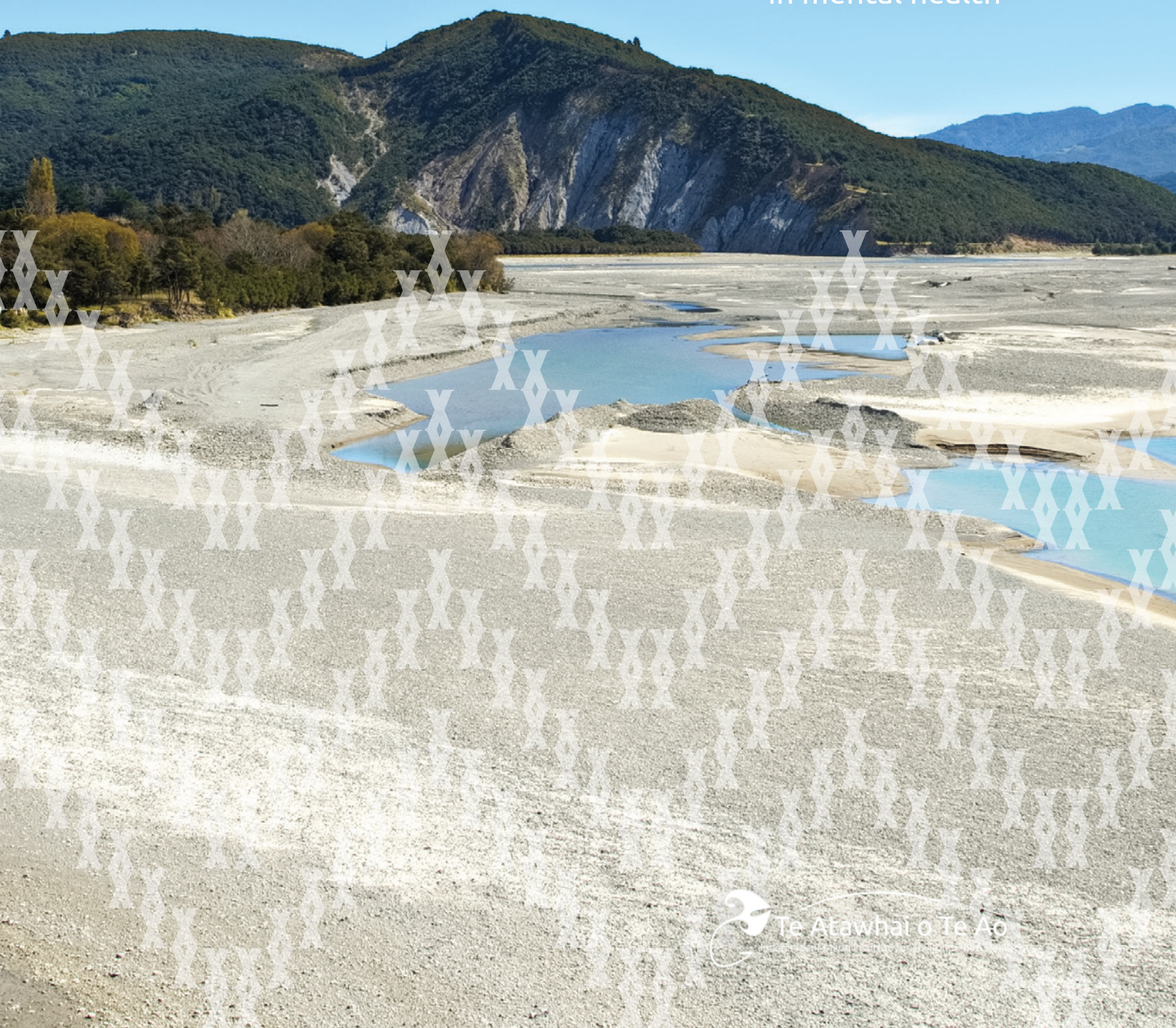
Everyday experiences of racism:

Suppressing Māori cultural expressions in mental health



Te Ātawhai o Te Ao

Everyday experiences of racism:

Suppressing Māori cultural expressions in mental health

By Dr Kim Southey
Edited by Dr Rāwiri Tinirau

Author
Dr Kim Southey

Editor
Dr Rāwiri Tinirau

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Waiapu River at Ruatōrea by Peter Moore.

He kōrero wāwahi:

Foreword

Tēnā kautau i runga i ngā tini āhuatanga o te wā.

This publication has been produced as part of the He Kokonga Ngākau Fellowships, an initiative of Te Atawhai o Te Ao that seeks to support and contribute to our research projects, and grow Māori research capability that promotes Kaupapa Māori research. These fellowships have been established to support Māori postgraduate students, practitioners, community researchers, and writers in their writing on kaupapa that have relevance to our organisation and wider community.

Dr Kim Southey (Ngāti Porou, Ngāti Kuia) draws on her doctoral research on re-presenting Māori and Indigenous understandings of being, and deconstructing the notion of mental illness. This publication focuses on how Māori and Indigenous expressions within the mental (and wider) health system are suppressed and restricted by a dominant (western) worldview. Dr Southey posits that the western insistence on representing things in the world through rational, logical explanations impacts on Māori cultural understandings, limiting how we can express ourselves. This is viewed by Dr Southey as a form of institutional racism.

