COLONISATION

The experience of a psychiatric nurse through the lens of

Reflective Autobiography

By

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ABSTRACT

The oppression of colonization lives on in the daily lives of colonized people. It is vital for us as nurses to understand the effects of that oppression, as well as the restrictive impacts, and dislocation from one's land and culture to-day. Nurses come from both the descendants of colonisers and the colonised. This thesis is a journey and a quest for insights into the impacts and significances of colonisation by looking at historical and socio-political contexts that have bearing on the health of colonised people who remain mostly powerless and marginalized. It is prompted in response to a cultural safety model which advocates that nurses should become familiar with their own background and history in order to be culturally safe in practice.

This reflective autobiographical account is a personal effort and provides the foundation for an exploration of issues during nursing practice encounters, from a colonised ethnic minority perspective. The method was informed by Moustakas research approach and Johnstone's Reflective Topical Autobiographical process. The selection of specific events are deliberate, to make visible some of the many barriers that exist within our health structures as pertinent issues for non-dominant cultures that remain on the margin of our society. Maori issues provide a contrast and became a catalyst for me as the author while working for kaupapa Maori services in Aotearoa/New Zealand.

The intention of this thesis is to generate new knowledge about what it means to be a nurse from an ethnic minority working in a kaupapa Maori mental health service, and to encourage other nurses to explore these issues further. Some recommendations are made for nurses in the last chapter, as I believe that they are ideally situated to build upon the strengths indigenous people already have and contribute positively toward the improvement of poor health outcomes of the colonized people in an embracing and collective way.

ACKNOWLEDGEMENTS

TIMATANGA - THE BEGINNING

A NON RELIGIOUS PRAYER IN RECOGNITION OF A DIVINE FORCE

Hymn of love

Start the day with love

Fill the day with love

End the day with love

God is love

Love is the energy in creation

God is the energising power of love

Therefore with all the angels and ark-angels

And all the glorious company of heaven

Evermore praising you and saying

Tapu, Tapu, Tapu Rawa

Ki tonu te Rangi, me te Whenua

I to kororia, kororia, kororia, kia koe

Io matua, matua Atua

Tihei, tihei, Mauriora

(Eru Potaka Dewes)

Waananga at Whakahurangi Marae Stratford, Taranaki - 2003.

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CHAPTER ONE: The focus & context of this research

1.1. Introduction

Colonisation is not a relic of the past that stopped when the colonial powers moved out of places they invaded. In many parts of the world, millions of people like me are displaced, as well as having undergone many changes through being assimilated. I was born in Mauritius, speak English and French, look Indian but do not feel Indian, travel on a British passport, and I am now a permanent resident in Aotearoa/New Zealand. I am a psychiatric nurse by profession, and through this reflective autobiography I am attempting to make sense of the impact of colonisation on my life and career as a nurse. Maori health is the context for my reflective autobiography as well as an analogy for my own colonial experiences. The process of my assimilation started during British colonial history. It continues today with real pervasive impacts, and an on-going Western cultural dominance in my life. Christianity as an instrument of colonization is going to be an important issue in many of my reflective times throughout this thesis as it directly relates to my colonized self. The effects of colonisation are often invisible to the naked eye. By that, I mean that the transformation in how I feel, think, and behave which all affects my nursing practice and the people I nurse brought about by colonisation often goes unseen.

I know that colonisation itself has resulted in a loss of my cultural 'self' and created a sense of diffusion within me. The findings of this study have made me understand myself in the context of my work within both Maori and mainstream services. The blurring of my history occurred through a lack of available educational information together with a Western interpretation of that history. The voice of colonized non-Pakeha nurses remains unheard, and therefore I feel that it is my responsibility to present my unique experience as a starting point for other colonized, non-Pakeha nurses in Aotearoa/New Zealand, in order to bring these issues to the attention of the nursing profession. Nurses often come from the descendants of the colonisers, the colonised, or are a fusion of both. If we are to become culturally safe as nurses during practice, we need to have some understanding of the colonial history of the people we nurse. Equipped with this knowledge, we can recognise the effects of our own social conditioning and critically analyse our attitudes

and the ingrained stereotypes that we hold. This thesis offers an original analysis of the issues facing contemporary nurses, along with an account of the historical factors that have shaped the lives of the many people that we come in contact with through our nursing practice, both as patients and as colleagues.

1.2. Main aims of this thesis

In this thesis, I wish to explain, through reflective autobiography, what colonisation means to me and my nursing practice, and how it has affected and still affects me today. My aim is to explore both the individual impact and the wider significance of colonisation and to increase its visibility, in order to raise the level of understanding in the nursing profession. The limited amount of information available on the topic inspires me to generate new knowledge, both for my own illumination and to inform my nursing colleagues. How can I make sense of the rapid changes that so profoundly influence my own life and my nursing? Get my bearings? Chart a path through this maze? Better still, how can I grasp the options and possible answers for those working within the nursing profession?

Another aim is to provide a voice as a nurse from an ethnic minority non-Westerner with a colonised history for health and for nursing, as well as inviting a dialogue by presenting a previously voiceless minority view. I am providing another side of a dialogue in my desire for nursing to value diversity and to promote the understanding that we need to eliminate injustices of all kinds, as they threaten the health of individuals, communities, and nations in the provision of quality health care for all. An ethnocentric point of view creates a monologue that can discriminate against minority groups. Discussions over the years have led me to believe that many nurses in Aotearoa/New Zealand refuse to believe that racism exists in this country, let alone within nursing itself. During my nursing, I have been passed over for promotion because of my ethnicity (an example is provided in Chapter four), and have been called a 'black bastard' and a 'nigger, wog and paki' by patients. Marginalisation and discrimination occur because nurses and nursing are not isolated from the values and beliefs of society. My autobiographical account evolves

according to my social position, which in turn is rooted in my colonial past. It is that difference that I believe creates a valid epistemology for nursing. This autobiography is also about the 'self' which is a part product of and a part contributor to nursing as my testimony and illumination in this thesis. Like many colonized non-Pakeha nurses from an ethnic minority living in Western societies, I often feel victimised, excluded, or on the margins of society. I therefore want to promote a climate of inclusiveness and mutual respect within nursing. On a personal level as a nurse, I want to validate my perceptions, and hope nursing as a discipline will begin to recognise the need for understanding the voices of minorities who live within the Western world. Lastly, I want the discipline to make conscious efforts to understand historical diversity as a necessary process for strengthening professional relationships amongst nurses, and to ensure that care received by minority people is congruent with their needs. By teasing out the strands of meanings, I aim to expose the underlying assumptions and belief systems embedded within our society, which affect me as a minority nurse. As a researcher, my reflective autobiography allows me to talk about the dialectical relationship between the subjective (what I experience and personally understand) and objective (what really happens) aspects of my nursing during actual practice. I thus create the interplay of two potential opposites, leading to a third possibility that is presented in this thesis.

1.3. Justifications

Cultural safety in nursing requires me, as a nurse working in both mainstream and Maori services, to know about aspects of my own history. My cultural loss was merely one small example of a wider process of de-acculturation brought about by colonization. In this thesis, I wish to position my colonial past as a central issue through 'reflective autobiography' as my unique way for creating new knowledge, which informs future practice. This methodology is based on Johnstone (1999) as a form of narrative inquiry. Colonisation as the central issue provides me with a reflective lens that fits within a heuristic approach, described by Moustakas (1990) as:

A way of engaging in scientific search through methods and processes aimed at discovery; a way of self-inquiry and dialogue with others aimed at finding the underlying meanings of important human experiences. The deepest currents of meaning and knowledge take place within the individual through one's senses, perceptions, beliefs, and judgments (p.15).

My own heuristic journey, undertaken for this thesis, enabled me to discover the hidden, personal meaning of colonisation. Reflective autobiography exists within the postmodern/postpositive paradigm, and as such has a connection with the naturalist form of inquiry. These research paradigms recognise the qualitative and subjective dimension of inquiry and reporting. They affirm the necessity of the researcher being open to new understanding, and the emergence of the unexpected. In essence, it comprises an 'excision from the life of the subject' (Denzin, 1978, p.221), and as such, 'may be compared with others' lives for the purpose of building shareable understanding of the life experiences of another' (Denzin, 1988a, p.28). Johnstone (1999) wrote that autobiography is an open-ended process and a ceaseless project, which enables the researcher to contribute further to the shared sociological project of investigating and increasing understanding of shared human experiences. Autobiography allows me to re-vise and re-tell my story in future as new insights, understandings, and meaning are experienced by my interpretive interactive self.

The raw data for this thesis are my lived experiences, which are captured in four A4 lecture books – my diaries. Copious amounts of time were spent in self-introspection and contemplation. The writing collected in these diaries was then transferred to a Word document on my computer. Reports, letters, newspaper articles, and essays became further sources of data, which I was able to re-read and analyse. This analysis was an ongoing process of reviewing my research data and sorting them into themes and sub-themes, from which emerged colonisation itself as the central issue to be described in this thesis.

The key features of academic rigour within this process of interpretive and qualitative writing are described by Roberts and Taylor (1998) as:

credibility, fittingness, and auditability. Trustworthiness and confirmability are found where these features are in accord. In reflective autobiography, as in other qualitative research methods, credibility is found where the narrative discourse and the subsequent illumination finds resonance and 'similarity' with the lived-enactment or lived experience and meanings of others (p.174).

Credibility is said to be present when the research reports the perspective of the participants as clearly as possible. I have endeavoured to use reflexivity as described by Koch (1998) in order to ensure rigour in my research approach and to assist the reader to know what is going on throughout the research process. Fittingness is described as when the research context, question, or theme finds congruity when viewed from 'context outside the study setting' and where the research has 'meaning and relevance' to the situation of others (Roberts & Taylor, 1998, p. 174). Auditability is understood to occur when the research process is made visible to the reader. The writer states that it is he or she who has lived the enactment and that it is his/her privilege to disclose meaning. 'Narrative truth' or 'narrative fidelity' is understood in reflective autobiography to mean that the work is 'lifelike, intelligible and plausible' (Sandelowski, 1991, p. 164).

Trustworthiness in reflective autobiography is found where credibility, fittingness, and auditability combine to demonstrate confirmability. A narrative autobiography of the self-lived-enactment, which resonates with others, is a demonstration of trustworthiness. Research that moves the participants towards enrichment is deemed to assess the trustworthiness of reflective autobiography as a method of academic inquiry.

