humbled beyond words. Their courage in coming forth and publically acknowledging their unwellness and not being afraid of being identified shows true inner strength. All whānau participants were realistic in that healing is ongoing and never ending. This research is truly a testament of what whānau can endure and how we ourselves can come up with the answers working collaboratively and in conjunction with whānau, hapū, iwi and community support.

Healing comes in different forms for different people. For my whānau sharing their journey's and stories has added more depth to their healing processes. Their stories give outsiders the opportunity to hear from their perspective how they have and continue to manage their unwellness.

The stories shared by the whānau participants have brought them closer as a whānau and has raised an awareness of how important it is to reach out and ask and take help when it is required whether it be from whānau, community, mental health providers or others.

Their identity as Māori has been compromised through the lack of knowledge and understanding of their being part of a bigger picture and culture. Their healing is an ongoing process of seeking their identity as Māori and where they fit on the continuum. As part of their healing journey it is about the connections to their wider whānau, hapū, iwi and community and interweaving them together.

Healing is ongoing for the whānau participants and what is evident in their stories is the support of a partner, remaining connected to whānau, hapū, iwi and community and knowing that the physical, spiritual, emotional elements of their body are all interconnected in keeping balanced and centred in their wellness in whatever context that looks like for each participant.

As the researcher my own unwellness was compromised where I almost did not complete this thesis through my own self-doubts and unwellness. I utilised the full three years to complete this research and what forged me forward were the stories that were given and how they could possibly help another whānau. I pray that I have given integrity to my whānau and the stories shared. This thesis would not have been possible without the support of my whānau, hapū, iwi and community.

On the 4<sup>th</sup>-8<sup>th</sup> January 2015, four generations of our whānau embarked on a one hundred and five kilometre walk from Te Rerenga Wairua to Ahipara. This walk is aptly known as the first leg of the Te Araroa Trail a walk from Te Rerenga Wairua to the Bluff. The walk was spread over a period of five days and was encouraged as a form of self-healing and whānau healing. Ninety percent of the walk was from Scott's point to Ahipara walking along the western coastline or 90 mile beach. The scenery was spectacular added was the whānaungatanga. Our oldest walker was 76 years of age and our youngest supporters were 9 months, 2 years, 5 years and 6 years of

age. We had two youth and seven adults who were consistent walkers. On our last day our walk was 17 kilometres and we had extended whānau join us on our last leg. The emotions were high and there was a huge sense of fulfilment and exhilaration.

Four members that participated in this research challenged themselves by participating in this walk. Two whānau participants although not avid walkers, commented that the walk was “life changing”. Te Rangimarie took her four children along with her on this journey and with whānau support walked three quarters of the journey. Te Rangimarie commented that she did not realise she had the potential to walk the distance and said the walk gave her confidence to overcome other challenges in her life. She also commented that while walking you have time to think and reflect on life in general with the added bonus of setting goals for the future. Te Rangimarie said she would do the walk again and looked forward to more whānau excursions of a similar nature.

Terēhia said the walk for her was life changing. Terēhia pushed herself to the extreme on the walk and along with Te Rangimarie did not think she was capable of lasting the distance. Terēhia walked three quarters of the distance as well. Terēhia said that she would like to go back and complete the sections she did not do and to feel the experience again.

Rupene was the kaumātua who led the walk and gave the history from Te Rerenga Wairua through to Ahipara.

One of my son’s and his son joined us on the journey and travelled from Australia. They in the past year had experienced the breakup of his marriage that had taken its toll on him and his two adult sons’. Our grandson said this was one of the most amazing thing he had experiences in his life and the walk helped him to push

through and cope with the breakup of his parents' marriage. He said he felt so much closer to his father, us as a whānau, something he will treasure for the rest of his life.

The walk had different meanings for each individual but as a whānau we grew closer than ever and as individuals we were able to challenge ourselves and look forward to a brighter future knowing we had the support of each other.

The sense of pride for my whānau words cannot describe. Rupene was to do the walk again following us with a group of people who had travelled from Napier on a similar journey to ours, to find healing.

This is further testament in the Māori world view that the sharing stories, humour, companionship in the form of whānaungatanga will ensure wellness is maintained.

## APPENDICES

|  |      |
|--|------|
| Sample interview questions sheet.....                            | i    |
| Massey Ethics Application forms.....                             | ii   |
| Information Sheet.....   | iii  |
| Participant Consent form.....                                    | iv   |
| Authority for the release of transcripts.....                    | v    |
| Support person confidentiality agreement.....                    | vi   |
| Letter of participation.....                                     | vii  |
| Screening Questionnaire to determine the approval procedure..... | viii |

## SAMPLE INTERVIEW QUESTIONNAIRE

When did you realise that you were unwell?