Dr Southey's research aligns with the Whakatika Research Project, a Te Atawhai o Te Ao project that focuses on collecting information on rangatiratanga and racism in Aotearoa New Zealand. Through this project, it has been found that existing definitions of racism do not adequately reflect the experiences of Māori, and that racism for Māori is historically layered but an ever-present issue in contemporary times. The wider objective of the Whakatika Research Project was to generate new quantitative and longitudinal knowledge of intergenerational trauma, which included the analysis of over 2,000 survey responses on Māori experiences of racism.

The Whakatika Survey, as well as Dr Southey's research on everyday experiences of racism through the suppression of cultural understandings within the mental health system, confirms that racism impacts on Māori on a daily basis in many ways. The harms of racism include grief and anger and it impacts our connections to tūpuna and mokopuna across generations. Racism and discrimination are widespread and will not be conquered through isolated activities; in addressing racism, what is needed, is a constant, consistent, Māori-focused, and multipronged approach.

Te Atawhai o Te Ao is also proud to host Dr Southey's post-doctoral fellowship (funded by the Lottery Health Research Committee, Department of Internal Affairs), which explores how Māori and Indigenous understandings of being can recreate mental health policy and practice in Aotearoa New Zealand. We wish Dr Southey every success with her research endeavours which contribute directly to addressing racism, utilising a Māori and Indigenous-centred approach.

Piki te kaha, piki te ora, piki te māramatanga ki tātau katoa.

Ngā mihi

Dr Rāwiri Tinirau

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He kupu whakaūpoko: Introduction

This paper focuses on everyday experiences of racism through an examination of the suppression of cultural understandings within the mental health system. The issues explored in this paper draw from a larger body of work encapsulated within the Whakatika Research Project (Smith et al., 2021), of which this paper is an output. Smith et al., (2021) use survey data to report on the prevalence and nature of racism affecting Māori on a day-to-day basis. The application of findings from the Whakatika Survey (Smith et al., 2021) in the context of mental health (as an element of well-being and focus of treatment) gives insight into how racism can impact cultural expressions within the mental health system. While the term 'everyday' might reference a sense of the mundane, everyday racism and its impact can be overwhelming. The omnipresent threat of racism (Bonilla-Silva, 1997; Smith et al., 2021) is evidenced in documented daily episodes and is highlighted by its many forms—namely systemic, structural, institutional, and interpersonal racism (Tinirau et al., 2021).

This paper is also part of a wider study (Southey, 2020), that deconstructs the notion of mental illness by exploring Māori and Indigenous understandings of being. The study examined both western and Indigenous worldviews from their most fundamental basis—the metaphysical settings that underpin our beliefs on reality including what constitutes human and more-than-human nature. The main points of this wider study will be drawn from to help shape ideas within this paper related to the cultural space afforded to Māori engaging with the mental health system, challenging the strict parameters of explanation set by a western clinical framework.

One of the fundamental ideas from within this wider study (Southey, 2020) that will be used to guide a discussion of cultural suppression within the current paper relates to the west's construction of the rational individual. This construct is worth discussing before it is referred to throughout this paper because of how it is regarded more conventionally when considered in terms of its seemingly positive virtues. Within this paper, there are references to the non-rational nature of Māori and Indigenous thought, but that should not be understood as a criticism or accusation of limitation. Rather, it is meant as a demonstration of holism and complexity that expands beyond what rational thinking is able to produce. Rationality, and the concept of rational thinking, is commonly associated with intellectualism, regarded as a positive attribute, particularly when judging an individual's intellectual capabilities (for example see Seeskin, 2008). However, rationalism has been criticised for its connection to a human (brain) centered, anti-holistic representation of the world; an orientation created by the pursuit of knowledge defined along essentialist lines, upholding ideas of objective and universal truths (Mika, 2015). The pursuit of essential knowledge as part of rationality's legacy has been said to disrupt and discard other possible ways of knowing that represent divergent views on what counts as 'intelligence' (Glazebrook, 2000). For example, Takirirangi Smith (2015) in discussing alternate ideas on the processes, and location, of thinking and contemplation describes an activity where "thought was centered within the ngākau and was a holistic process" (p. 261). In line with this, Smith (2000) also (re) locates thinking within a wider network of existence, pushing past the boundaries implicated by rationality's focus on the self-contained individual thinker, describing the collective influence that entities have on our thinking. According to Smith, this holistic network can include, for example, 'Te Wānanga a Rangi' (knowledge from above such as intuitive, instinctive knowledge) which points to a more complex understanding than what rationalism and the act of detached internalised thinking can provide. Therefore, if, within this paper, limitation is suggested, then it applies to the idea of the rational individual, demanding that space be made to foreground the more complex holistically connected Indigenous thinker. From here, it is possible to imagine new spaces of understanding where the meaning of our experiences follow the more holistic premises available through Māori thinking.

Types of racism and mental health

Racism is often discussed as a complex phenomenon that exists in different forms, influencing how societies operate and individuals and groups are positioned within societies (Paradies & Cunningham, 2012). Broadly speaking, racism is described in terms of systemic, institutional, and interpersonal racism (Came, 2014; Jones, 2000). However, these distinctions belie the complex interactions between different forms of racism where systems create lived realities, and popular beliefs of the world recreate the social systems in which we live. Nazroo et al. (2020) make this argument when discussing racism's complex points of convergence within the mental health system, highlighting the relationship between systemic and interpersonal influences.

A significant aspect of this shared influence between what are often seen as conceptually different types of racism is the role that collective emotional beliefs of groups of people play in the construction of shared cultural perspectives that manifest as institutional practices. In this sense, Nazroo et al. (2020) argue that "structural racism consists of not just material, but also cultural and ideological dimensions" (p. 266). As Nazroo et al. explain, day to day experiences of discrimination increase the risk of psychosocial stress commonly viewed in terms of personal risk factors creating the imagery of the at-risk individual. This imagery influences the experience of those who engage with the mental health system, shaping institutional responses, and influencing "how identities are perceived, valued, mobilised, and interacted with" (Nazaroo et al., 2020, p. 264).