I have drawn as my context on many parallel issues that surfaced during my lived nursing practice while working in kaupapa Maori services that continue to resonate with me and amongst my Maori colleagues. I firmly believe that we are all collectively responsible for social problems that can affect us directly or indirectly. Unlike other animals, we humans do not forget our past wrongs, as I believe we have a need to put right those wrongs. As a nurse, I consider myself an agent for social change and I am always looking for innovative ways of improving my nursing practice. On occasion, my views are at odds with those of my colleagues of European ancestry as I believe we are coming from

different paradigms. However, this also has consequences for me that saw me inherit the label of a 'social activist' which I discuss later. Colonial experiences drives me to question the way I practice my nursing in my desire to alleviate human suffering around me, as well as to promote and maintain wellness.

1.4. A nurse grappling with his colonial past

Colonisation has seen the emergence of Britain as 'Great Britain' and hierarchies created by the opposition between white and non-white racial ideologies. This concept of 'great' becomes coded along with racial constructs, so that most people belonging to the non-dominant/non-white racial group are excluded from the ranks of 'greatness'. This thesis examines my social and cultural human conditioning through the impact of past colonisation and how that affects me today as a non-white. It draws parallels from Maori experiences through my lived nursing practices. I wanted my narrative to be reflected amongst the empirical 'Social Sciences' within my nursing, as a platform and horizon of social criticism. Learning about colonisation itself provided me with that different perspective to view the world. The underpinnings of nursing wisdom must be inspected for ethnocentricity, classism, and androcentrism (De Marco, Campbell & Wuest, 1993). In the 18th and 19th centuries, during the peak of colonial times, anthropology became a discipline in which people in non-Western societies began to be seen as politically and economically inferior to those in Western nations. This has had and continues to have a profound effect on colonised people worldwide. Little attention has been paid in nursing to the impacts of colonisation on non-Westerners who live in the West today. As a nurse, I saw the need to shed some light on how that has affected the awareness of my own cultural struggle whilst at the same time reflecting on Maori health. For the purpose of this thesis, I have used a United Nations Educational, Scientific, & Cultural Organization (UNESCO) definition of culture as a 'set of distinctive spiritual, material, intellectual and emotional features of society or a social group and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs' (UNESCO, 2002, p.1). I have also taken the meaning of 'colonialism' to be defined as a 'policy of maintaining colonies, (esp., derog.) alleged policy of exploitation of backward

or weak peoples' (Concise Oxford Dictionary, 1976, p.197) Colonisation transforms the meaning of culture for many colonised people as well as creating inequalities and dependency. Knowledge of that history gives me the ability to enter spaces that are forbidden to others and allows me to connect with and work on a 'level playing field' with Maori people. The discovery of that history is an important part of this thesis and is expanded further later on. The Maori struggle for self-determination is a recognition of the need to break free from Pakeha (European) political and cultural domination. It is important for me to understand what that domination means for me.

1.5.   Westerners as the dominant culture in nursing

I have linked to imperialism (as in colonisation) theories of dependency developed in South America (Cardoso, 1972; Furtado, 1984). According to these dependency theorists, global society has developed in an uneven way, such that the main core of the industrialised world (The United States, Europe, and Japan) has a dominant role, with the Third World countries being dependent upon it.

Throughout my narrative, I wanted to make visible the hidden structure of oppression and its hidden relations. In order to justify the use of autobiography, I argue that narrative is fundamental to qualitative research work (Krieger, 1999). In this thesis, I present my reflective autobiography as a personal narrative that matters to me as a nurse. I wanted to emphasize the ongoing tensions constituted by my memories of the past and the anticipations of a better future. Pratt (1992, pp. 4–6) argues 'that the coloniser – as much as the colonised – is implicated in the transcultural dynamics of the colonial encounter' today and beyond. As an ethnic nurse living in a western country, I have frequently experienced racism. I have also witnessed the marginalisation of other ethnic minority people by members of their own ethnic group.

I had never had the privilege of personal authorship, let alone realised that, in a real sense, authorship is fraught with intellectual problems. I have no doubt that the academic world can serve the oppressors more than the oppressed and privilege the rich over the poor. I knew of my desire to make sense of my own existence and the need to bring some

sense of coherence to the course of my life and those of other oppressed people. I am aware that most people I know would take the easier path of denial and simply want to get on with their life. I felt that, if I did not write this thesis, my entire life would be worthless and meaningless, and that there would be therapeutic as well as academic reasons for completing it. I now realise that colonisation has had an impact on my identity, and that re-forging my "personal identity", as Denzin and Lincoln (2003, p.220) suggest, "seems largely contingent on how well I bridge the remembered past with the anticipated future". This is my way of showing genuine caring as a nurse and beyond. This knowledge is unique and available to me and this thesis is my way of sharing it with other nurses.

Thus narrative matters to me because, as Carr (1986) observes, 'coherence seems to be a need imposed upon us whether we seek it or not' (p. 97). It was my 'selfhood' at stake, and for someone who had never written much in my life before, this would be a big risk as well as the most meaningful piece of writing I had ever undertaken. MacIntyre (1984) suggests that individual narrative is a way of making sense of ourselves for our own integrity and personal understanding. The stories we use, link our existence from birth to death, which can be both delicate and erroneous. Prior to writing this thesis, my life has felt as a mere existence. In contrast, now, I want to live my life by creating my own choices with my own future directions. Colonisation defines me as an inferior human being and as such, it has robbed me of my sense of worth. Therefore, this was my way of restoring my own human dignity as well as enhancing my human capacity. I am recreating my living world for the first time and creating hope and optimism for other colonised people. Freeman (1993, 1998) and Kerby (1991) wrote that in the last analysis, one cannot distinguish between the lifestory one constructs in a lifetime from what we inherit, experience and what we desire. I hope to be able to do just that in my lifetime.

As an oppressed person, I am now aware of the many often invisible layers of oppression that sit around me. I now know that I have ceased to merely exist in someone else's world. I can create my own world to live in, while maintaining my unique selfhood as an individual amongst the world's communities as an equal human being. I have achieved self-liberation and a free spirit of the mind; I have been truly illuminated.

Autobiographical narrative has given me meaning, direction, and guidance. Within nursing research, it has allowed me to undergo an exploration that affords knowledge sharing and interpersonal knowing. Autobiographical memory is a resource which remains largely untapped in nursing; It is this resource that I have explored. The reflective autobiographical method is a distinctive research method in its own right which is slowly gaining the attention of nursing researchers. Its potential use in nursing education and research domains is unlimited (Johnstone, 1999).

1.6. Significance of the study for nursing

In a post-modern era and global economy, the world is quickly becoming more of a cultural melting pot (Stratton, 1998). Therefore, nursing has to make way for those on the margin. It is my belief that my stories, and the way I view and interpret events in the world, will contribute as a part of the testimony of the voiceless, powerless, and oppressed people that the Western world has now labeled as 'third world persons'. Through such testimonies, new paradigms can evolve in the future in order to resist the hegemony of Western knowledge and domination. Colonised people need to understand the deeper impact of colonisation, because the way the coloniser identifies us establishes what they will permit us to do, and 'how we identify ourselves establishes our own view of what we can do' (Nelson, 2001, p. 22).

This reflective autobiography will examine my lived experience of working in a kaupapa Maori Service and previously in mainstream Mental Health Services in Aotearoa/New Zealand. It recognises that services differ throughout the country and acknowledges the government's desire to achieve improvements in Maori health (Mental Health Commission, 1997). However, it asserts that government efforts also rely on individual commitment and contribution, directly or indirectly, and that we as nurses, must become more informed, through individual efforts, about the needs of minority people with a colonised past.

This thesis looks at the effort of a non-Maori nurse in striving to make a difference with its ensuing consequences. I believe that we are both the products and architects of our

social worlds. Therefore, as nurses, we cannot keep 'sitting on the fence', for we have a lot to contribute to that future world of which we are an integral part. To my knowledge, nobody else has written a nursing thesis in which colonisation emerges in order to give insight to personal life and professional nursing. Therefore, this project makes a substantive contribution on its own towards advancing nursing inquiry and knowledge. Autobiography is described by Denzin (1989a p.30) as 'an account of a person`s life as lived and as recorded or told by that person'.

1.7.   Overview of the study

This thesis is organized into seven chapters. The first chapter provides an introduction to the focus, context of the project, study aims, and justifications, while also giving an insight into my personal and inner struggle to come to terms with my colonial past. It identifies colonisation as a main theme and explores its significance for me and my nursing practice. This story, can be told and re-told again. There is no logical beginning and no end. As life evolves, so will stories of one kind or another. I write about the notion of Westerners as a dominant culture in nursing as experienced by me as it is important for those nurses who find themselves on the margin.

Chapter Two provides the historical background to this thesis. I summarise the colonial histories of Mauritius, England, and Aotearoa/New Zealand, and indicate how these histories might provide personal insights to guide my future nursing in Aotearoa/New Zealand. A rationale for the use of history is given. A brief account of the British involvement in slavery and indentured labour is provided to indicate its dominating positions with a personal reflection. It is important for me to understand the motivation behind and reasons for British expansion and why British people migrated to other parts of the world because the Pakeha (European) population were the other Treaty partner, and as a nurse I inevitably come in contact with both Maori and Pakeha populations. Wakefield's Theory of systematic colonisation gives an insight into how colonial policy in Aotearoa/New Zealand was driven in the mid-nineteenth century. Chapter Three looks at narrative as a research tool in nursing and the rationale for using it. I give an overview

of the theoretical underpinnings of reflective autobiography and describe how Maori health itself became my research context. Johnstone's (1999) eight steps, namely choosing reflective autobiography, choosing a topic, immersion, data collection, incubation, illumination, contemplation, and writing the reflective autobiography, are described in more detail. I have added a personal reflection as a 'ninth step' in which I present the insights I have gained during the research process. Lastly, in the conclusion to Chapter Three, I argue for the relevance of reflective autobiography to contemporary nursing research.

I present my lived experiences as a direct consequence of advocating for minority voices in Chapter Four. I touch on a review of nursing job applications and provide some explanations from the theory of social dominance. I introduce the nurse as a social advocate in a field of psychiatry that is coercive by nature, and describe how, by attempting to do this, I became labeled as a social activist. I give an account of how I stepped out of the psychiatric system and struggled to set up Maori services together with Maori colleagues. I give an account of the personal impact that this had on me, and my whanau. The experiences that I outline in this chapter are direct consequences of my advocating for Maori health in Aotearoa/New Zealand. They are unique, and point to the fact that this is an unsafe landscape. The chapter invites others to tell their stories in order to give a true picture of other's experiences in actual practice.