How did you know it was a mental illness?

How did this make you feel?

Have you been diagnosed? If not, why?

On a scale of 1-10 with one being extreme end and ten being less extreme, where would you place yourself and why?

What was the reaction from your loved ones?

Has their perception of you changed since knowing your unwellness?

How do you feel during periods of unwellness?

What strategies do you use to help recover during these periods?

Do you recognize the triggers of your unwellness?

What strategies do you use to help recover during these periods?

Do you recognise the triggers of your unwellness?

Are you on medication, if not why?

What type of healing plan do you have to maintain your wellness?

What are things whānau can do to help you through your unwellness?

Do you share your experiences with other whānau members that have a mental illness?

Are the illnesses the same or different?

Do you share as a whānau your healing strategies?



## Human Ethics Application

### FOR APPROVAL OF PROPOSED RESEARCH/TEACHING/EVALUATION

#### INVOLVING HUMAN PARTICIPANTS

*(All applications are to be typed and presented using language that is free from jargon and comprehensible to lay people)*

#### SECTION A

##### 1 Project Title

**Projected start date  
for data collection**

**Projected end date**

*(In no case will approval be given if recruitment and/or data collection has already begun).*

##### 2 Applicant Details *(Select the appropriate box and complete details)*

###### ACADEMIC STAFF APPLICATION (excluding staff who are also students)

**Full Name of Staff Applicant/s**

**School/Department/Institute**

**Campus *(mark one only)***

Albany

Palmerston North

Wellington

**Telephone**

**Email Address**

###### STUDENT APPLICATION

**Full Name of Student Applicant**

**Employer *(if applicable)***

**Telephone**

**Email Address**

**Postal Address**

**Full Name of Supervisor(s)**

**School/Department/Institute**

**Campus *(mark one only)***

Albany

Palmerston North

Wellington

**Telephone**

**Email Address**

###### GENERAL STAFF APPLICATION

**Full Name of Applicant** .....

**Section** .....

**Campus (mark one only)**      Albany       Palmerston North       Wellington

**Telephone** .....      **Email Address** .....

**Full Name of Line Manager** .....

**Section** .....

**Telephone** .....      **Email Address** .....

**3 Type of Project** (provide detail as appropriate)

|                                   |                                  |                                  |
|-----------------------------------|----------------------------------|----------------------------------|
| <b>Staff Research/Evaluation:</b> | <b>Student Research:</b>         | <b>If other, please specify:</b> |
| Academic Staff                    | Specify Qualification            | <input type="checkbox"/>         |
| General Staff                     | Specify Credit Value of Research | <input type="checkbox"/>         |
| Evaluation                        | (e.g. 30, 60, 90, 120, 240, 360) |                                  |

**4 Summary of Project**

Please outline in no more than 200 words in lay language why you have chosen this project, what you intend to do and the methods you will use.

*(Note: All the information provided in the application is potentially available if a request is made under the Official Information Act. In the event that a request is made, the University, in the first instance, would endeavour to satisfy that request by providing this summary. Please ensure that the language used is comprehensible to all.)*

- 5 List the Attachments to your Application**, e.g. Completed “Screening Questionnaire to Determine the Approval Procedure” (compulsory), Information Sheet/s (*indicate how many*), Translated copies of Information Sheet/s, Consent Form/s (*indicate of how many*), Translated copies of Consent Form/s, Transcriber Confidentiality Agreement, Confidentiality Agreement (*for persons other than the researcher / participants who have access to project data*), Authority for Release of Tape Transcripts, Advertisement, Health Checklist, Questionnaire, Interview Schedule, Evidence of Consultation, Letter requesting access to an institution, Letter requesting approval for use of database, Other (*please specify*).

**Applications that are incomplete or lacking the appropriate signatures will not be processed. This will mean delays for the project.**

**Please refer to the Human Ethics website ( <http://humanethics.massey.ac.nz> ) for details of where to submit your application and the number of copies required.**

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**SECTION B: PROJECT INFORMATION**

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**General**

6 I/We wish the protocol to be heard in a closed meeting (Part II). Yes  No

*(If yes, state the reason in a covering letter.)*

7 Does this project have any links to previously submitted MUHEC or HDEC application(s)? Yes  No

If yes, list the MUHEC or HDEC application number/s (if assigned) and relationship/s.

8 Is approval from other Ethics Committees being sought for the project? Yes  No

If yes, list the other Ethics Committees.

