RECONNECTING WHĀNAU

Pathways to recovery for Māori with bipolar disorder

*Waikaremoana Waitoki**

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Abstract

While Māori are known to experience a higher burden of mental health and addiction problems compared to non-Māori (Baxter, 2008), little exploratory research has been conducted into Māori experiences of bipolar affective disorder. Bipolar disorder is at times regarded as a "life sentence", with little hope of recovery. The recovery-focused mental health literature, however, argues wellness is achievable for even the most intractable conditions (Lapsley, Nikora, & Black, 2002; Mental Health Commission, 2001). The aim of this research was to gather information about the experiences of Māori who were diagnosed with bipolar affective disorder. Interviews were conducted with 22 Māori wāhine (women) and tāne (men), and using thematic analyses, themes relevant to their life stories were uncovered. This research sought to contribute to the realisation of Māori potential by explicitly shifting from deficit-focused frameworks to a focus on systemic factors that influenced Māori wellbeing. Highlights were that whānau (participants) who were connected with friends, partners and family were motivated to achieve wellness and to stay well.

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Keywords

Introduction

> I had all of these terrible things happen in my childhood. It would have been a miracle if I hadn't ended up with bipolar or a mental illness. (Niwareka)

The comment above reflects a feature of bipolar affective disorder where it is not always known whether situations within a person's life act as triggers to an existing biological vulnerability or whether the symptoms are normal reactions to intensely distressing life events. In either case there is a clear need to provide appropriate and timely supports to ensure that Māori live in ways defined as important to them. The results of this research show that Māori with a diagnosis of bipolar disorder experienced greater unmet need throughout the entire course of their mental illness, placing them at significant disadvantage.

Since 2006, diagnoses of mental health disorders for Māori have increased (Mauri Ora Associates, 2006; Ministry of Health, 2012; Waikato District Health Board, 2008). Baxter's (2008) research into Māori mental health rates provided evidence that Māori have higher needs than non-Māori. Māori feature disproportionately across all health statistics and experience the highest rates of health disorders among ethnic groups in New Zealand (Baxter, 2008; Māuri Ora Associates, 2006; Neilson-Hornblow, 2009; Oakley-Browne, Wells, & Scott, 2006). Baxter's (2008) findings concluded that Māori are 1.7 times more likely to develop a mental disorder compared with non-Māori, and also showed that three in five Māori are likely to experience a mental illness at some point in their lifetime.

Bipolar disorder

Descriptions of bipolar disorder have changed with the new *Diagnostic and Statistical Manual of Mental Disorders 5* (*DSM-V*) released by the American Psychiatric Association in 2013. However, as this study was conducted prior to 2013 the previous version of the manual was used (*DSM-IV*; American Psychiatric Association, 2000).

Bipolar disorder is a mood-related disorder producing episodes of extreme contrasts both in mood in functioning (Gruber, Eidelman, Johnson, Smith, & Harvey, 2011; Power, 2005). People with bipolar disorder are known to experience high levels of life stress even during symptom-free periods, while individuals who live with significant, negative life events relapse faster and take longer to recover from bipolar episodes than those without such events (Jones & Tarrier, 2005).

While the pathway to bipolar disorder is widely known to have biological and genetic links, the evidence for socio-political and historical links is mounting. Bio-psycho-social explanations of mental illness provide avenues to consider the various interactions between psychological, sociological and biological factors and how they contribute to mental illness across the lifespan. Research shows that a home environment with psychosocial stressors such as abuse, harsh and critical communication style, deprivation, drug and alcohol abuse, violence, sexual abuse and neglect is associated with mental illness, with certain individuals more susceptible than others (Mason & Bevan-Pearson, 2005; Walker & Diforio, 1997). Other researchers argue that for some individuals, exposure to child abuse produces changes in brain and personality development that increases susceptibility to mental illness such

as schizophrenia (Read, Perry, Moskowitz, & Connolly, 2001).

Theories premised on experiences by indigenous peoples of collective trauma resulting from colonisation, genocide, land loss, cultural assimilation and assaults to nationhood offer unprecedented links to a range of mental health and addiction disorders. Although these theories are not the focus of this report, future research for Māori and bipolar disorder is needed.