Within Aotearoa, Māori who engage with the mental health system have been disproportionately affected by practices that, while discussed within the context of institutional and systemic processes, are also examined in terms of how people are perceived including in relation to the level of risk they are believed to present (i.e., at an interpersonal level) (Shalev, 2020). For example, Māori are more likely to be subject to seclusion and restraint, a practice defined as, "the social and physical isolation of individuals in a place of confinement for twenty-two to twenty-four hours a day" (Shalev, 2017, p.16). Two reports commissioned by the New Zealand Human Rights Commission describe the unequal impact of seclusion and restraint on Māori, suggesting that these inequities may be linked to unconscious bias related to ethnicity (Shavez, 2017; 2020). Others who have examined rates of seclusion and restraint by ethnicity make explicit connection between the unequal impact of these practices and racism, describing inequities as an embodiment of discrimination; the acts of physical restraint reflecting systemic racialisation in mental health and perceptions of threat, risk, and severity (Cummins, 2015; Nazroo et al, 2020).

In the context of what is being explored in the current paper, the importance of discussing methods like seclusion and restraint in more intimate terms (i.e., as embodiment) lies in the ability to see the impact of practices, largely described in institutional systemic contexts, as things that take effect at the interpersonal level. Viewing institutional practices in this way gives us a blueprint for examining how aspects of institutional, systemic racism take effect in the lived realities of those who engage with institutions. This recalls the point made by Nazroo et al. (2020) on the intersecting nature of different forms of racism – systemic, structural, institutional and interpersonal. Seclusion and restraint provides a particularly helpful example of how institutional practices (and institutional racism) reach into and impact at the personal level, especially given the physical, visceral nature of this practice. However, it is possible to apply this thinking to other forms of restraint at play within institutions; ones that serve to limit the movements of Māori engaging with the mental health system in ways that may not draw our attention as easily as overt violent and physical practices like seclusion. These forms of restraint, normalised in models of care and treatment, represent another type of convergence between the systemic and the interpersonal, marking the limits of how Māori are permitted to think about our experiences, dictating the degree to which tāngata whaiora (people with experience of mental illness, who are seeking wellness, or recovery of self. Literally translated as people seeking wellness) and their whānau can engage with Māori worldviews (Southey, 2020). While this non-physical form of restraint may not present an observable apprehension of the Indigenous self as directly, within this paper, the author argues that the suppression (and restraint) of cultural expressions is no less harmful.

Systemic silencing: limiting cultural expression

Systemically, the tendency to privilege monocultural frameworks has been tied to the power structures that support dominant worldviews. In line with this, early descriptions of Māori experiences of systemic racism were described in relation to institutional practices where:

> ***[Dominant groups] simply ignore and freeze out the cultures of those who do not belong to the majority. National structures are evolved, which are rooted in the values, systems, and viewpoints of one culture only. Participation by minorities is conditional on their subjugating their own values and systems to those of 'the system' of the power culture.***
>
> (Ministerial Advisory Committee on a Māori Perspective on Social Welfare, 1988, p. 19)

The experience of engaging with systems that limit frames of understanding, setting up the expectation that all cultural viewpoints will be modified to align with dominant knowledges, has been well documented by those who have challenged monoculturalism. Within mental health, Indigenous practitioners have called for a recognition of Indigenous knowledges that follow different patterns of thinking (for example, Durie, 2002). Levy and Waitoki (2016), when discussing Māori psychologies, describe these patterns of thinking as, "a place of opportunity where we privilege our meta-knowledge about the seen and unseen, of knowing and not knowing, and being comfortable with how we interpret and make sense of Māori realities and experiences" (p.18). However, as Taitimu et al. (2018) point out, the western clinical lens remains as a dominant perspective within mental health settings which carries an attitude of suspicion towards non-dominant belief systems and philosophies as part of its dominant position within a wider system of power.

Evidence from within mental health's operational literature appears to support the observation made by Taitimu et al. (2018). For example, Cermolacce et al. (2010) note that the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) included a discussion of the concept of "bizarreness" or "bizarre delusions," pointing to divergent beliefs that were considered, "patently absurd [with] no possible basis in fact (DSM-III) . . . [and] "clearly implausible and not understandable and not derived from ordinary life experiences (DSM-IV)" (Cermolacce et al., 2010, p. 668). The ontological premises underpinning the concept of 'fact' and the view of reality being strictly definable based on factual thinking, however, presents challenges to worldviews that favour more diverse and complex expressions, including the "seen and unseen" referred to by Levy and Waitoki (2016, p.18). Further, references to 'ordinary life experiences' within the DSM highlight the (ongoing) application of standardisation in considering how people live and see the world, including in terms of diverse cultural contexts (Mujica-Parodi et al., 2000). The concept of bizarreness also brings the practice of standardising human behaviour and thinking into sharp focus (Randel et al., 2008), posing a risk to the more inexplicable qualities of Māori and Indigenous beliefs and knowledges that resist standardisation, enforcing the expectation of order in which paradoxes, contradictions, and multiple features and expressions are considered as deficits to be filtered out (Southey, 2020). While the concept of bizarreness has been excluded from the DSM-IV (American Psychiatric Association, 2013), the symbolism of bizarreness, embedded in a clinical frame of understanding the way that people see the world, remains part of the assessment framework (Llewellyn & Van Heugten-van der Kloet, 2018). [1]