In Chapter Five, my cultural encounters are depicted as examples of my cultural learning through lived nursing practice. I look at a 'sacred moment' with Kahurangi as experiential learning from direct contact with Tangata Whaiora. I examine the dilemma of maintaining professional nursing boundaries and my determination to keep a promise I made to a dying man. I end this chapter with a reflection on an experience that I have termed 'an analysis from my competing thoughts'.

I trace the development of Maori health initiatives in Taranaki, Tui Ora being an operational arm to inter-sectoral-planning, funding, and service provision, and Taranaki District Health Board being the leading specialist Mental Health provider, in Chapter Six. I outline the background to the establishment of Te Rau Pani, its goals and objectives. I

provide an account of how I became the clinical coordinator and some initial objections to my appointment. I give some insight into a challenge which we were confronted with. I also look at clinical risks and the development of policies and procedures to minimize those risks. Lastly, I give an account of the Nga Pukenga Hei Whai Mahi-Employable project. This chapter exposes some of the issues a non-Maori nurse may face in working in a kaupapa Maori service.

Finally, in Chapter Seven, I reflect on my findings and provide a final summation. Colonisation is about the abuse of power itself; therefore, understanding what power is and its discourses, is important for me and other nurses. As a colonised non-Pakeha nurse in Aotearoa/New Zealand, the health services present many barriers for me during my nursing practice. I have attempted to open up a debate through the many reflections presented in this thesis. By doing so, I hope to render them more visible and that other nurses, both Maori and non-Maori, will consider their own position during their nursing encounters with another culture. I have included some implications for nurses, and have outlined the significance of my findings with recommendations for nurses and nursing research.

I present the contents of this thesis as the knowledge base that is necessary for me as a colonised non-Pakeha nurse to come to terms with and move on in my life. This informs my practice now and unknowingly has done so in the past and will continue to do so in the future.

CHAPTER TWO: Background to this thesis

2.1. Introduction

What prompted me to write this thesis are my experiences as a non-Maori psychiatric community nurse living in Aotearoa/New Zealand, and what I see happening around me. In 1989, I was part of a community mental health team that included only one Maori health worker. The worker and I became involved with a group of Maori men who became homeless and had nowhere to live. We ended up establishing the first residential home for Maori people with mental illness in Taranaki. It then progressed to my working more closely with the small Maori team and becoming more aware of Maori health issues and the difficulties the Maori team and Maori communities were having in their attempts to set up services for their people.

I became more involved within the Maori communities of Taranaki working mostly as a volunteer. Together with two Maori male colleagues, we set up Te Roopu Tane, which included Maori men's groups, stopping violence programs, sexual abuse counselling, Maori youth at risk programs, and family counselling. What we tried to do proved almost impossible given that we did not have much financial support. It was necessary to address issues of attitude and prejudice on the part of people in mainstream health services because they held a great deal of power. This meant dealing with such social mechanisms as personal and institutional racism in the context of a violent colonial history, and coming to terms with the underlying power relations, both historical and contemporary. Maori health began to form the context of my work.

I was not aware of my own conditioning, and how it was affecting me and my nursing practice. I started to become aware of the health and disease issues of the indigenous people of Aotearoa/New Zealand through my work as a community psychiatric nurse. I found myself in the middle of a Maori struggle for change in a climate of colonially inherited institutional racism during the initial stages of setting up the first kaupapa Maori community residential prisoners' rehabilitation centre (Te Ihi Tuu). With other Maori people, we were at the coalface of community protests with racist overtones. For two years, we fought through the legal process to get resource consent in order to establish

services for Maori that we knew were lacking in the community. I had also been to the funeral of at least four young Maori males, and it remains my opinion that those deaths need not have happened had the right services been available within our community. At the same time, some of those who vehemently opposed us were the very lawyers who made a handsome living defending those young Maori males through legal aid. I concluded that they did not represent Maori interests at all.

Furthermore, my continued work within the Maori communities in Taranaki helped me make the connection between historical events, political agendas, economics and ill health. Through my own previous experiences, I know that the deprivation of land, economic resources, and identity – the results of colonization – have major health and disease outcomes that have been largely ignored, unrecognized and unanalyzed in nursing until challenged recently by the ideas of cultural safety (Ramsden, 2002). However, when I started working in this area I knew little of my colonial history let alone that of Aotearoa/New Zealand. I needed to correct that serious deficit in my knowledge as to the cause, effect and outcomes of colonization. This is important knowledge for me and other nurses who choose to work with Maori people, who are a seriously at-risk group in this country. I had to start this learning as a nurse by freeing myself of past guilt, hate and anger, and its crippling emotional outcomes.

I understand all too well the distrust experienced by Maori when interacting with a health service that has its roots in the colonial administration. The vast majority of nurses come from the non-Maori Pakeha (European) population. I too wanted to add my voice as a colonized non-Pakeha/ non-Maori nurse to the global debate on the current poor status of indigenous people. I needed to gain insight into the historical and socio-economic processes that brought about those human states, and to try to understand how people in power perceive such issues. I wanted to demystify my colonial history in terms of its development of attitudes, stereotypes, and beliefs toward indigenous people. I see a need for anti-racism work within nursing and our wider communities in this country with an understanding of colonial history so that we can collectively grow as a true nation in the future. My understanding of my own history, which I formed during the writing of this thesis, has resonance in an era of social struggle. The Brazilian educator Paulo Freire's

book (1996) *Pedagogy of the Oppressed* affirms my self-understanding as a colonized oppressed person who must overcome the internal and external structures that oppress me and inhibit my own 'concientizacao' (consciousness). The ideas of 'concientizacao' are expanded in chapter four; these helped me during my reflective times as well as in the analysis of my data in Chapters Four, Five, and Six. In order to attain self-illumination and to transform myself, I needed to look back at history and its connections to my 'self' as I was unaware at the beginning of my research of the use of history as a research tool itself in nursing.

2.2. History as data

To include history in this thesis, I had to grapple with the concepts of objectivity and subjectivity. Therefore, my history is presented as a dialectical relationship of subjectivity and objectivity. My position is better understand through the description of Freire (1996):

> To deny the importance of subjectivity in the process of transforming the world and history is naive and simplistic. It is to admit the impossible: a world without people. This objectivistic position is as ingenuous as that of subjectivism, which postulates people without a world. World and human beings do not exist apart from each other, they exist in constant interaction (p. 2).

I wanted to locate my historical information, collate, and sort it into themes that were congruent to me, and then draw out significant meanings from such history. This is not merely an opinion, but based on the idea that social reality exists not by chance, but as a product of human action. Transforming that reality is said by Freire (1996) to be "a historical task, a task for humanity" (p.33). I was interested in finding out what facts I could obtain, as such history has eluded me for a long time. Matejski (1986) speaks of history as a chronicle of human responses to changes in their environment as they attempt to understand more clearly their past in relation to the present. I too wanted to find, evaluate, analyse, and interpret the evidence limited to me. Polit and Hunger (1987) describe this type of study as efforts to test hypotheses in relation to causes, effects or

trends of events in the past to enlighten current behaviours and practices. Church (1987) asserts that a sense of history seems appropriate as a pre-requisite to a professional mentality. Thus, throughout history, colonised people worldwide have been objectified, devalued, marginalised, exploited, killed, and subjected to various forms of abuse. I wanted the profession to pay more attention to history and to view humanity more fully from a spiritual and holistic perspective. My spiritual foundation as a Christian is located in my colonial obscure past. It is my sincere hope that this thesis will foster the development of new knowledge, and show us our errors of the past. With this in mind, I now invite you to enter my world and to feel the spiritual bond that makes us all human and equal in God'S sight. I must not be caught up in anger or guilt. The past can be confronted no matter how ugly and painful it is, for in such actions, healing and solutions can emerge. This begins with learning about our history and where we all fit in as I continue my journey of discovery throughout this thesis.

2.3. A nurse's discovery of his colonial roots and their significance

I was born, and grew up on the island of Mauritius. In the education system there, I was taught the history of England but never the history of Mauritius. It is an old country and has a history rooted in several colonial pasts. In the 15th and 16th centuries, during the race for exploration, Malays and Arabs visited it. The Portuguese retained the island for some 75 years, although they did not make any settlement, and were satisfied with using it as a stopover while they concentrated their efforts on India, where they were establishing an empire (Varma, 1980). There followed a period of Dutch settlement from 1598 until 1710, when they left. The French then settled Mauritius and established the island as a naval station to assist with their colonial expansion while competing against the British in India.

The British captured Mauritius in 1810, and subsequently maintained their strong position in India and eventually defeated the French, which tarnished the reputation of the French nation. After the conquest of Mauritius, the British firmly established themselves in India. Their supremacy was complete because the French gave up the idea of building

up an empire in that sub-continent. The Indian Ocean was cleared of privateers and corsairs. The British had no problems in carrying on trade with India and other countries. Before the opening of the Suez Canal in 1869, they controlled trade and commerce, which were carried through the Indian Ocean to the East, the Far East, and Australia. Such a commanding position made them rich international traders.

In summary, Mauritius indicates my connection to France, Britain, and India and the part played by colonisation in my history. Both the French and the British used Mauritius in their quest to establish an important colony in India, which was fertile ground for exploitation. Maurel (2000) wrote:

> After the British took over Mauritius in 1810, they generously offered the French inhabitants capitulation terms that allowed them to preserve their French laws, customs, language, religion and property. Mauritius then enjoyed over a century and a half of reasonably peaceful British rule. French culture continued to dominate, however, and has endured to the present day, notably in the form of the French language, which is spoken by most people. Despite the formal abolition of slavery in 1833 in other parts of the British Empire, French plantation owners in Mauritius defied the ruling and continued to practice slavery until 1835. This proved to be a turning point in the history of Mauritius, as the ending of slavery led to the mass immigration from the Indian subcontinent of some 400, 000 Hindu and Moslem indentured labourers. Lured by the promise of a better life, they came to work on the sugar-cane plantations in conditions which were initially not much better than slavery. By 1909 immigration had ceased, but the Indian population was there to stay and rapidly became the majority group, staking its claim in Mauritius when universal franchise was granted in 1959 (p.18).