9 For staff research, is the applicant the only researcher? Yes  No

If no, list the names and addresses of all members of the research team.

---

**Project Details**

10 State concisely the aims of the project.

11 Give a brief background to the project to place it in perspective and to allow the project's significance to be assessed. *(No more than 200 words in lay language)*

12 Outline the research procedures to be used, including approach/procedures for collecting data. Use a flow chart if necessary.

13 Where will the project be conducted? Include information about the physical location/setting.

14 If the study is based overseas:

i) Specify which countries are involved;

ii) Outline how overseas country requirements (if any) have been complied with;

iii) Have the University's Policy & Procedures for Course Related Student Travel Overseas been met?

*(Note: Overseas travel undertaken by students – refer to item 5.10 in the document "Additional Information" on the MUHEC website.)*

15 Describe the experience of the researcher and/or supervisor to undertake this type of project?

16 Describe the process that has been used to discuss and analyse the ethical issues present in this project.

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## Participants

17 Describe the intended participants.

18 How many participants will be involved?

What is the reason for selecting this number?

*(Where relevant, attach a copy of the Statistical Justification to the application form)*

19 Describe how potential participants will be identified and recruited?

20 Does the project involve recruitment through advertising? Yes  No

*(If yes, attach a copy of the advertisement to the application form)*

21 Does the project require permission of an organisation (e.g. an educational institution, an academic unit of Massey University or a business) to access participants or information? Yes  No

If yes: i) list the organisation(s)

ii) attach a copy of the draft request letter(s) to the application form, e.g. letter to Board of Trustees, PVC, HoD/I/S, CEO etc (include this in your list of attachments (Q5)).

*(Note that some educational institutions may require the researcher to submit a Police Security Clearance.)*

22 Who will make the initial approach to potential participants?

23 Describe criteria (if used) to select participants from the pool of potential participants.

24 How much time will participants have to give to the project?

---

## Data Collection

25 Does the project include the use of participant questionnaire/s? Yes  No

*(If yes, attach a copy of the Questionnaire/s to the application form and include this in your list of attachments (Q5))*

If yes: i) indicate whether the participants will be anonymous (i.e. their identity unknown to the researcher). Yes  No

ii) describe how the questionnaire will be distributed and collected.

*(If distributing electronically through Massey IT, attach a copy of the draft request letter to the Associate Director Service Delivery, Information Technology Services to the application form. Include this in your list of attachments (Q5) – refer to the policy on “Research Use of IT Infrastructure”).*

*(Note: All requests for IT related aspects of ethics committee approvals can be directed through the IT service desk in the first instance – the request will be registered and on a response timeline, with the Associate Director dealing with the request).*

- 26 Does the project involve observation of participants? If yes, please describe. Yes  No
- 27 Does the project include the use of focus group/s? Yes  No   
*(If yes, attach a copy of the Confidentiality Agreement for the focus group to the application form)*  
**If yes, describe the location of the focus group and time length, including whether it will be in work time.**  
*(If the latter, ensure the researcher asks permission for this from the employer).*
- 28 Does the project include the use of participant interview/s? Yes  No   
*(If yes, attach a copy of the Interview Questions/Schedule to the application form)*  
**If yes, describe the location of the interview and time length, including whether it will be in work time.** *(If the latter, ensure the researcher asks permission for this from the employer)*
- 29 Does the project involve sound recording? Yes  No
- 30 Does the project involve image recording, e.g. photo or video? Yes  No   
**If yes, please describe.** *(If agreement for recording is optional for participation, ensure there is explicit consent on the Consent Form)*
- 31 If recording is used, will the record be transcribed? Yes  No   
**If yes, state who will do the transcribing.**  
*(If not the researcher, a Transcribers’ Confidentiality Agreement is required – attach a copy to the application form. Normally, transcripts of interviews should be provided to participants for editing, therefore an Authority For the Release of Tape Transcripts is required – attach a copy to the application form. However, if the researcher considers that the right of the participant to edit is inappropriate, a justification should be provided below.)*
- 32 Does the project involve any other method of data collection not covered in Qs 25-31? Yes  No   
**If yes, describe the method used.**
- 33 Does the project require permission to access databases? Yes  No   
*(If yes, attach a copy of the draft request letter/s to the application form. Include this in your list of attachments (Q5). Note: If you wish to access the Massey University student database, written permission from Director, National Student Relations should be attached.)*
- 34 Who will carry out the data collection?

---

SECTION C: BENEFITS / RISK OF HARM (Refer Code Section 3, Para 10)

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35 What are the possible benefits (if any) of the project to individual participants, groups, communities and institutions?