Research suggests that for Māori who have engaged with the mental health system as tāngata whaiora, attempts to frame experiences by applying Māori constructions have been met with resistance. Taitimu et al. (2018), in researching the experiences of tāngata

1. The issue is with the idea of plausibility and how this idea is enforced along metaphysical lines. The issue is applied in a global context (i.e., in analysing how the idea of what is plausible, real, or valuable is applied when measuring the worldview of non-dominant communities - including Māori). What constitutes a delusion would be part of the question of plausibility. The question is, 'what does a dominant western culture believe is plausible from their cultural perspective?' We live in a power system where that cultural worldview is then applied as the standard against which other cultures are measured. In mental health this measurement is referred to as clinical assessment and diagnosis.

whaiora, found that there is an ongoing tendency for a western clinical lens to be used to evaluate Māori expressions within the system. As Taitimu et al. explain:

> ***[I]t was ... apparent that many participants had their constructions ignored, marginalised, or pathologised within mainstream settings. This indicates that in some instances, there has not been a significant shift in the system in terms of acceptance of Māori constructions. This may be especially the case for the diagnosis of schizophrenia, as it remains the most medicalised mental disorder.***
>
> (Taitimu et al., 2018, p. 171)

Further, Taitimu et al. (2018) note that within an international context, there is a push to apply western clinical diagnostic constructs to diverse cultural populations, advertised as a move to ensure these populations have equal access to mental health care. As part of this process of universal and standardised application, the concept of mental health literacy is framed as a pathway to providing access to a gold standard of care. However, the language of equity co-opted by the Movement for Global Mental Health, can be seen as code for "the degree to which one agrees with psychiatry's belief that one's distress is a manifestation of a biologically-based illness", an agreement that carries the goal of liberating Indigenous and minority cultures from "local spiritual or social causal beliefs . . . characterised as misinformation or ignorance" (p.156).

The view that non-dominant cultural perspectives and knowledges represent a type of epistemic and ontological deficiency poses risks to Māori in terms of what Ahenakew et al., (2014) refer to as limiting "the possibilities of articulation" (p. 217). The intangible aspects of Māori models of health and well-being, while gestured to in health policy[2] are at odds with a dominant western knowledge structure—one that prefers the presentation of all things as observable, measurable objects represented through an exclusively western scientific lens (Boulton, 2005; Kiro, 2001; Waitangi Tribunal, 2019). Further, the practice of utilising western viewpoints as a type of 'implicit standard' (Sampson, 1993) against which other cultural knowledges can be measured demonstrates the disqualification of non-dominant cultural viewpoints from being counted as legitimate—an act of epistemic racism that is a central feature of systemic racism (Swan, 2018).

Recently, we have seen an example of this attitude applied to Māori and Indigenous models of care within a local mental health context. Moon and Derby (2019), in examining Māori and Indigenous understandings of trauma, challenge the idea that models of trauma-informed care can be based on collective, intergenerational, and holistic perspectives[3], which differ from western trauma treatment models that focus on an individual's direct experience of trauma. Their method of disqualifying Māori and Indigenous perspectives generally consists of presenting the components of western definitions of trauma and determining that Māori and Indigenous models are not the same. Moon and Derby also take exception to a non-clinical grounding, stating that Māori and Indigenous models of trauma represent a "deficit in a clinical understanding of trauma" (2019, p. 4), and that some of the Indigenous people who have written about trauma have no qualifications in psychology. Using this implicit standard of definition from within western psychology, Moon and Derby lay out a determination of "what trauma is, and how it is (and is not) acquired" (2019, p. 5). There is, it seems, no room for divergent understandings of trauma.

2. Examples include *He Korowai Oranga, Māori Health Strategy* (2002).
3. Examples include Pihama et al. (2017), and Smith and Tinirau (2019).

The attempt to assess Māori and Indigenous perspectives by using non-Māori, non-Indigenous conventions is problematic. As Durie states:

> ***Both indigenous knowledge and science are shaped by particular worldviews and each is bounded by a set of conventions that confer credibility and consistency as well as limitations. Importantly, the tools of one should not be used to analyse and understand the foundations of the other.***
>
> (Durie, 2009, p. 242)