Like Aotearoa/New Zealand, Mauritius remained part of the British Commonwealth, with the British Monarch as its head of state. It won its independence from Britain in 1968, and was proclaimed a republic in 1992. I am a part of that history, although its detail remains a mystery to me. Researching such a history in the future may be useful to me. From my own perspective, I found slavery and indentured labour abhorrent because it

offended against my own Christian ethics. As I continue my reflective thinking, I gain further insight and enlightenment. The British used Christianity as a way of saving the 'savages' from themselves. However, exploitation was their mode of operation, as the slave trade indicates. One of the most damaging influences of colonization on me has been my experience of racism during my life journey and in my nursing practice. I needed to understand its origin as it affects me, and found such relevance through history and feel compelled to seek some illumination of what racism means to me.

2.4. A nurse's understanding of racism as a colonial invention

My understanding of racism is broad and the following historical summary is from my readings and my interpretations of them. Racism became prominent with the rise of the slave trade in the 18th century. Racism allowed the slave trade to flourish. Black African people, could be bought and sold like legitimate property. Their owners could treat or mistreat them as they so desired as they were considered less human. The Catholic church reinforced this harsh treatment to anyone who did not belong to the 'one true church', as they were looked upon as inferior beings. Darwin's theory of evolution, was used by science in an attempt to show that Black people were less intelligent than the White people, they had smaller brains and were only good for manual labour. They were regarded as uncivilized and barbaric with insignificant history.

In America, slavery was abolished when it became too expensive during the time of industrialization. Goods produced needed a free market and slaves could not buy any commodities but instead stood in the way of economic reforms. This subsequently led to the Northern and Southern American civil war. The Southern plantation owners relied on slave labour. Following their defeat, slavery was transformed into low wage labour. The main European colonialists were the Dutch, French, German, Belgian, Spanish and the British. They expanded the exploitation of millions of people throughout the world as seen during the Portuguese, Dutch, French and British occupation of India. Racism was made worse with the belief that Black people needed a firm White hand to civilize them.

This racist practice, couple with greed continue to-day and allows the rich and powerful nations to exploit the poorer nations who are mostly non- European.

After the Second World War, black immigration to Europe provided for the much needed labour. Britain used this as a cheap source of labour from its acquired empires to fill in the dirty, ill paid jobs that the British people would not do. Racism allowed this practice to grow then and to continue to-day. In the Western world, including Aotearoa/New Zealand, as jobs become scarce, black people are more likely to be unemployed, or in low paid jobs. Now that unemployment is rising in the Western world, the labour of Black people is not needed, they are expedient. Talks of repatriation of Black people have been spoken of in Europe and Australia.

While living and practising as a nurse both in England and Aotearoa/New Zealand, those political shifts have had a personal effect on me as someone with dark skin, living in a pro-European state. My research has made me personally realise some dynamics of history as I undergo a consciousness shift, and this has changed my worldview and my stance as a colonized non-Pakeha nurse. For me, the knowledge that I have acquired are sad historical facts and yet I failed to understand how we as supposedly intelligent human beings cannot learn from our past mistakes and how history keeps repeating itself, especially when we look at the conflicts in the world today. As a nurse and a man, I refuse to accept that at the core of my being lies a desire to exploit another human being and create so much misery in the process. This tension between the forces of evil and good – I live on a day-to-day basis. I have developed a phrase that I remind myself of on a constant basis: 'the evil of another man can be averted, but there is no escape from my own evil'. This is what allows me to keep my own sense of right and wrong. Surely, as a nurse, my role must be to alleviate suffering. As a colonized non-Pakeha nurse, I cannot allow hurt to turn into anger nor can I wallow in guilt, shame and indifference. I believe that we all need to heal first and to come to terms with the past in order to create a better world for the future. Ramsden (2002) called upon nurses to know one's own historical background, and this was initially obscure to me partly because of my education which I had in Mauritius. "Widespread concerns about the quality of mental health care received by Black people in Britain have existed for about 30 years. The Sainsbury Centre for

Mental Health, a respected mental health charity in the United Kingdom is attempting to tackle the problem" O'Dowd (2002, p.14). Living in England, I know that racism is having a pervasive effect on the lives of Black people. A review *Breaking the circles of fear* confirms existing research and statistical evidence showing that "Black African and Caribbean people are over-represented in mental health services and experience poorer outcomes than their White counterparts" (O' Dowd, 2002, p.14). The same is true for Maori in Aotearoa/ New Zealand.

At 53 years of age, although I have spent over thirty years of my life living in the Western World, the impact of colonisation and racism has left me with a sense of coming from a 'third world' – yet I do not feel that I belong to India or Mauritius either. During the colonial period, it served the interests of the British (and their European cohorts) to exaggerate the democratic character of their own societies while diminishing any socially redeeming features of societies of other colonised nations. Social divisions and inequities were a convenient tool in the arsenal of the colonisers. On the one hand, tremendous tactical gains could be achieved by playing off one community against another, creating the impression that those nations were rife with uniquely abhorrent social practices that only an enlightened foreigner could attempt to reform. Those social ills were discussed with a contemptuous cynicism and often with a willful intent to instill a sense of deep shame and inferiority. Strong elements of such colonial imagery continue to dominate European ideologies even today. A liberal, dynamic West embracing universal human values is said to be poised against an obdurate and unchanging East, clinging to odious social values and customs. I have found on several occasions that, when I have wanted to talk to my European friends and relatives about colonial history, they feel uncomfortable, and would rather that I forget about the past and look to the future. We would rather bury our heads in denial than try to face up to our ugly past. Do we not have enough evidence in our troubled world that this reality does not just go away, but has an uncanny way of coming back to create more miseries in this world? For this very reason, I have found myself compelled to look back at that ugly past. Unlike many millions who prefer to be oblivious to this, I became fascinated instead by the history of British colonisation and its

connections to me as I gained more insight by looking backward at my history and forward at my nursing journeys.

2.5. Colonisation- Drawing on the individual background of a nurse

Today, the impacts of colonisation are felt deeply by my 'self', as well as other indigenous people worldwide. This thesis is my reflection, analysis, and revelation of that colonial experience, and my way of reclaiming a pre-colonial form of history and culture. It is located amidst migratory patterns – both the movement of colonisers into colonised areas like Mauritius and India, and my own immigration to England and Aotearoa/New Zealand, which also become data for my research. Colonisation and its encounters is the main theme that emerges in this study. This thesis also seeks to uncover the damaging effects of ideas of European superiority over non-Europeans on both the self-identity of the colonised and in the instability of the conceptual underpinnings of the colonisers.

Initially, while living in England and working as a 'foreign nurse', I found myself being constantly devalued. I retreated in silence within my own state of powerlessness. Rather than risk conflict that might get in the way of my relationships (which would have left me isolated and therefore more powerless) I learnt to present a pleasing but 'false' outer self whilst suppressing my inner self as a way of fitting in. I now recognise this as what Said (1999) describes as a submerging aspect in me. Through my psychiatric nursing, I quickly understood that this was an unhealthy coping mechanism. It left me vulnerable to negative emotions like anger, hate, and depression. Racism and discrimination are going to be a reality for me to navigate through my life. I propose that this situation is common for many colonised people, and provides an explanation for the large number of Maori, Aboriginal, and, in England, West Indians, in the justice and mental health systems.

I believe that the mind and the body are deeply inter-connected, and that our thoughts and emotions powerfully affect our physical and psychological health. I know that to prevent disease, I need to change my thoughts and attitudes. I understand that the state of my body as well as my mind work together, in interaction with specific social, cultural, historic and nursing contexts. The numerous reflections created during this project were

part of my illuminations, and as such, I needed to discover what colonisation means for me.

2.6. Meanings of colonisation

I gained significant understanding of colonization through the reading of Sohat and Stam, (1997) who describe:

> colonisation is the act of colonising, invading, conquering and then taking over another people's land, resources, wealth, culture and identity. It is a continuing process and, in my life, it is hard to conceive of where it began and where it ends. Colonisation has been practised by Greeks, Romans, Aztecs, Incas, and many other groups. The words 'colonisation', 'culture', 'cult' (that is, religion) all derive from the same Latin verb, *colo,* whose past participle is *culturus*, thus placing in play a constellation of values and practices which include occupying the land, cultivating the earth, the affirmation of origins and ancestors, and the transmission of inherited values to new generations. While nations had previously often annexed adjacent territories, what was new in European colonialism was its planetary reach, its affiliation with global institutional power, and its imperative mode, its attempted submission of the world to a single 'universal' regime of truth and power. The colonial process had its origins in internal European expansions (the crusades, England's move into Ireland, Spanish *reconquista).* It made a quantum leap with the 'voyages of discovery' and the institution of New World slavery (a form of social stratification in which some individuals are literally owned by others as their property). It reached its highest point with turn-of-the-century imperialism, when the proportion of the earth's surface controlled by European powers rose from 67 per cent (in 1884) to 84.4 per cent (in 1914), a situation that began to be reversed only with the disintegration of the European colonial empires after World War II (Magdoff, 1978). Some of the major corollaries of colonialism – the process whereby Western nations established their rule in parts of the world away from their home territories – were: the

expropriation of territory on a massive scale; the destruction of indigenous peoples and cultures; the enslavement of Africans and Natives Americans; the colonisation of Africa and Asia; and racism, not only within the colonised world but also within Europe itself (pp 15-16).

I am a descendant of Indians who were indentured labourers sent to Mauritius during the time of the British colonisation of India. Growing up in Mauritius as a colonised person, the limited education I received taught me about the history of England from William I to Henry VIII. References were never made to the central role of European colonialism within capitalist ideology. There was no information available to me on the history of Mauritius. Eurocentrism (understanding of the ideas or practices of another culture in terms of those of European culture) is so embedded within me and in my everyday life, that I often do not even notice it. The centuries of European domination has altered my culture, the everyday language I speak. My conditioning has created a fictitious sense of an innate superiority of European-derived cultures and peoples. These sentiments are true for me even to-day. "I am exposed to Europe as a single source of meaning, as the world's center of gravity, as ontological 'reality' to the rest of the world's shadow" (Shohat & Stam, 1997 p.2.). Yet, I know that I can never be a European, but that I am a 'product' of an invisible colonial past and present. The ideas of exploitation were deliberate and can be found in the theory of systematic colonisation advocated by Wakefield (Metcalf, 1999), which I present next and contribute to my on-going illuminative journey.