36 What discomfort (physical, psychological, social), incapacity or other risk of harm are individual participants likely to experience as a result of participation?

37 Describe the strategies you will use to deal with any of the situations identified in Q36.

38 What is the risk of harm (if any) of the project to the researcher?

39 Describe the strategies you will use to deal with any of the situations identified in Q38.

40 What discomfort (physical, psychological, social) incapacity or other risk of harm are groups/communities and institutions likely to experience as a result of this research?

41 Describe the strategies you will use to deal with any of the situations identified in Q40.

42 Is ethnicity data being collected as part of the project? Yes  No

If yes, please describe how the data will be used.

*(Note that harm can be done through an analysis based on insufficient sample or sub-set numbers).*

43 If participants are children/students in a pre-school/school/tertiary setting, describe the arrangements you will make for children/students who are present but not taking part in the research.

*(Note that no child/student should be disadvantaged through the research)*

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SECTION D: INFORMED & VOLUNTARY CONSENT (Refer Code Section 3, Para 11)

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44 By whom and how, will information about the research be given to potential participants?

45 Will consent to participate be given in writing? Yes  No

*(Attach copies of Consent Form/s to the application form)*

If no, justify the use of oral consent.

46 Will participants include persons under the age of 16? Yes  No

If yes: i) indicate the age group and competency for giving consent.

ii) indicate if the researcher will be obtaining the consent of Yes  No   
parent(s)/caregiver(s).

*(Note that parental/caregiver consent for school-based research may be required by the school even when children are competent. Ensure Information Sheets and Consent Forms are in a style and language appropriate for the age group.)*

47 Will participants include persons whose capacity to give informed consent may be compromised? Yes  No

*If yes, describe the consent process you will use.*

48 Will the participants be proficient in English? Yes  No

**If no, all documentation for participants (Information Sheets/Consent Forms/Questionnaire etc) must be translated into the participants' first-language.**

*(Attach copies of the translated Information Sheet/Consent Form etc to the application form)*

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*SECTION E: PRIVACY/CONFIDENTIALITY ISSUES (Refer Code Section 3, Para 12)*

49 Will any information be obtained from any source other than the participant? Yes  No

**If yes, describe how and from whom.**

50 Will any information that identifies participants be given to any person outside the research team? Yes  No

**If yes, indicate why and how.**

51 Will the participants be anonymous (i.e. their identity unknown to the researcher?) Yes  No

**If no, explain how confidentiality of the participants' identities will be maintained in the treatment and use of the data.**

52 Will an institution (e.g. school) to which participants belong be named or be able to be identified? Yes  No

**If yes, explain how you have made the institution aware of this?**

53 **Outline how and where:**

**i) the data will be stored, and**

*(Pay particular attention to identifiable data, e.g. tapes, videos and images)*

**ii) Consent Forms will be stored.**

*(Note that Consent Forms should be stored separately from data)*

54 i) Who will have access to the data/Consent Forms?

ii) How will the data/Consent Forms be protected from unauthorised access?

55 How long will the data from the study be kept, who will be responsible for its safe keeping and eventual disposal? (Note that health information relating to an identifiable individual must be retained for at least 10 years, or in the case of a child, 10 years from the age of 16).

*(For student research the Massey University HOD Institute/School/Section / Supervisor / or nominee should be responsible for the eventual disposal of data. Note that although destruction is the most common form of disposal, at times, transfer of data to an official archive may be appropriate. Refer to the Code, Section 4, Para 24.)*

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**SECTION F: DECEPTION (Refer Code Section 3, Para 13)**

56 Is deception involved at any stage of the project? Yes  No   
If yes, justify its use and describe the debriefing procedures.

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**SECTION G: CONFLICT OF ROLE/INTEREST (Refer Code Section 3, Para 14)**

57 Is the project to be funded or supported in any way, e.g. supply of products for testing? Yes  No

If yes: i) state the source of funding or support:

- Massey Academic Unit
- Massey University (e.g. MURF, SIF)
- External Organisation (provide name and detail of funding/support)

ii) does the source of the funding present any conflict of interest with regard to the research topic?

iii) identify any potential conflict of interest due to the source of funding and explain how this will be managed?

58 Does the researcher/s have a financial interest in the outcome of the project? Yes  No   
If yes, explain how the conflict of interest situation will be dealt with.

59 Describe any professional or other relationship between the researcher and the participants? (e.g. employer, employee, work colleague, lecturer/student, practitioner/patient, researcher/family member). Indicate how any resulting conflict of role will be dealt with.