The features and outcome of bipolar disorder are affected by the presence of negative life events; disruptive situations and ongoing stressors that impact symptom severity; relapse rate; and recovery (Cerullo & Strakowski, 2007; Johnson, 2005; Johnson et al., 2008). Furthermore, bipolar disorder impacts on an individual's ability to live well, affecting social relationships (McGorry, 2005; Ramon, Healy, & Renouf, 2007), working life and physical health (Adrian & Hammen, 1993; Ministry of Social Development, 2010).

Māori are a highly vulnerable population whose experiences of psychosocial adversity and exposure to stress contribute to a greater risk for depression, substance abuse, anxiety, schizophrenia and bipolar disorder. With these risks in mind, it is vital to consider the pathways that contribute to high diagnosis rates of bipolar disorder for Māori, and importantly, to consider Māori-determined pathways to recovery.

Conceptual framework

In this research we explicitly used Whānau Ora (family health and wellbeing) as a conceptual framework that rejects deficit theorising about Māori mental health. Deficit-based frameworks, or the problem-focused approach to understanding Māori mental health needs, tend to conceptualise risk factors in terms of individual and/or family deficiencies and dysfunction (Bishop, Berryman, Tiakiwai, & Richardson, 2003). The narrow, individual-as-the-cause approach contributes to the spread of unrelated, problem-specific interventions that increase susceptibility to poor outcomes for all concerned (Ball, 2010; Guerra & Bradshaw, 2008).

Whānau Ora

The New Zealand Government's expectation for Māori health development is Whānau Ora, in which Māori families are supported to achieve their maximum health and wellbeing (Ministry of Health, 2002). The Whānau Ora model was used in this research as a framework to conceptualise positive pathways for Māori who have a diagnosis of bipolar disorder. The framework considers the interrelated needs of all whānau (family) members rather than focusing solely on diagnosis or treatment in isolation from the wider whānau, community, social, political and medico-legal context of Māori lives.

Whānau Ora as a unifying concept encompasses Māori aspirations of good mental health as being embedded in cultural identity (Mental Health Commission, 2007). Prioritising collective wellbeing for whānau, in the many ways it manifests, provides an environment where security, connection, support, belonging and identity can be nurtured (Irwin et al., 2011). The significance of whānau as agents for change and a catalyst for Māori development has been at the heart of Māori paradigms of wellbeing for many decades (Mental Health Commission, 2007).

Recovery

Although the term "recovery" supposes that one has "recovered" and is "living well", it is clear that recovery refers to the episodic nature of mental illness and shifts thinking away from the chronicity paradigm where mental illness is seen as permanent and individuals or groups are

blamed for their mental health status (Ramon et al., 2007, p. 109).

The Mental Health Assessment and Outcomes Initiative (MH-Smart) Tāngata Whaiora Roopu conceptualises recovery as "recognising the importance of whānau in the process of recovery, diversity of whānau, contributors to whānau breakdown and the importance of rebuilding whānau" (MH-SMART Outcomes Initiative Tāngata Motuhake/Whaiora Roopu, 2005, p. 1).

According to He Korowai Oranga—the Māori Health Strategy:

The outcomes sought for whānau include:

- whānau experience physical, spiritual, mental and emotional health and have control over their own destinies
- whānau members live longer and enjoy a better quality of life
- whānau members (including those with disabilities) participate in te ao Māori and wider New Zealand society.

These outcomes are more likely where:

- whānau are cohesive, nurturing and safe
- whānau are able to give and receive support
- whānau have a secure identity, high self-esteem, confidence and pride
- whānau have the necessary physical, social and economic means to participate fully and to provide for their own needs
- whānau live, work and play in safe and supportive environments.
                (Ministry of Health, 2002, p. 1)

With these views in mind, understanding Māori experiences of bipolar disorder requires recognition of the multiple intersecting pathways into unwellness and recovery and an emphasis on inclusiveness, collectiveness and interdependence.

The study

Findings: Pathways into mental illness

We describe a small part of the study relating to pathways into mental illness in the following sections: "Adolescence: The pivotal period", "Unmet need", "Support to be parents" and "Maintaining social connections". The intention is to show how addressing the negative effects of bipolar disorder require timely family-focused interventions.

In our study, the term "whānau" was used to describe each participant, whereas the term family refers to the relatives of each participant/whānau. Twenty-two whānau participated in this study: 15 wāhine (women) and 7 tāne (men). Ages ranged from the early 20s to late 70s. Eight wāhine had children and grandchildren and four tāne had children and or grandchildren. The majority of whānau were employed in the mental health service as support workers, administrators or policy developers. Other whānau were unemployed, or studying part- or full-time. Relationship status ranged from single, recently separated or divorced, married, in a de-facto arrangement, or the status was unspecified.