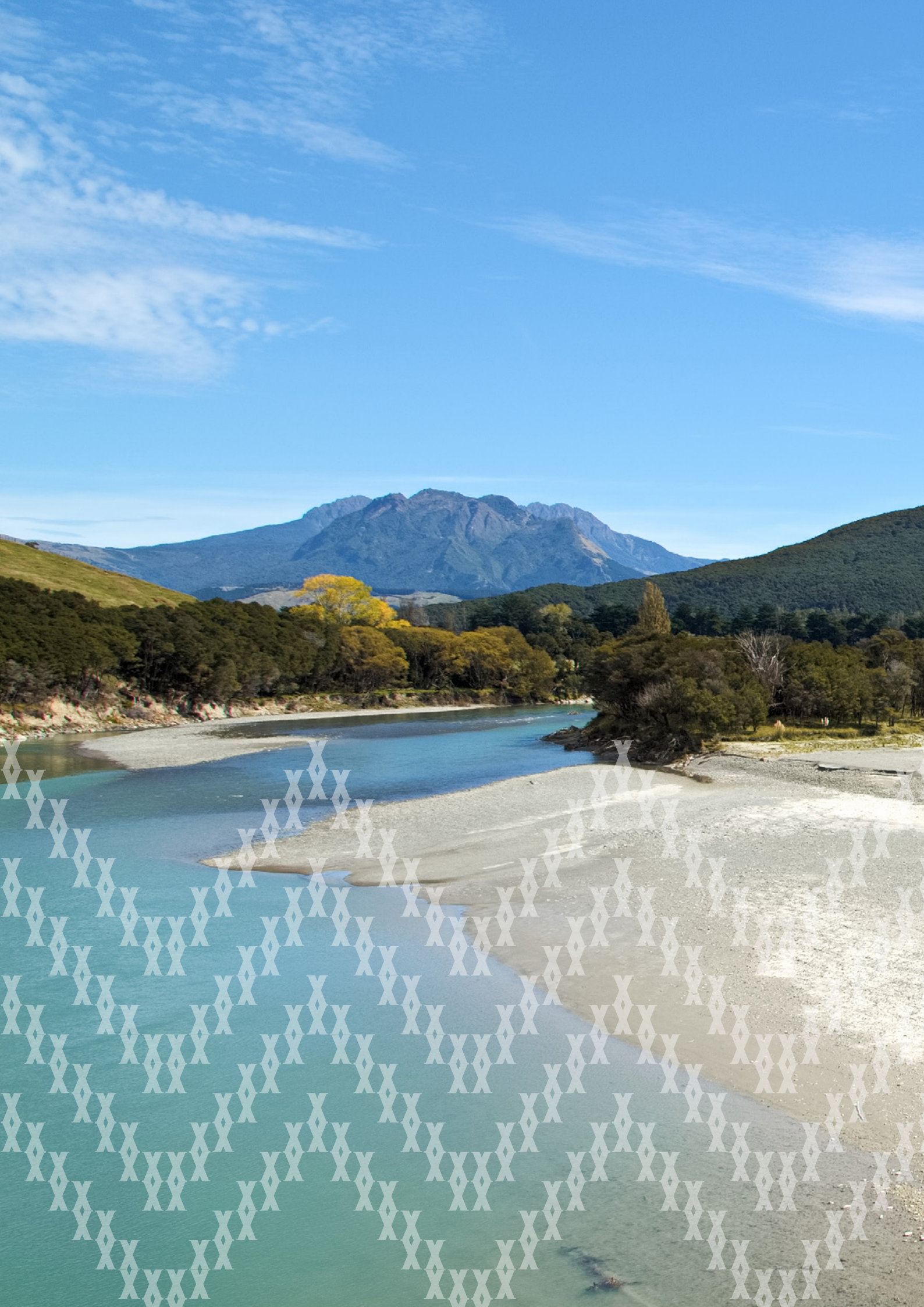
Durie's caution highlights the incongruency created by attempts to draw Māori and Indigenous worldviews into external frameworks. However, what is significant in the context of this paper is the potential for limiting tāngata whaiora sensemaking that these types of critiques of Māori and Indigenous thinking represent—the overbearing instruction upholding the exclusive, universal legitimacy of western health models that states, "you can't think that" (Southey, 2020, p. 180). For Māori engaging with the mental health system, this represents the potential for an everyday experience of cultural suppression—one that is driven by both institutional epistemic norms and the application of these norms as clinical practice. The potential for Māori to articulate experiences from within Māori ontologies is diminished along with the types of support that can be accessed. As Borell et al. (2009) explain, the way we name issues frames the solutions we construct, privileging certain approaches over others. In terms of Māori models of mental health, like the models of trauma discussed here, framing experiences in strictly western (clinical) terms maintains the privileging of western discourses, determining "the wider rules of practice which ensure that western interests remain dominant" (Smith, 1999, p. 47).

Tāngata whaiora and possibilities for articulating Māori subjectivities

The ability for people to construct personal subjective meanings of their experiences within the context of mental health has been linked to enhanced outcomes (Lambrecht & Taitimu, 2012; Randal et al., 2008). Despite this, subjective expressions are often excluded from mental health treatment approaches (Roe & Lachman, 2005). Further, Herbert (2019) describes how in addition to subjective expressions being restricted within treatment settings, they are often used to justify clinical concerns, interpreted as pathology where "if you speak of sadness, they speak of depression. If you speak of happiness they speak of exaltation or mania" (para. 4).

For Māori engaging with the mental health system, the ability to appeal to cultural subjectivities is impacted on by the knowledge systems that support the pathological lens. However, in a wider sense, Māori cultural subjectivities are fundamentally impacted by what Gillett (2009) describes as a view of the world as an "impersonally specifiable" (p. 5) space, where ideas of the individual, objectivity, and discernibility are embedded in western beliefs of how the world functions. Māori understandings of the world emerge from different epistemic and ontological settings, ones that Marsden (2003) describes as subjective experiences of reality that are not always available to rational synthesis, a view that is relevant to the critique of the metaphysics that underpins the notion of rationality presented earlier in this paper.

The distinction between Māori and western viewpoints within mental health has been captured by Milne (2005) when analysing the systems' efficacy in providing support for Māori. Milne's work included gathering insights from Māori who had experienced the treatment system directly, some of whom argued for independent Māori approaches to healing, opposing integration models, and expressing concerns of what was seen as a deep and fundamental dissimilarity between Māori and Pākehā (European



settlers of New Zealand) thinking. A central theme emerging from these responses was in fact entitled, "Māori think differently from Pākehā" (Milne, 2005, p. 12), illustrated beautifully by one kaumatua who represented this view of fundamental difference by describing their own experience of seeking help from a mainstream service. The kaumatua wondered how, without the right understanding of their state of unwellness and its relationship to fundamental parts of their being, including a mauri that was 'jarred and shaken', a mainstream service would know what to do. In his own words, he wondered how this mainstream approach would, "help to reinstate my mana [power, status, prestige] and my mauri [energy; life force]" (Milne, 2005, p.13). This question forces an examination of the mental health system's philosophical settings and poses a challenge to a western knowledge framework—one that follows Blaser's (2014) call to take multiple ontologies seriously, letting go of dominant positions where "we surrender any effort to hear about 'things' that our categories cannot grasp" (p. 52).