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**SECTION H: COMPENSATION TO PARTICIPANTS (Refer Code Section 4, Para 23)**

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**60** Will any payments, koha or other form of compensation or acknowledgement be given to participants? Yes  No

If yes, describe what, how and why.

*(Note that compensation (if provided) should be given to all participants and not constitute an inducement. Details of any compensation provided must be included in the Information Sheet.)*

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**SECTION I: TREATY OF WAITANGI (Refer Code Section 2)**

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**61** Are Māori the primary focus of the project? Yes  No

If yes: Answer Q62 – 65

If no, outline: i) what Māori involvement there may be, and

ii) how this will be managed.

**62** Is the researcher competent in te reo Māori and tikanga Māori? Yes  No

If no, outline the processes in place for the provision of cultural advice.

**63** Identify the group/s with whom consultation has taken place or is planned and describe the consultation process.

*(Where consultation has already taken place, attach a copy of the supporting documentation to the application form, e.g. a letter from an iwi authority)*

**64** Describe any ongoing involvement of the group/s consulted in the project.

**65** Describe how information resulting from the project will be shared with the group/s consulted?

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**SECTION J: CULTURAL ISSUES (Refer Code Section 3, Para 15)**

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**66** What ethnic or social group/s (other than Māori) does the project involve?

**67** Are there any aspects of the project that might raise specific cultural issues? Yes  No

If yes, explain. Otherwise, proceed to Section K.

68 Does the researcher speak the language of the target population? Yes  No

If no, specify how communication with participants will be managed.

69 Describe the cultural competence of the researcher for carrying out the project.

*(Note that where the researcher is not a member of the cultural group being researched, a cultural advisor may be necessary)*

70 Identify the group/s with whom consultation has taken place or is planned.

*(Where consultation has already taken place, attach a copy of the supporting documentation to the application form)*

71 Describe any ongoing involvement of the group/s consulted in the project.

72 Describe how information resulting from the project will be shared with the group/s consulted.

73 If the research is to be conducted overseas, describe the arrangements you will make for local participants to express concerns regarding the research.

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#### SECTION K: SHARING RESEARCH FINDINGS (Refer Code Section 4, Para26)

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74 Describe how information resulting from the project will be shared with participants and disseminated in other forums, e.g. peer review, publications, and conferences.

*(Note that receipt of a summary is one of the participant rights)*

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#### SECTION L: INVASIVE PROCEDURES/PHYSIOLOGICAL TESTS (Refer Code Section 4, Para 21)

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75 Does the project involve the collection of tissue, blood, other body fluids; physiological tests or the use of hazardous substances, procedures or equipment? Yes  No

If yes, are the procedures to be used governed by Standard Operating Procedure(s)? If so, please name the SOP(s). If not, identify the procedure(s) and describe how you will minimise the risks associated with the procedure(s)?

76 Does the project involve the use of radiation (x-ray, CT scan or bone densitometry (DEXA))? Yes  No

If yes, has the Massey Licensee been contacted and consulted? Yes  No

(A copy of the supporting documentation must be provided with the ethics application, i.e. relevant SOP, participant dose assessment calculation sheet and approval of the dose assessment from the relevant authority).  
 NOTE: See "Additional Information for Researchers" (Item 4.2) document for further detail.

(If yes to Q75 and/or Q76, complete Section L; otherwise proceed to Section M)

77 Describe the material to be taken and the method used to obtain it. Include information about the training of those taking the samples and the safety of all persons involved. If blood is taken, specify the volume and number of collections.

78 Will the material be stored? Yes  No   
 If yes, describe how, where and for how long.

79 Describe how the material will be disposed of (either after the research is completed or at the end of the storage period).

(Note that the wishes of relevant cultural groups must be taken into account)

80 Will material collected for another purpose (e.g. diagnostic use) be used? Yes  No   
 If yes, did the donors give permission for use of their samples in this project? Yes  No   
 (Attach evidence of this to the application form).

If no, describe how consent will be obtained. Where the samples have been anonymised and consent cannot be obtained, provide justification for the use of these samples.

81 Will any samples be imported into New Zealand? Yes  No   
 If yes, provide evidence of permission of the donors for their material to be used in this research.

82 Will any samples go out of New Zealand? Yes  No   
 If yes, state where.

(Note this information must be included in the Information Sheet)

83 Describe any physiological tests/procedures that will be used.

84 Will participants be given a health-screening test prior to participation? (If yes, Yes  No   
 attach a copy of the health checklist)

**Reminder: Attach the completed Screening Questionnaire and other attachments listed in Q5**

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**SECTION M: DECLARATION** *(Complete appropriate box)*

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**ACADEMIC STAFF RESEARCH**

**Declaration for Academic Staff Applicant**

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. My Head of Department/School/Institute knows that I am undertaking this research. The information contained in this application is to the very best of my knowledge accurate and not misleading.