Adolescence: The pivotal period

The findings of this research highlight pathways into mental illness for some whānau that could have been avoided earlier. Exposure to varying levels of childhood adversity, such as sexual and physical violence, parental mental illness, multiple and/or abusive foster care, and abandonment issues, led to acute levels of post-traumatic stress, substance abuse, poor relationship choices, depression, anxiety and safety issues. Whānau also pointed to adolescence as a difficult period where anxiety, depression and substance abuse dominated, often in response to adversity.

It is relevant that an existing problem was evident across most whānau, suggesting that,

for some, had those issues been addressed earlier, they may have avoided a severe mental health diagnosis for behaviour that was often a reaction to extreme stress. On the other hand, some whānau found that a bipolar diagnosis and medication gave them a sense of structure and coherence to their lives.

Unmet need

In relation to mental health diagnosis, all whānau had been diagnosed with bipolar affective disorder at some point in their lives. The narratives collected from each whānau revealed chronic levels of unmet need that began (for some) in childhood, adolescence and, for others, in early adulthood. The levels of unmet need created a cycle of health disparity, placing whānau at a significant disadvantage resulting in lost productivity and potential. Moreover, that need crept into the senior years, as whānau became primary caregivers to their grandchildren or they were disconnected from their children and grandchildren.

Support to be parents

Across the study whānau experienced conditions that impacted on their ability to raise their children, such as unstable and inadequate housing, poverty, low education, difficulty getting good jobs, and problems holding down full-time employment. Gender issues were evident as female whānau were often powerless in their intimate relationships and during pregnancy and childbirth. Some women lived in constant fear of losing their children, while others had their children taken from them, or were told not to have children. Several male whānau were equally concerned about losing their children or that they were not able to provide for their families, challenging their notions of being a husband, partner and father.

Maintaining social connections

Wellness means being able to live normal, fulfilling and productive lives with family and friends (Lapsley, Nikora, & Black, 2002). Māpihi said her friends helped her to recover by keeping her company:

> The things that have made the most difference to me were when friends would say, "Come and do something with us", and I would usually say no. But they never gave me the chance to say no …

During the illness phase of bipolar disorder, whānau often experienced disconnection and feelings of isolation, or wanting to isolate themselves from others. It was noticeable that some whānau required intensive support and ongoing supervision and care for basic needs such as providing shelter, taking care of children, keeping safe, eating, sleeping, washing and keeping mobile. For some, reconnecting with family and friends meant fixing the damage done during times of illness. Durie (1999) emphasised the importance of considering a Māori patient's entire sense of wairua (spirituality) and well-being, and enabling them to re-connect with whānau without assuming that medication and symptom-only focused treatments are the best approaches (Jones, Mulligan, Higginson, Dunn, & Morrison, 2013).

Conclusion

The overall finding from this research points to the urgency to provide additional support to strengthen whānau and their families throughout their lifespan. When external and internal factors to achieving wellness were optimal, whānau were more productive in their lives enabling them to reconnect with and enjoy their family and personal relationships.

Improving Māori mental health and reducing inequalities cannot be achieved by health

services alone while social and economic factors such as employment, housing and poverty continue to impact on mental health, wellbeing and recovery (Cram, 2011; Durie, 1999; Kingi, 2011). Also, inequity in access to health services across the life-span prevents the full realisation of wellbeing for Māori (Mental Health Commission, 2012), creating cycles of disparity. Tangible mental health for Māori requires access to te reo Māori (the Māori language), land and marae (traditional meeting grounds), and ready access to primary health care, education, housing and employment opportunities (Ministry of Health, 2005).

It is important that all policy directives emphasise the importance of whānau receiving timely, high quality, effective and culturally appropriate services (Mental Health Commission, 2004). This approach recognises the whānau as the principal source of connection, strength, support, security and identity, and that each person within that whānau is central to the wellbeing of Māori individually and collectively.

Glossary

marae	traditional meeting ground
tāne	men
te ao Māori	the Māori world
te reo Māori	the Māori language
wāhine	women
wairua	spirituality
whānau	family; participants in the study
Whānau Ora	family health and wellbeing

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