Much is at stake here for tāngata whaiora and whānau (family) who experience these dominant positions as face-to-face encounters. The biomedical model remains a central tenet of the health system (Masters-Awatere & Graham, 2019), recognised by Came (2014) as one part of the many sites of racism that have prevented progress in developing space for Māori knowledges to be actualised as models of care. Research on Māori experiences of mental health treatment settings shows that some have felt forced to reframe their experiences in psychiatric terms, sacrificing personal and cultural subjectivities in efforts to avoid what they see as real risks of being judged or pathologised (Taitimu et al., 2018). Objectification of the self within mental health has also been raised as an issue directly linked to western scientific research and discourse, where Sadler (2004) observes that many patients begin to think of themselves as DSM jargon developing self-identities as diagnostic concepts.

Within the rigid confines of a dominant western epistemology, systemised in standard processes within mental health treatment settings, Māori articulations are restricted, silencing more complex, holistic representations. This point is captured by Rangihuna et al., (2018) who warn:

> ***The use of 'the psychiatric format', that is, a medical paradigm employing one-on-one interviewing, a DSM-5 diagnosis, a biomedical cause of disease, and a treatment regime involving psychotherapeutics, medication, and seclusion eschews any consideration of the relationships, meaning, values, beliefs, and cultural practices that are important to Māori.***
>
> (Rangihuna et al., 2018, p. 79)

Moreover, the silencing of Māori cultural subjectivities has been described as something that stems from a discriminatory attitude towards Māori ways of knowing described by Smith (2019) as the reclassification of Māori knowledges as myth.

Mika (2017) links western health models and the insistence on tangible indicators of well-being to a reliance on what is visible and therefore available to objective thought. However, as noted earlier, a Māori view of well-being allows for a model that is more complex and in fundamental ways, less immediately accessible to rational thinking (Marsden, 2003). The potential of these complexities links back to what has been discussed here in relation to the benefits of personal subjective accounts and meaning-making within mental health. But it also provides potential in terms of presenting a ground of thinking where the less tangible aspects of well-being support an understanding of how Māori ontologies, foregrounded through questions on the reinstatement of 'mana and mauri', can be effectively catered to in health systems.

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For Mika, considerations of tangible contributors to well-being (for example, access to appropriate food resources and clean environments etc.), must be considered alongside non-tangible aspects that include our ability to

> *resonate properly with one's place, perceive other things in the world as if they are all connected and living, acknowledge and name the self as one animate entity among many others with essentially no separation from them, and label a concept along holistic lines (Mika, 2017, p. 45).*

Expanding the parameters of meaning within mental health is, therefore, a fundamental step in ensuring that Māori models of health, including the intangible aspects of being, are taken seriously within the mental health system.

Māori and Indigenous constructs in mental health: Beyond rigid notions of mental illness

The implications that Māori constructs have for the concept of mental illness and mental health include posing a necessary challenge to the idea that mental illness is a universal fact, making room for other possibilities in how we view things. In line with this, it should be noted that, outside of Māori and Indigenous critiques, much that has been written on mental illness as a problematic notion has focussed on how the idea of mental illness has emerged as a constructed concept embedded in cultural and historical perspectives (For example see, McCann, 2016; Walker, 2006). As Smith (2012) states, "what makes ideas 'real' is the system of knowledge, the formations of culture, and the relations of power in which these concepts are located" (p. 50). Moreover, in terms of the concepts of mental illness and mental health, from a Māori viewpoint, we might also consider a challenge that Smith poses to the very notion of the mind, stating that "whilst the workings of the mind may be associated in Western thinking primarily within the human brain, the mind itself is a concept or an idea" (2012, p. 50); Māori constructs would point to a more embodied sense of intelligence.

Other ways of knowing have emerged from Māori and Indigenous frameworks that relocate 'thinking', to a more holistic plane. For example, Smith (2000) links acts of expression such as writing and speaking to mauri and whakapapa (genealogy; lineage; descent), describing these acts as a form of co-creation; the endless connections at play with ancestors and other relations who are fully involved in our experiences. This sense of relational being is also reflected in Rifkin's (2017) description of Indigenous temporal spaces where our relationships with others form "rhythms—patterns of consistency and transformation that emerge immanently out of the multifaceted and shifting sets of relationships" (p. 33), forming a view of communities as intelligent organisms. A similar sentiment, in terms of embodied intelligence, is also expressed by Aluli-Meyer (2006) who raises the possibility of an alternative view of the self through a holistic Indigenous metaphysics of (something more than) the mind, described as knowing from what the body sees rather than from generalisable rational interpretations.