Staff Applicant's Signature .....

Date: .....

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**STUDENT RESEARCH**

**Declaration for Student Applicant**

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and discussed the ethical analysis with my Supervisor. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants.

The information contained in this application is to the very best of my knowledge accurate and not misleading.

Student Applicant's Signature .....

Date: .....

**Declaration for Supervisor**

I have assisted the student in the ethical analysis of this project. As supervisor of this research I will ensure that the research is carried out according to the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants.

Supervisor's Signature .....

Date: .....

Print Name .....

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**GENERAL STAFF RESEARCH/EVALUATIONS**

**Declaration for General Staff Applicant**

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and discussed the ethical analysis with my Line Manager. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. The information contained in this application is to the very best of my knowledge accurate and not misleading.

General Staff Applicant's Signature .....

Date: .....

**Declaration for Line Manager**

I declare that to the best of my knowledge, this application complies with the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and that I have approved its content and agreed that it can be submitted.

Line Manager's Signature .....

Date: .....

Print Name .....

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**TEACHING PROGRAMME**

**Declaration for Paper Controller**

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. I understand my obligations and the rights of the participants. I agree to undertake the teaching programme as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. My Head of Department/School/Institute knows that I am undertaking this teaching programme. The information contained in this application is to the very best of my knowledge accurate and not misleading.

Paper Controller's Signature .....

Date: .....

**Declaration for Head of Department/School/Institute**

I declare that to the best of my knowledge, this application complies with the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and that I have approved its content and agreed that it can be submitted.

Head of Dept/School/Inst Signature

Date:

Print Name



MASSEY UNIVERSITY  
COLLEGE OF HUMANITIES  
AND SOCIAL SCIENCES  
TE KURA PŪKENGĀ TĀNGATA

Te Hui Kotahitanga mo te whaka-ora i roto i nga mātauranga o te mate hinengaro:  
*The Intergenerational Transmission of Healing from the Experience of Mental Illness*

INFORMATION SHEET

He toi rangi, He toi matua, he toi tangata

Tihēi Mauri Ora.

Blessings from above, blessings from our tupuna, blessings from our people

The breath of life

Tena Koe e \_\_\_\_\_

My name is Rangī Naera and I am doing my first year in Masters of Philosophy, Māori Studies by thesis only through Massey University, Palmerston North. I am very excited with my chosen topic "Te Hui Kotahitanga mo te whaka-ora i roto i nga mātauranga o te mate hinengaro": *The intergenerational transmission of healing through the experience of mental illness*.

My research aims to bring forth how through the experience of mental illness healing is achieved and maintained. Informal conversations to date with whānau members suggests a strong desire to be involved in a research project that allows us to tell our story and share our journey and by doing so support other members of our whānau. It is with humility and respect that I invite you to be a participant in this exciting research.

Given that the whānau will be identifiable through this research I cannot guarantee that you and your whānau will remain unknown. Please discuss your involvement in this project with your immediate whānau as involvement could have some negative consequences for both you and your immediate whānau. For example, whānau could experience stigma or discrimination associated with misunderstandings of mental illness.

The interview will be a maximum of three (3) hours at a place and time determined by you. All interviews will be digitally recorded. You may ask for the recorder to be turned off at any time during the interview. Please consider having a person present at the interview, such as partner, friend, or kaumātua, to support you as some of the questions or memories may cause undue stress. If this occurs the interview can cease and if desired continue at another time. Contacts for professional support services will also be provided. With your permission I too would like to my husband to be present to support me in my role as researcher.

Once all the interviews have been completed you will be invited to attend a whānau hui to distribute the findings of the research and develop a model of healing for extended whānau members, hapū, iwi and community. The intent of this model is to alleviate stigma and discrimination, contribute to already limited literature on this topic and add to organisation policy and attitudinal change.