2.7. Wakefield's theory of systematic colonisation

An example of the colonising spirit of the time is Wakefield's (Metcalf, 1999) theory of colonisation, which he calls 'systematic colonisation' and England tried for a time to enforce by Acts of Parliament, which attempted to effect the manufacture of wage-workers in the colonies. Marx (*Capital,* vol. 1, chapter 33) demonstrates that

> It was in the colonies that he discovered the truth as to the conditions of capitalist production in the mother country. In the interest of the so-called national wealth,

he seeks for artificial means to ensure the poverty of the people. Capitalist economics proves how the development of the social productive power of labour, co-operation, division of labour, use of machinery on a large scale, are impossible without the expropriation of the laborers, and the corresponding transformation of their means of production into capital. The expropriation of the mass of the people from soil forms the initial basis of the capitalist mode of production. For their owners and employers, slaves and indentured labourers were a way of combining capital and labor in particular works. Wakefield further laments that the impulse to self-expropriation on the part of labouring humanity for the glory of capital exists so little that slavery is the sole natural basis of colonial wealth.

In England, the labouring class composed the bulk of the people (Marx, 1867). The British upper class saw the rising labour costs in the New American settlements and the ability for labourers to accumulate capital as a threat to capitalism itself, which they wanted to preserve. Wakefield advocated a systematic way of controlling both the flow and cost of labourers in the colonies, in order to regulate their ability to accumulate wealth and to allow for their on-going exploitation (Metcalf, 1999). In Europe, these conditions existed to some degree. For years, the English Government applied this systematic colonization method as advocated by Wakefield in the colonies (Marx, 1867). Those that had responsibility for the British settlement of its colonies, like Wakefield and his New Zealand Company, had specific theories about colonisation and methods to accumulate capital which were applied throughout the British colonies.

We can see this practice with the slave trade and, later on, indentured labour, devised by the British and implemented in Mauritius during colonization. Carter, (1994) describes:

> The migration of Indian people to Mauritius took place alongside much larger population movements, both within the subcontinent and stretching from it to many parts of the British Empire. The scale and timing of these 19th-century labor migrations were influenced by changes in rural production relations which resulted from intrusive capitalist development in the British Raj (India). The policies, which the British introduced in India to stimulate economic growth

deprived peasants of their land and artisans of their crafts, creating massive unemployment. This potential wage labour force was directed to cash-crop ventures like sugar cane plantation in Mauritius and other British colonies. Thus, the abolition of slavery gave rise to indentured labour. Economic insecurity, coupled with natural calamities, drove the Indian migrant population to desperation and provided overseas capitalists with recruits who were induced to sign a five-year indentured contract in return for little more than a ready meal and the promise of future remuneration (p.24).

The 19th- century Indian dispersion has been characterised "as a new form of slavery, and the manner in which the new labor force was incorporated into plantation life bore much resemblance to the institution of slavery it replaced" (Carter, 1994, p.2). Migration was placed under government controls which were henceforth to regulate every aspect of lives of Indians under indenture. Indian labour migration was determined almost entirely by the labouring needs of the receiving or factory industries. Mauritius, which began to import Indians on a large scale immediately after the abolition of slavery, is a good example of a capitalist exploitation of Indian people on a large scale. The legacy of such displacement is with me, and millions of other people to-day worldwide. These issues are interwoven in this thesis in order to firstly raise them within a nursing context, and secondly to render them more visible.

2.8. New Zealand history

I have always believed that, to be culturally safe, I needed to at least, have an insight into the history of Aotearoa/New Zealand. Meyst (2005, p.21) states that 'my nursing education had not included this important part of our country's history', and goes on to say that this highlights the failure of New Zealand's education system to teach the history of its own country. As a new migrant myself, it is my responsibility to find out about the historical and social context for both Maori and Pakeha as advocated by the late Ramsden (2002), in order to become more informed in my nursing practice in Aotearoa/New Zealand. Nursing is a personal knowledge of self and others in a relationship (Jacobs-

Kramer & Chinn, 1988). As part of my research, I looked at Belich's (1996; 2001) well researched books on the history of Aotearoa/New Zealand, and discovered some facts which have resonance for me and the history of my ancestors. The British had learnt a great deal by the time they embarked on their quest for Aotearoa/ New Zealand. In this chapter, I was mindful of Ramsden's (2003) call to know history in order to avoid 'blaming the victim'. My experience in Aotearoa/New Zealand led me to believe that many people are either ignorant of that history or that they are caught up in denial, blame, shame, anger or indifference. I have not tested this assumption in any scientific way. I have tried to take a pragmatic and non-judgmental approach whilst reading these materials. I had to limit what I could present in this thesis. There is no theorising or synthesizing, but the information is simply a summary of the facts found in my coming to terms with that history.

In the context of getting to know history, I have tried to understand what England was like before colonisation and the industrial revolution (which speeded up the process of colonisation). I have also tried to find out more about the founding Pakeha (European) population; early Aotearoa/New Zealand; the New Zealand company. I have included as Appendix 3 a summary of the land history in Aotearoa/New Zealand after 1840, when the Treaty of Waitangi was signed with a focus on the confiscation of Maori land through legislative means.

The dispossession of Maori was well thought through and executed over history, and it has had an enduring effect on Maori health today. Maori health ought not be looked at alone without some knowledge of its history. These facts are very important if we are to understand the on-going Maori grievances that we are now witnessing in this country. I leave it for each individual nurse to decide what constitutes his or her body of nursing knowledge. This is my unique autobiographical account of my lived encounters and personal contribution to the body of nursing knowledge, which I deem necessary for me to practice safely as a nurse in Aotearoa/New Zealand. It is also up to individual nurses and ultimately the nursing profession to decide what body of knowledge is relevant for nursing.

The outcome of colonisation at the turn of the 20th century was the impoverishment of Maori; marginalisation of elders and chiefly authority; and a structural relationship of Pakeha (European) dominance and Maori subjugation (Walker, 1990). Despite a Treaty which guaranteed Maori protection under British law, what followed was a forced change from a tribal lifestyle inextricably bound to the natural environment, to a new reality dictated by the social and political contradictions of Victorian Britain. Durie (2001) reminds us of the treaty which was meant to offer Maori people protection under British law, instead brought about many injustices. The sociopolitical systems were often contradictory, Euro-centric and exploitative in reality. The British settlers were themselves escaping oppressive conditions and yet were ready to impose them upon Maori people in Aotearoa/ New Zealand. The contention that has impacted upon Maori is not taken solely in regard to early colonial experiences, but reaches deep into present-day issues pertaining to Maori (Wickliffe, 2000; Robertson, 1999). As a nurse raising my own consciousness, is a matter of self- responsibility, as such knowledge is rarely found in the nursing literature. Incorporating such knowledge in a summarised version whilst searching for a methodological tool to guide this research endeavour, proved to be challenging.

2.9. Exploring other methodological possibilities

I consider 'Critical Race Theory' (CRT) an exciting, revolutionary theory that puts race at the center of critical analysis, especially as I initially wanted to add a critical aspect to Johnstone's (1999) reflective autobiography. However, most of my autobiographical writing was of a reflective nature, and I therefore removed the critical aspect from my methodology. I found it difficult to contain my thinking within the limitations of the thesis. I also found no canonical set of doctrines or methodologies to which all CRT scholars subscribe. I then went on to consider the Critical Social Theorists, who made me aware of self, processes, and the need for change in keeping with the potential for self-transformation in 'that all thought is fundamentally mediated by power relations that are socially and historically constituted' (Kincheloe & Mc Laren, 1994, p. 414). I have not

considered issues of power to be central to this thesis, but have focused instead on colonization as the central issue for my project.

I knew that my autobiography was my attempt to deconstruct my past, which I also considered as a possible approach for my thesis. I found reading the deconstructionist writer Derrida difficult to understand, let alone using his deconstructionism as a method to examine my current position. Being involved in kaupapa Maori services became a personal challenge and puzzlement for me, and this sparked my need to understand my 'self' and the world in which I live (Moustakas, 1990). Johnstone's (1999) article – 'Reflective Topical Autobiography: An under utilized interpretive research method in nursing' – influenced my decision to use reflective autobiography as a method. I became aware that my autobiography would allow my subjective self to be the centre of the life-story. I knew that I was the sole authority in making sense of my life-story, as lived by me, and wanted those lived experiences and its reflective understandings to be the subject of the autobiography. Johnstone's (1999) description of her eight steps fitted my project. These steps are: choosing reflective autobiography, choosing a topic, immersion, data collection, incubation, illumination, contemplation, and writing the reflective autobiography. She describes the steps immersion, incubation, and illumination as being taken directly from the six phases of heuristic research advanced by Moustakas (1990). These steps are described more fully in Chapter Three. This methodology suits the intent of this project. I have explored the impact of colonisation on me and its significances in my day-to-day lived nursing practice, while contextually being involved in kaupapa Maori services in Aotearoa/New Zealand. I have used this opportunity to explore the 'self' in the context in which I work. I realize that the work is subjective but claim in this thesis to be the sole authority of those experiences. Cultural safety demands that I examine the attitudes, values, and beliefs that I hold in relation to groups whose world views and experiences are different from mine. These possibilities were realised through my reflective autobiographical accounts, and I now present my reasons for selecting this methodology.

2.10. Why an autobiographical approach

An autobiographical approach allows me to 'convey meanings' and to announce 'multiple' openings to understanding (Richardson, 1992, p. 126). It also helps to break nursing research norms and opens 'windows on lived experience' (Richardson, 1992, p. 136). This study has allowed me to be open to exploring my lived nursing practice and I consider this method of research to be an opening for further research opportunities. In many ways reflective autobiography has proved to be a personal healing journey, by placing me at the centre of the discourse. Historical context, cultural realities, and political voices are layered upon experience. Relationships, values, and motivation are examined in order for the individual to draw meaning from memory. The subjective reality of autobiographical discourse is given voice by the narrative expression of memory or 'narrative arrangements of reality' (Elbaz, 1987, p. 1). Memory is shielded by self, choosing to remember self, but is also open to insightful understanding of opening to self. There is the inseparability of the researcher and the researched, the absence of prior theorizing, the research being undertaken in its natural setting, the legitimisation of intuitive knowledge, and the recognition of multiple realities (Lincoln & Guba, 1991).