These examples of different ways of knowing disrupt the strict interpretation of the person as an individual who can be analysed in scientific terms through an examination of cognitive processes. Rather than simply representing a cultural preference for how we can talk about ourselves and our experiences, Māori and Indigenous ways of knowing have the potential to provide wellness to those permitted to engage with these worldviews. Conversely, for Māori seeking treatment in the mental health system, when only limited frames of reference are permitted, whole systems of meaning must be discarded, restricting the possibilities of how tāngata whaiora can perceive themselves. In line with this, Mika (2015) asserts that the world affects the Māori perceiver. The mere act of contemplation has an effect on the self—a simultaneously spiritual and material shaping that is part of the indivisible relationship the self has with all things in the world. Reminiscent of Smith's (2000)

description of co-creation, there is a type of spiritual and material indivisibility at play—one that has the potential to impact on our well-being. As Mika (2015) explains, if epistemic structures, including those that govern institutions like mental health, force us to view ourselves and the world through a disconnected, objective lens, a type of violence is enacted. This violence can be viewed as a form of severing—disconnecting the self from important cultural premises that locate people within cosmologies (Murphy, 2011; Rangihuna et al., 2018), more than human genealogies (Simmonds, 2014), and the spaces marked by the unseen (Levy & Waitoki, 2016). But it is also a violent suppression of all things that do not easily fit within predetermined boundaries—the complex, creative, cultural expressions that exist outside of the frame.

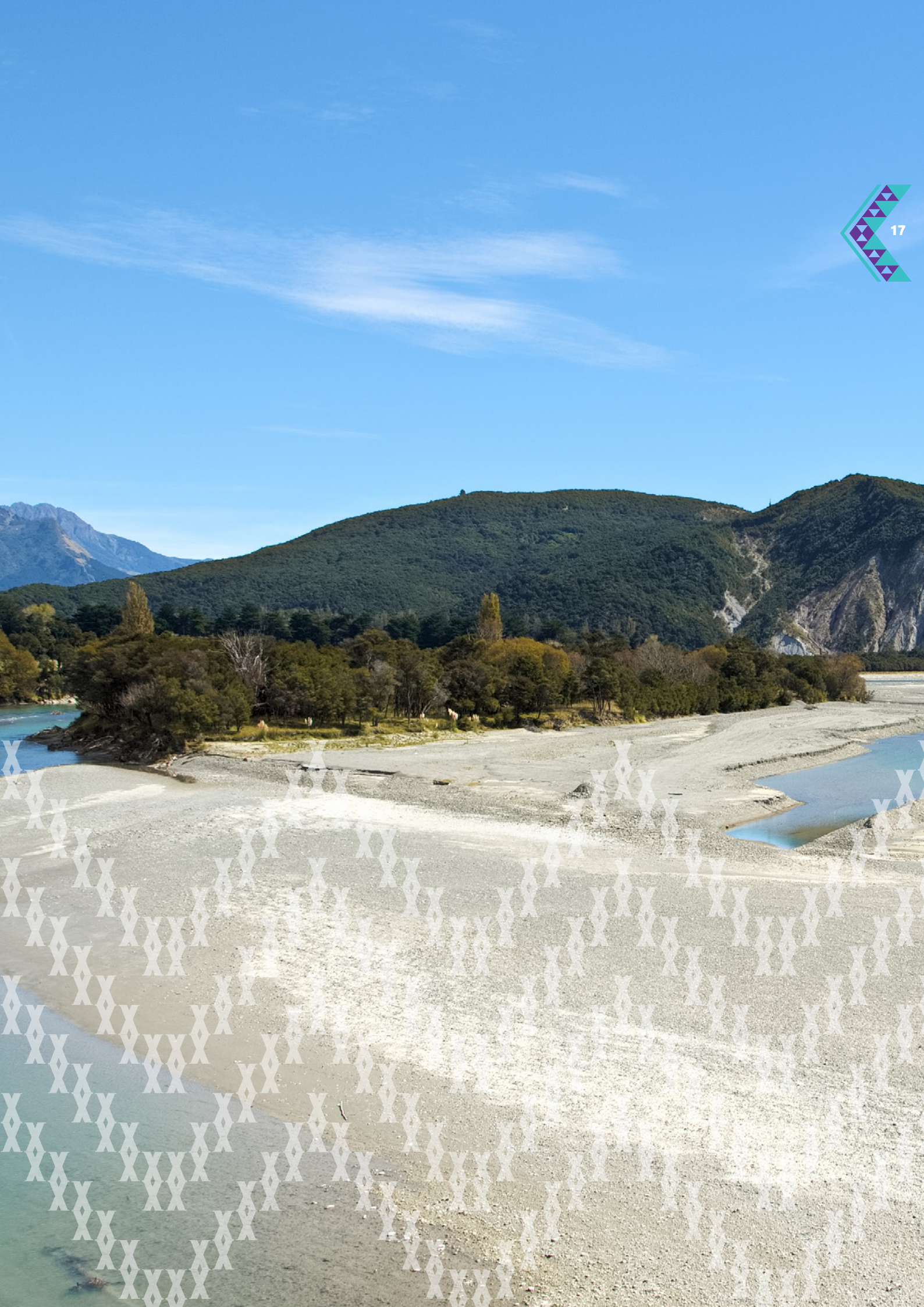
He kupu whakakapi: Conclusion

Examples of cosmologies and invisible connections can appear normal from a Māori worldview, however, it is important to consider how these things may be seen within a system guided by different ontological premises. A view of the world that favours visible and measurable variables (the visible aspects of a person's physical and social existence), and its suspicion of the intangible has real impacts on tāngata whaiora whose expressions appear to fit long-held beliefs on bizarreness and disorder. If what makes ideas 'real' are the systems of power that support these points of view (Smith, 2012), then the systemic institutional privileging of western epistemologies and ontologies reflected in the dominance of the western clinical framework must continue to be challenged. Rather than representing a standard of efficacy that cannot be achieved through engaging other knowledge systems, it is argued that this privileging represents an epistemic and ontological form of restraint—one that exists alongside the many instances of physical restraint (seclusion) experienced by Māori in mental health settings. As an experience of everyday racism, these forms of restraint, both physical and metaphysical, highlight an ongoing bias that Māori may experience when engaging with the mental health system—the separation and seclusion of Māori from belief systems that offer potential for healing and recovery.