MASSEY UNIVERSITY  
COLLEGE OF HUMANITIES  
AND SOCIAL SCIENCES  
TE KURA PŪKENGĀ TĀNGATA

Te Hui Kotahitanga mo te whaka-ora i roto i nga matauranga o te mate hinengaro:  
*The intergenerational transmission of healing from the experience of mental illness*

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the 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 to the interview being sound recorded. *(if applicable include this  
statement)*

I wish/do not wish to have my recordings returned to me. *(if applicable include this  
statement)*

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name - printed \_\_\_\_\_



**MASSEY UNIVERSITY**  
COLLEGE OF HUMANITIES  
AND SOCIAL SCIENCES  
TE KURA PŪKENGĀ TANGATA

Te Hui Kotahitanga mo te whaka-ara i roto i nga matauranga o te mate hinengaro:  
*The intergenerational transmission of healing from the experience of mental illness*

**AUTHORITY FOR THE RELEASE OF TRANSCRIPTS**

I confirm that I have had the opportunity to read and amend the transcript of the  
interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and  
publications arising from the research.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name - printed \_\_\_\_\_



**MASSEY UNIVERSITY**  
 COLLEGE OF HUMANITIES  
 AND SOCIAL SCIENCES  
 TE KURA PŪRENGA TANGATA

Te Hui Kotahitanga mo te whaka-ora i roto i nga matauranga o te mate hinengaro:  
*The Intergenerational transmission of healing from the experience of mental illness*

**SUPPORT PERSON CONFIDENTIALITY AGREEMENT**

I ..... (Full Name - printed)

agree to keep confidential all information concerning the project .....

I will not retain or copy any information involving the project.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**MASSEY UNIVERSITY**  
COLLEGE OF HUMANITIES  
AND SOCIAL SCIENCES  
TE KURA PŌKENGĀ TANGATA

Te Hui Kotahitanga mo te whaka-ora i roto i nga matauranga o te mate hinengaro:  
*The intergenerational transmission of healing from the experience of mental illness*

**LETTER OF PARTICIPATION**

Date

Tena koe \_\_\_\_\_

Further to our discussion regarding the research project Te Hui Kotahitanga mo te Whaka-ora i roto i nga mātauranga o te mate hinengaro: *The Intergenerational Transmission of Healing from the experience of Mental Illness* you are invited to participate in this exciting research project.

If you are interested please confirm your desire to be involved with my supervisor Dr Margaret Forster on 06 356 9099 Extn 7091 or send her an email at [M.E.Forster@massey.ac.nz](mailto:M.E.Forster@massey.ac.nz).

Once Dr Forster has received confirmation of interest to be involved I will contact you to make an appointment for an interview. Please note that response to this letter does not commit you to being involved. You will formally be asked to participant and sign a consent form before the interview begins.

Heoi ano,

Rangī Naera



**Massey University**

Te Kūhanga ki Pōrehuroa

## SCREENING QUESTIONNAIRE TO DETERMINE THE APPROVAL PROCEDURE

*(Part A and Part B of this questionnaire must both be completed)*

Name:  
Project Title:

This questionnaire should be completed following, or as part of, the discussion of ethical issues.

### Part A

The statements below are being used to determine the risk of your project causing physical or psychological harm to participants and whether the nature of the harm is minimal and no more than is normally encountered in daily life. The degree of risk will then be used to determine the appropriate approval procedure.

If you are in any doubt you are encouraged to submit an application to one of the University's ethics committees.

Does your Project involve any of the following?  
(Please answer all questions. Please circle either YES or NO for each question)

#### Risk of Harm

|  |     |    |
|--|-----|----|
| 1. Situations in which the researcher may be at risk of harm.  | YES | NO |
| 2. Use of questionnaire or interview, whether or not it is anonymous which might reasonably be expected to cause discomfort, embarrassment, or psychological or spiritual harm to the participants.  | YES | NO |
| 3. Processes that are potentially disadvantageous to a person or group, such as the collection of information which may expose the person/group to discrimination.   | YES | NO |
| 4. Collection of information of illegal behaviour(s) gained during the research which could place the participants at risk of criminal or civil liability or be damaging to their financial standing, employability, professional or personal relationships. | YES | NO |
| 5. Collection of blood, body fluid, tissue samples, or other samples.  | YES | NO |
| 6. Any form of exercise regime, physical examination, deprivation (e.g. sleep, dietary).   | YES | NO |
| 7. The administration of any form of drug, medicine (other than in the course of standard medical procedure), placebo.   | YES | NO |
| 8. Physical pain, beyond mild discomfort.  | YES | NO |
| 9. Any Massey University teaching which involves the participation of Massey University students for the demonstration of procedures or phenomena which have a potential for harm.   | YES | NO |