The use of the reflective autobiographical research method affirms the notion that individuals find meaning by interpreting and making sense of that which is around them. Purpose, meaning, and knowledge are bound by the context of lived experience or lived-enactment (Denzin, 1978; 1992). Research based on lived-enactment allows nurses to honour this kind of knowing, and to examine nursing practice in the light of 'intuitive and situated knowledge' (Fitzgerald, 1995, p. 3).

My decision to choose reflective autobiography as a form of inquiry in nursing is also to offer a new means of practical understanding. I became aware of the difficulties that I was experiencing in choosing a method of research that was completely new, while having to pay attention to academic rigour, which required that I provide a clear explanation of the decisions made during this project. I acknowledge that this has been a difficult process. I initially tried to address too many issues in this thesis and struggled to

narrow it down. This required a lot of reflection on the themes that were emerging in my literature review.

Inevitably, readers will become aware that this thesis raises some socio-political issues around social justice/equity for Maori people as ways for bridging the health gap in this country. As a nurse, I know that science has often indirectly conspired against colonised races worldwide. Science cannot address these complex human endeavours. Reflective autobiography lends itself as a suitable methodology, which is proving more popular amongst nurses (Johnstone, 1999). The next chapter looks at the theoretical and empirical underpinnings of this thesis. It explores in more detail the dilemma through this journey, and my justification for the use of reflective autobiography.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

This chapter looks at my methodology as a way of foregrounding the theoretical perspective used in this thesis. It provides a rationale for my choice of method and describes the techniques and procedures I have used. I discuss Johnstone's (1999) eight steps that fitted my project. Issues of rigour, such as credibility, fittingness, and auditability are discussed. Finally, reflective autobiography is the research process within this post-modern method. It has allowed me to understand, make sense of a hidden past by reflectively examining the many themes that have emerged. These are congruent to the very essence of my being as a colonised nurse. Kaupapa Maori was the catalyst for me that became my subconscious motivator, although prior to doing this thesis I could not make this connection. Data are drawn from my lived experiences through the process of reflective autobiography as advanced by Moustakas (1990). This has allowed me to stay within certain parameters while capturing what I consider, to be the most important insights that surfaced during the research process. As I was seeking to give voice to the voiceless, I shall begin by describing my personal journey into my research process.

Why did I choose reflective autobiography in the first place? Initially, I wanted a degree of freedom of self-expression while remaining politically neutral and complying with the steps of the research design. However, I soon realised that by giving voice to the voiceless, I was already representing a political view shrouded by some complex and controversial issues. To speak is to be political, as politics is the power to determine the fate of other people. Therefore, I decided that neutrality is not possible, and consequently chose reflective autobiography, enabling me to reflect, examine, and gain awareness through my own illumination. This chapter introduces this methodology, along with the dilemmas and difficulties that I experienced as a novice writer and researcher. Recently, I have been heartened to discover that more nurses are using autobiography as a research method. (Harden, 1996; Giddings, 1997; Harker, 2000). McEldowney (2002) spoke of autobiography as

a focus on the individual as participant; the personal dialogical nature of the research process; the practical nature of the findings appealing to a wider audience; and, an emphasis on the subjective nature of the research that goes beyond the empirical and scientific standards (p. 40).

Within the context of my reflective autobiographical account emerged the process of colonisation, which is of great significance to my life today. I was aware from a very young age that the social starting positions of the descendants of colonisers were better than those – like me– whose ancestors had been colonised. Clayton and Williams (2004) rightly state that 'the present circumstances of the global poor are shaped by a dramatic period of conquest and colonisation, with severe oppression, enslavement, even genocide, through which the native institutions and cultures of four continents were destroyed or severely traumatised' (p.271). I wanted to narrate what the experience of colonisation meant for me because that experience itself positions me as a critical social commentator. Furthermore, I wanted to raise ethical issues as, " we must not uphold extreme inequality in social starting positions when the allocation of these positions depends upon historical processes in which moral principle and legal rules were massively violated," (p.271) as they were in India, Mauritius and New Zealand. "A morally deeply tarnished history should not be allowed to result in radical inequality" (Clayton & Williams, 2004, p. 271). Although virtually all these colonies have now attained their independence, the process of colonialism reshaped the social and cultural map of the globe (Giddens, 1989). I had never considered these issues in any depth before and reflective autobiography offered me the opportunity to do so.

3.2. Choosing reflective autobiography

I chose reflective autobiography because it allowed me to combine my topic together with the reasons I came to study it. Autobiography studies will often depend on the prejudices and personality of the researcher (Patton, 1990; Blaikie, 1993). My topic started as Maori health but changed into something else as my lived experiences working in a kaupapa Maori service and colonisation emerged as the central focus. That shift came

about as I gained self-understanding as my research progressed. Colonisation was the historical link although its lingering effects are present and still felt by me, and Maori people I encounter today. However, prior to this project, I had never imagined articulating the effects of that colonising force on me. Narrative is also particularly suitable to conveying the experience of indigenous peoples (Ramsden, 2002). Therefore, life-story narrative presented an opportunity to help me to illuminate, analyse and theorise by revealing my life as lived over time and within particular historical, cultural, social and political contexts. I am hoping that my narratives will teach and evoke reflective thinking about aspects of nursing practice that are not to be found in textbooks but are situated within lived experiences only. I found myself progressing from teacher to learner by reflecting on history and lived practice, and by gaining theoretical understanding as a means of contributing to nursing knowledge.

Denzin (1989a) describes autobiographical narratives as "the words we speak and attach to ourselves" (p.78). Autobiographical writing places the writer at the centre of the discourse. Therefore, I felt that this was the right method to explore my cultural and historical context – to enable a political voice to emerge out of a personal experience. I wanted my subjective reality as autobiographical discourse to become explicit throughout my narrative expression of memory or "narrative arrangements of reality" (Elbaz, 1987, p.1). These ideas have been incubating in my head ever since childhood, with no opportunity for expression, and I was unaware that I had been shutting the door on possible insight and understanding.

As I gained insight, it dawned on me that autobiographical interpretation of the self is understood as self-entrusting to self-disclosure. Gooch (1996, p.139) describes this self-disclosure or revelation as "a coming to see." Colonisation undermines the self-confidence of the colonised by creating a diffusion of identity through both its brutal assault on existing ethnic culture and its ensuing attempt to assimilate the colonised as subservient to the dominant culture of the coloniser. This often leaves the colonised with an invisible or intangible psychic scar, which may contribute to their vulnerability to mental illness. At first, oppressive measures ensure compliance while they erode away at the establishment of genuine trust. On the other hand, reflective inquiry demands a gifting

of the self-lived-enactment narrative, which in turn assumes the potential for rejection and vulnerability (Cash et al, 1997). Reflective autobiography is located in the hermeneutic circle of reinterpretation "as meaning, purpose and future direction are explored" (Sandelowski, 1991, p.165).

3.3. Nursing research and rationale for the method chosen

During my nursing life (some 30 years), I have never seen nursing research as such in practice. How, then, do I reconcile the gap between my nursing theory and research and the practice of psychiatric nursing as I experience it? The Victoria University of Wellington Graduate School of Nursing and Midwifery offered me an opportunity and gave me the confidence as a nurse to explore my theory and practice gap through research. Reflective autobiography, as a method, allowed me to showcase my lived experiences retrospectively. The method is chosen as I believe that it is important to draw theories directly out of practice experience, and the only way this can be done is through reflection on that practice experience. This is an alternative to the more traditional approach in which we have tended to assume that theory (or research findings) provides generalizations, which then guide specific practices. In this latter view, the tendency has been to try to bring practice in line with the way nursing is theorized, and to encourage nurses to use research in their practice. A reflective approach takes a different stance. Instead of questioning the ways in which practitioners do or do not use theory/research, a reflective stance questions the ways in which theory, practice, research and the relationships between them have been formulated. This opens the way for alternative paradigms to develop which might be more congruent with the actual experiences of nurses. A number of writers have consistently argued that theory and research do not necessarily precede practice (for example, Argyris & Schon, 1974; Schon, 1983; Scott, 1990; Kondrat, 1992; Peile, 1994; Polanyi, 1996) but that theory and research methodology tends to underplay practice itself. Any useful theory therefore needs to be modified by and responsive to the uncertainties of practice. Any approach to understanding nursing should necessarily integrate theorizing, researching and practising. Reflection on practice thus involves the potential for theory development, research

inquiry and practice improvement. I am not arguing that nurses do not need to be taught about theory and research. My point is rather that we also need to question how we relate practice, theory and research to real-life contexts. The view I take in this thesis is that practice research may be usefully undertaken using a range of research methodologies and techniques, and that no one exclusive approach is necessarily preferable to another.

I have chosen to focus on practice research (by this I mean research which is directly about my practice and my life) because I believe this is an area that needs attention in nursing. Using a reflective autobiography can   help the practitioner to uncover, articulate and develop the implicit assumptions that constitute the 'practice wisdom' that one develops inductively from practice. The use of reflective autobiography allows me for the first time to reflect upon the research practice and theory gaps much more deeply than I have ever done before. During the writing of this thesis, I was aware of a tension within me. I was afraid to enter the 'academic doorway' and was fearful of exposing the many facets of my inextricably intertwined personal, professional and political self. I initially felt very vulnerable. Schon (1983, p.4) further alerted me to the way in which we all frame problematic situations in different ways, according to our disciplinary backgrounds, organizational roles, histories, interests, and political/economical perspectives. For example, a social worker may focus more on the social aspect of practice than a nurse might. These differences not only occur amongst nurses – my experiences indicate that they also occur within each of us. Whenever I am challenged about my views (by people with different values or interests), or information of which I was previously unaware comes to my attention, I adapt, modify, condition, or on some occasions, change my most recent interpretation of the data. Autobiography engages me as both the researcher and as an individual subject – not just as a tool to gather data, but an integral part of the field being studied. I was further encouraged by Anderson, et al. (1988), who believe that in order to obtain some generalizability in a subjective approach, objectivity may be present, in that the creation of new meaning "objectifies our subjectivity." The weaving of reflective autobiography into text, however, is not an easy task.