He kuputaka: Glossary

Use of tuhutō (macrons): the introduction of macrons over some Māori vowels, have (1) clarified definitions and (2) made it easier to pronounce Māori words (i.e., knowing where to place the emphasis as you are saying the words). When we quote sources from earlier periods where macrons have not been used, we have not included the macron to remain true to the original text. In the glossary, we have included both versions of the word (with and without macrons).

arapaki	interior woven wall panels
awa	river
Hawaiki	ancient homeland
kaokao	the name of a tukutuku pattern
mana	power; status; prestige
mauri	energy; life force
Ngāti Porou	tribe from the East Coast, north of Gisborne
niho taniwha	'teeth of the taniwha'—signifying strength and resilience
Pākehā / Pakeha	European settlers of New Zealand
takapou wharanui	matrimonial woven 'mats'
tāngata whaiora	people with experience of mental illness, who are seeking wellness, or recovery of self; literally translated as people seeking wellness (Ministry of Health, 2004).
tapu	scared
te ao Māori	the Māori world
te ao Pākehā	the Pākehā world
Te Wānanga a Rangi	knowledge from above such as intuitive, instinctive knowledge
tohu	sign, symbol, token
tukutuku	interior woven wall panels
whakapapa	genealogy; lineage; descent
whānau / whanau	family
whanaunga	relative; relation; kin



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Ngā āhuatanga toi: Conceptual design

For Māori, water and its sources, are symbols of healing and as a result, polluted waterways are seen as tohu (signs, symbols, tokens) of illness. However, as the definition of tāngata whaiora implies, we are in a constant state of seeking wellness for ourselves and our environment because, for Māori, we are interconnected with each other and our environs. The cover photo (taken by Peter Moore) is of the Waiapu River at Ruatōrea and is the river that the author (Dr Kim Southey) connects and recognises as the lifeline of her iwi, Ngāti Porou (tribe from the East Coast, north of Gisborne).

The river connects people and places. It is a source of sustenance, for food, water, cleaning and the like. The river runs to meet the sea, which reminds us of where we came from (Hawaiki: ancient homeland) before arriving here. It reminds us of a time when we were free to live our customs without external interference and where there was a mutual understanding of how and why we did what we did. The subject of this publication alerts the reader back to this time, yet as a result of colonisation, Pākehā and other foreign customs and practices have been forced upon us, seen as being superior to tikanga Māori. This, in and of itself, has created mental health issues for Māori, given the differences between te ao Māori (the Māori world) and te ao Pākehā (the Pākehā world).

The Waiapu River, like other river systems, has been impacted upon by issues such as sedimentation, erosion, natural degradation, and unsustainable land-use practices to name a few. There is a need to heal our river systems, which might require an understanding of things from a scientific perspective, making use of geological and ecological information. But in other ways, that are more holistic, it requires that we understand these issues from a relational perspective – looking at how the awa (river) has been regarded, and conceptualised. The awa is our whanaunga (relative, relation, kin). Starting from this point, we could make changes in how the awa is related to and restored.

We see similar issues affecting tāngata whaiora. How tāngata whaiora are regarded sets up the conditions for how they are treated, which is predominately supported by a clinical view which in turn silences more holistic ways of considering the person. Just as Ngāti Porou are working to bring iwi knowledge into the centre of the healing process for Waiapu, there needs to be a space for Māori understandings of being in the healing process that tāngata whaiora experience.

Therefore, and in terms of the conceptual design of this publication, the theme of the awa runs throughout with the imagery and the symbols used.

This publication also falls under the Whakatika Research Project, where the use of the UV overlay using the arapaki/tukutuku (interior woven wall panels) pattern of kaokao (the name of a tukutuku pattern), as a representation of a warrior stance at the ready, of unison, and of strength. Within Whanganui, and according to Te Otinga Waretini (1990), the kaokao pattern was used on takapou wharanui (matrimonial woven 'mats'), used for those of high rank, and woven using human hair. The tapu (sacredness) associated with takapou wharanui is therefore apparent and was used to help with conception and ensure a long line of succession.

The colour blue is borrowed from the sky of the Waiapu River photo and is a depiction of our aspirations of a world without racism. A lofty goal, but a worthy one. The symbols located next to the page numbers are inspired by the kaokao pattern but also features the niho taniwha ('teeth of the taniwha', signifying strength and resilience). The colour purple is used in recognition of the gallant bravery demonstrated by Lt. Te Mona-nui-a-Kiwa Ngārimu and the C Company of the 28th (Māori) Battalion at Tunisia in March 1943 (Ngata, 2002). Ngārimu died as a result of his bravery, and his parents were presented the Victoria Cross for bravery in October 1943 at Ruatōrea, attended by over 8,000 people (Ngata, 2002). This act of bravery was, among other consequences, to unite Māori and Pākehā and the cause of much respect, even from the enemy, at the

time (Ngata, 2002). Given the various design elements outlined in this section, in order for true, meaningful change to occur, it requires commitment and unity from all: Māori, Pākehā, government agencies, health professionals, workers, and more, to ensure our children are born into a different, better world.


Te Atawhai o Te Ao
Independent Māori Institute for Environment & Health