### Informed and Voluntary Consent

|   |     |    |
|---|-----|----|
| 10. Participants whose identity is known to the researcher giving oral consent rather than written consent (if participants are anonymous you may answer No).                                   | YES | NO |
| 11. Participants who are unable to give informed consent.   | YES | NO |
| 12. Research on your own students/pupils.   | YES | NO |
| 13. The participation of children (seven (7) years old or younger).   | YES | NO |
| 14. The participation of children under sixteen (16) years old where active parental consent is not being sought.   | YES | NO |
| 15. Participants who are in a dependent situation, such as those who are under custodial care, or residents of a hospital, nursing home or prison or patients highly dependent on medical care. | YES | NO |
| 16. Participants who are vulnerable.  | YES | NO |
| 17. The use of previously collected identifiable personal information or research data for which there was no explicit consent for this research.   | YES | NO |
| 18. The use of previously collected biological samples for which there was no explicit consent for this research.   | YES | NO |

### Privacy/Confidentiality Issue

|  |     |    |
|--|-----|----|
| 19. Any evaluation of organisational services or practices where information of a personal nature may be collected and where participants or the organisation may be identified. | YES | NO |
|--|-----|----|

### Deception

|   |     |    |
|---|-----|----|
| 20. Deception of the participants, including concealment and covert observations. | YES | NO |
|---|-----|----|

### Conflict of Interest

|   |     |    |
|---|-----|----|
| 21. Conflict of interest situation for the researcher (e.g. is the researcher also the lecturer/teacher/treatment-provider/colleague or employer of the research participants or is there any other power relationship between the researcher and research participants?) | YES | NO |
|---|-----|----|

### Compensation to Participants

|   |     |    |
|---|-----|----|
| 22. Payments or other financial inducements (other than reasonable reimbursement of travel expenses or time) to participants. | YES | NO |
|---|-----|----|

### Procedural

|   |     |    |
|---|-----|----|
| 23. A requirement by an outside organisation (e.g. a funding organisation or a journal in which you wish to publish) for Massey University Human Ethics Committee approval. | YES | NO |
|---|-----|----|

## Part B

### FOR PROPOSED HEALTH AND DISABILITY RESEARCH ONLY

Not all health and disability research requires review by a Health and Disability Ethics Committee (HDEC).

Your study is likely to require HDEC review if it involves:

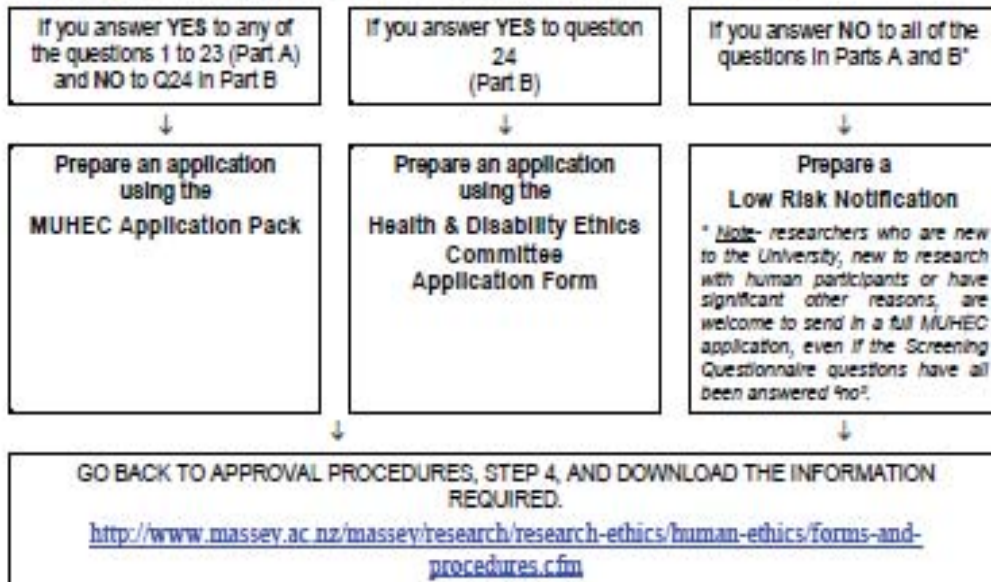
- human participants recruited in their capacity as:
  - consumers of health or disability support services; or
  - relatives or caregivers of such consumers; or
  - volunteers in clinical trials; or
- human tissue; or
- health information.

In order to establish whether or not HDEC review is required: (I) read the Massey University Digest of the HDEC Scope of Review standard operating procedure; (II) work through the 'Does your study require HDEC review?' flowchart; and (III) answer Question 24 below.

If you are still unsure whether your project requires HDEC approval, please email the Ministry of Health for advice ([hdsca@moh.govt.nz](mailto:hdsca@moh.govt.nz)) and keep a copy of the response for your records.

|   |     |    |
|---|-----|----|
| 24. Is HDEC review required for this study? | YES | NO |
|---|-----|----|

Select the appropriate procedure to be used (choose one option):



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