3.4. The weaving of reflective autobiography into text

Denzin and Lincoln (2000) suggest that there is an affinity between testimony, autobiography, memoir and diary. Autobiography can affirm a self-identity that is separate from the subaltern group or class situation that it narrates. Reflective autobiography can capture turning-point experiences or existential moments (Moustakas, 1973) in the life of a given person, and can serve as a revelation by making the lived experience of a person directly available to others. Writing my life story from the position of an ethnic minority individual living in Aotearoa/New Zealand, a country entangled in neo-colonialism, would itself shed some interesting insight. To write reflectively is to become political.

Reflective practice is "political" in an even more self-conscious sense, as to study practice has the potential to change it. The process of studying it is also "political," from the practice own standpoint, and is liable to change through the process of action (Denzin & Lincoln, 2000). It is a process of enlightenment about the standpoint from which one studies practice as well as about the practice itself. Reflexive ethnographies primarily focus on a culture or subculture by using the author's own experience in the culture reflexively in order to look at self-other interactions more deeply. (Ethnography is the branch of anthropology that deals with the scientific description of individual human societies.) In "native" ethnographies, researchers who are natives of cultures that have been marginalized or exoticised by others write about and interpret their own cultures for others. "Complete-member researchers" is a term coined by Adler and Adler (1987) to refer to researchers who are fully immersed in and committed to the group they study. During the research, the researcher as a "convert" identifies with the group and becomes the "phenomena" (Mehan & Wood, 1975). In literary auto-ethnographies, an author's primary identification is as an autobiographical writer rather than a social scientist, and the text focuses as much on examining a self autobiographically as on interpreting a culture for a "non-native" audience (Deck, 1990). The above-mentioned notions were instrumental, both in legitimising the approach and direction this thesis took, and in enabling me to make sense of my own involvement in kaupapa Maori service development in Taranaki. My own colonial history – as a Mauritian – has been one where

many cultures have been thrust onto an island and into a melting pot. The term "bricoleur" therefore would suitably describe me. Levi-Strauss, (1966) describes a bricoleur as a "Jack of all trades or a kind of do-it-yourself person" (p. 17). For my thesis, I have chosen the term Denzin and Lincoln (2000) use: "a bricolage – that is a pieced-together set of representations that are fitted to the specifics of a complex situation" (p. 4). All great cultures of the past and of the present are known to borrow unashamedly from one another to enrich the common heritage of the human species. This fusion of cultures took place in Mauritius. Reflective autobiography lends itself aptly as a method for this thesis. As this project progressed, I have considered myself as a bricoleur not by choice, but as a matter of surviving. I have continued to undertake further reading in the areas of post-modern, postpositive and naturalist inquiry (Lincoln & Guba, 1991; Lyotard, 1992; Norris, 1993). I continue to remain open to a post-modern method and its theoretical underpinnings to guide my writing.

3.5. The research process

This was initially a difficult process for me. Johnstone's (1999) eights steps are taken directly from Moustakas's (1990) six phases of heuristic research as outlined in Table 1 on the next page.

Table 1: Comparison between Moustakas's 6 phases & Johnstone's 8-step process

MOUSTAKAS'S 6 PHASES	JOHNSTONE'S 8 STEPS
Initial Engagement	Choosing Reflective Topical Autobiography
Immersion	Choosing a Topic
Incubation	Immersion
Illumination	Data Collection
Explication	Incubation
Creative Synthesis	Illumination
	Contemplation
	Writing the Reflective Topical Autobiography

I used all eight steps of Johnstone's reflective topical autobiography, in no particular order. I wanted to take a critical approach to fit with my attempt at emancipation. (For me, this meant that I wanted to become free of standardised expectations and roles, and acquire the freedom to embrace knowledgeable, creative and intuitive practice). I was looking for empowerment (the process of giving and accepting power), hegemony (the ascendancy or domination of one power over another as in colonisation), and praxis (change in action through critical reflection on practice) (Roberts & Taylor, 1998, pp. 125–126). I had felt the effects of oppression and needed to find a means of self-liberation. Therefore, an understanding of my history and the notion of Freire (1972) 'effects of false consciousness' was important for me in order to realise that there are alternative ways of knowing and being (Roberts & Taylor, 1998, p.124). I now present the eight steps and describe how they informed the research process. I have added a self-reflection as a ninth step as a basis of my own self-analysis and enlightenment. This thesis does not aim to be a "how to do guide," with lots of checklists, 'dos and don'ts' or useful tips. It tries to make visible to nurses, areas that require some attention. As each

one of us nurses, we bring our own individuality to our nursing practice, our history, cultures, experiences, influences, prejudices, desires, drives, aspirations and our sense of who we are. Shared history of nursing, however, predates our existence as nurses having many inherited oppressive elements that have constrained us as nurses and held us in their grasp for so long. As nurses, we have therefore a good understanding of oppression. My personal experience is political, and that "political" impacts upon the personal. My political evolutionary process began subconsciously when I embarked upon making changes in my life and my nursing practice. Colonisation and health are interwoven and automatically emerge as my topic.

3.6. Choosing a topic

It is often "a personal challenge and puzzlement … to understand one's self and the world in which one lives" (Moustakas, 1990, p.15). "The source of the topic lies in the epiphanies as turning point experiences" (Denzin, 1989b, p.15) which have a deep and significant impact on the person's life. This situation forces the individual into a position of critical self-consciousness by evoking their usual internal theorizing mechanisms. They are able to move from the not-knowing to the knowing position. Moustakas (1973) explains this existential moment as:

> awareness of the rightness of a value or conviction or decision. It may be a moment so utterly revealing. Maybe a moment of realization of that which one is, a sudden understanding of life, and that it will alter one's destiny or a moment when apparently enduring value destroyed. The existential moment is sometimes the beginning of a new conviction or commitment emerging from a distinctive and particular identity. Such moments provide substance for searching, struggling, feeling, asserting, yielding, facing and choosing a direction that challenges and enhances realization of potentialities both in the individual and his (or her) growing relationships (p.2).

Existential moments experienced by a person "enable that person to stretch beyond what he (or she) has known, into a new realm of discovery" and lead to a recognition of his or

her "own existence in the world and the unique and incomparable nature of that existence" (Moustakas, 1973, pp. 1–2). This experience has been true for me as I have increased the level of my understanding and subsequently accepted my own past. It does not go away but remains hidden amongst the many layers of deception, distortion or past attempts to assimilate or condition a human being into a life of servitude. Over the years, I have personally attended several Tangi of young Maori men, who, in my opinion, died premature deaths. These served as my epiphanies. Not wanting to accept the status quo has been within me ever since I can remember, as a child, witnessing the continuous reign of Europeans and their attempts to domesticate the colonised people as "inferior races" (Fanon, 1963, p.17). Unknowingly, I was already immersed in my topic, and needed to find some answers.

3.7. Immersion

As the researcher, I was totally immersed in what Moustakas (1961, p.ix) describes as "an intensive lived experience of the self." My subjective lived experience (including the experience of writing about the experience) became the raw data of the investigation (Ellis & Flaherty, 1992). As the researcher, I was engaged in "deep and systematic introspection, introspection narrative and self dialogue such as those commonly used in heuristic psychology" (Moustakas, 1990; Ellis and Bochner, 1992). It is through these strategies that "the perceptual, emotional and cognitive details of the self-researcher's lived experiences can be explored, brought out into the open and described" (Johnstone, 1999).

I have had a sense of being completely submerged in a past I had little knowledge of since my early childhood. I did not understand these feelings. My perception was clouded; my emotion was inappropriate at times; and cognitively I had little insight because all the information that I was provided with lacked any logical explanation. I had little opportunity of access to academic pathways as the little education that I received was achieved with great sacrifices from my parents amid the constant struggle for basic necessities like food and clothes. Books were not available then, although there have been

great improvements since. My father had to work at two jobs in order to pay for the college fees of his three children. On further reflection, before I even started this thesis, I was in a state of confusion brought about by an absence of educational opportunities. "Ignore the past" was the message I took from the West. Do not live in the past and move on. Denial is a mechanism which psychiatry teaches us is unhealthy. Yet, the covert messages, if you live in the Western world, force you down this path of compliance.

Immersion for me was necessary as I did not even know what my research topic was. Was it about Maori Health, or Mental Health, or both? Eventually, the tortuous hours, days, and months spent would entangle the many significant themes which lay at the bottom of the past. Ah ha! This must be the illumination phase. Themes like oppression, racism, discrimination, were internalised by me. The process of assimilation is well ingrained within every cell in my body but my spirit and soul still refuse to give in entirely. It is that struggle between the body, mind and soul within my external environment that created the tension within which I painfully wrote, while still trying not to upset the prevailing views of a master Eurocentric narrative.

3.8. Data collection

Once totally immersed, the researcher documents the key ingredients of his or her existential moment, or "turning point." That whole experience is captured in rich descriptive form as the researcher undergoes this paradigm shift and experiences a "collision" with "another horizon." The emotions, stresses, coping strategies, the context of the experiences, the problems experienced and the experience of having the experience are captured in diaries, personal journals, letters, self dialogues, and "recursive questioning techniques" such as dream analysis, essays, photographs, visual art work, and poetry. All these can offer the insights and understandings of an epiphany. Furthermore, the same autobiographical presentation can become a source of data and can be re-visited and retold. Doing this thesis, I was compelled to set aside time for writing. I used four A4 lecture books for my diaries and spent a lot of time in self-introspection and contemplation. My notes on my reflective autobiography became the raw data. I

transferred these onto computer disk later. I found that 3.00 o'clock in the morning was my best time to think, because I was relieved of any family commitment. I would keep one of my diaries by my bedside and often would wake up with some insight that I would then write down. In Chapter Four, the report of an inquiry from my previous job interviews became a source of data, as well as a letter that I wrote (appendix 2). Previous essays on cultural safety, which I wrote while doing the nursing knowledge paper; newspaper articles; as well as a write-up on a piece of aesthetic art presentation, became other sources of data which I was able to re-read and analyse. The experience of working in a kaupapa Maori service acted as a trigger that propelled me on my thesis topic. Following approval from the manager of Te Rau Pani (the Maori Service that I work for), reports, business plan, conference papers, and the service documentations all became data for my thesis, while periods of reflection, incubation and contemplation offered me insight, illumination, and understanding of my epiphanies.

3.9. Incubation

In this process "the researcher retreats from the intense, concentrated focus of the project to enable another level of the expansion of knowledge and understanding and awareness" (Moustakas, 1990). There were many times when I became preoccupied for weeks and needed to retreat from the intensity of the project. Work also offered me an escape, and I would then leave the thesis for two to three weeks. This allowed me to incubate my ideas and thoughts, and assisted me at another level of the expansion of knowledge, understanding and awareness. The draw back was that I was not available to people, and often my preoccupation made me inaccessible to my family – especially my children. All the in-depth thought and retrospective ideas were distilled to enable the main theme and sub-themes to evolve throughout the thesis.

3.10. Illumination

This occurs when the researcher experiences "a breakthrough into conscious awareness of qualities and a clustering of qualities into themes inherent in the question [topic]"

(Moustakas, 1990, p.29). Illumination for me occurred on several occasions when the "penny dropped." It was during these times that I began to realize that colonisation was emerging as a major theme in my research into Maori mental health. However, colonisation also emerged during the illumination phase as a process that had influenced the lives and destinies of my own ancestors, and ultimately my own life. It was like putting a big jigsaw puzzle together in order to make sense of my entire existence. Indian blood runs through my veins, yet the impact of colonisation on me made me a stranger to my own inheritance. I carried a sense of shame as a "third-world person." The image that is portrayed of India in the media that I am accustomed to in the West is one of a poverty-stricken country with illiterate people and millions starving in hopelessness, filth, and overcrowded conditions. India is a place I have always avoided getting to know whilst denying any association with. There are many parallels with Maori history. We were, and still are, assimilated in Western ways to such a point that our cultures of origin have been rendered almost invisible with little or no understanding of its impacts. I have become a stranger to the epidermis layer that identifies me as Indian, and yet history has robbed me of Indian culture. I felt that I could neither reject nor completely assimilate these multiple layers of contradiction in my life. I found resonance in Fanon (1963, p.8) – "you are making us into monstrosities; your humanism claims we are at one with the rest of humanity but your racist methods set us apart." I was trapped within my own body – colonisation was the sentence passed on me, and the Western world is my prison, not my salvation. A sense of discomfort, disintegration, mystery and confusion has reigned over me throughout my life. I would search for answers in my own thoughts as well in the works of Said, (1993), Freire, (1993), Ramsden, (1993), and towards the end, Fanon, (1963). These did not occur in any particular order; instead, at times, my thoughts would jump from different themes that all seemed to have a connection to colonisation and its aftermath. Those readings spoke to me as I started to gain insight into my past. A good example of this is when I remembered how, as a child, my mother offered me the opportunity to go and learn the Tamil language. By then she had lost the language, and I remember clearly how Freire's (1996) notion of internalised oppression fitted my response then. I refused to learn, as I thought "it was a backward language." I have come across the same situation amongst many of my Maori colleagues today. The same

messages were given to us all by our elders: "to succeed in the world you have to learn the white man's ways." These were the times when I began to identify these many themes as emplotments. In this thesis, where colonization emerge as patterns of conspiration, oppression and exploitation. The coloniser subjugates the colonised by overt and covert violence, and then proceeds to assimilate the colonised people into servitude. This took place in India, Mauritius, and Aotearoa/New Zealand – indeed, everywhere colonisation took place. The means to achieving this may have differed, but there can be no mistake about the end- result. I have deliberately choosen certain experiences as they were turning points in my life and subsequently in my nursing career whilst being exposed to working within kaupapa Maori services in Aotearoa/New Zealand.

3.11. Contemplation

Contemplation is the analysis prior to writing the reflective autobiography of "what has awakened in consciousness, in order to understand its various layers" (Moustakas, 1990, p.31). This deep contemplation is examined reflectively in order to uncover meanings, understandings, representations and pertinent themes and images. For me, there were moments of deep contemplation and time to think about the meaning of those data. During these moments, themes became more obvious to me the more I dwelled and critically analysed those thoughts prior to capturing them in my diaries. I had difficulty in separating the main theme initially from the many sub-themes that were emerging, and deciding how to prioritise them in a sequential order as well as how to write about them in a logical and congruent way. For example, I did not know what my topic for this thesis was – I was struggling because I was searching for a bigger explanation. Racism seemed so illogical to me, yet I knew that I could easily become a racist myself. There were numerous times when I had to interrogate myself as to whether I was, or could become, a racist person. I would then go and read about Bishop Tutu and Nelson Mandela. I would ask myself these questions: how many nurses or people in the health profession would be considered to be racist, and by whose definition are we to measure this? Words, in my experience, have no meanings if the behaviours do not match. I remember in my own family incidents where the darker your skin was, the more derogatory taunts you were

exposed to. These were good examples of the "internalised oppression" described by Freire, (1993).

3.12. A nurse seeks insights through Frantz Fanon's work

Friere's work complimented Fanon, which I read toward the end of my research. Fanon's (1967) book, *Black Skin White Masks*, has been very insightful and has helped me to understand myself and the colonial forces that have conspired against all colonised people world-wide. Fanon's two best-known books are about translation and re-translation. In *Black Skin White Masks*, he argues that black men and women have already been translated not only as colonial subjects in French imperialism, but also internally – psychologically. He goes on to say that their desires for whiteness are a kind of "metempsychosis" (Fanon, 1967). Their very desires have been transposed, though they have never, of course, actually become white. They have black skin, with a white mask. In *Wretched of the Earth*, Fanon saw colonialism as an abortive attempt to "decerebralize" a people into "natives," and inscribed with a "schizoculture" of colonialism as its devalued other (Fanon, 1963). During my nursing practice in a Kaupapa Maori service, I often find resonance when people describe similar circumstances to me.

3.13. Writing the reflective autobiography

There are no set rules for writing the self-life-story. However, one big challenge for me as a novice in research was the nature of autobiography itself, with the potential risk that subjectivity poses to academic rigour. For me, there were personal gains in using a subjective and reflexive approach to nursing research. I never knew that I could openly use my own experiences and reflections in order to uncover valuable meaning, and to find a different type of objectivity. This presented me with three issues:

Firstly, the challenge for me as a subjective researcher of learning "how to write visually, in a way that reflects how what is seen is felt, knowing then that seeing is feeling" (Denzin, 1992, pp. 24–25).

Secondly, the telling of the mysterious in a way "that would avoid the risks of dissolving the lived experience in a solution of impersonal concepts and abstract theoretical schemes" (Ellis & Bochner, 1992, p.99). I believe that as humans, we are kinetic, intuitive, psychological/emotional, social and spiritual beings rather than being purely material, and any scientific validity that research demands needs to reflect this when it comes to the research of lived experiences.

Thirdly, the challenge of writing in a way that affirms the self-narrative "as a mode of inquiry that should be judged not so much against the standards and practices of science as against the practical, emotional, and aesthetic demands of life" (Ellis & Bochner, 1992, p.99).

3.14. Relevance of reflective autobiography to contemporary nursing research

Nursing research has drawn upon biographical method, in particular case-studies, personal narratives, exemplars, and first-person accounts (Cotteril & Letherby, 1993; Gadow, 1995; Hatch & Wisniewiski, 1995; Koch, 1998; Jacobs, 1998; Johnstone, 1999). However, very few nurses have used "the self" as is emphasised in and by the reflective autobiographical method. The method is therefore relatively unknown, and has been under-utilized in nursing research. Of all health professionals, nurses usually have the most direct patient contacts and therefore are well placed to utilize reflective examinations of subjectively perceived human lived experience (subjectivity) and the physical, social, political, cultural, moral and historical contexts of that experience.

Nurses as researchers of subjectivity must "learn how to write visually, in a way that reflects how what is seen is felt, knowing then that seeing is feeling" (Denzin, 1992, pp.24–25). The emerging field of the sociology of the emotions has the potential to advance nursing knowledge via its interpretive research method. Colonised non-Pakeha

nurses need to be supported and encouraged to undertake research, as there are few that have the luxuries of time, money, and other resources necessary to conduct independent study. Writing this thesis has provided me an opportunity that colonisation denied me. That is, to undertake some of the journey through this world from my own viewpoint and not those of others.

3.15. Conclusion

Reflective autobiography challenges empirical methods and affirms the self-narrative "as a mode of inquiry that should be judged not so much against the standards and practices of science as against the practical, emotional, and aesthetic demands of life" (Ellis & Bochner, 1992, p.99). As a new field within the sociology of emotions, it is "utilized in the interests of developing potentially one of the richest sources of information for current and future researchers, scholars, theorists, educators and practitioners of nursing" (Johnstone, 1999, p.136). This thesis embraces the use of narrative as a mode of inquiry and places me as the writer at the centre of the reflective autobiographical discourse.

Autobiography as a method is slowly being used by nurses as an exploratory tool to understand student health needs; the "scope" of nursing-school interventions; the "essences" of practice; and the "ideological values" that lie within the text (Vendler, 1988). In this chapter, I have provided an account of how I arrived at my decision to choose reflective autobiography as a methodology, together with the significance of Maori health as a topic itself; its relevance to me; and the rationale for such a choice. I have given an account of the major features of autobiography and the theoretical underpinnings that guided me during the writing of this thesis. Particular emphasis is given to the notion of a "bricoleur," a French word that resonates with me, both as a word inherited from a colonial language, and as an apt description of how I have often felt as a result of my colonial history. I have experienced reflective autobiography as a vehicle for the exploration of nursing practice, issues of great concern to me, both professionally and personally. I am aware that to speak is to be political, and situate myself in this thesis as a social commentator with a deep concern for the human condition, especially at present, as

race has emerged as a political football during the 2005 election campaign. Diekelmann (1993) argues, "telling stories publicly is political, critical, and transformative" (p.6). As a non-Maori, raising these issues can often evoke strong feelings in both Maori and Pakeha and can have consequence as I will now depict in Chapter Four.

CHAPTER FOUR: The Advocacy role in nursing and its impacts

4.1. Introduction

The data in Chapters Four, Five, and Six have been chosen to allow me to reflect on three specific events during my lived nursing practice to make visible some of the difficulties I encountered in my role as a community psychiatric nurse. Through this reflective autobiography, I was able to assess the significance of these events by revisiting, remembering details, writing and re-writing several times in my diaries, interpreting, reflecting, theorising and analysing. That whole process helped me find meaning in my practice. Nurses make up the largest group in our health structure, and contribute toward the many barriers that minority groups have to struggle against within our society. These events, I believe, are not isolated but part of a larger problem within our health services. In my opinion, they hamper real progress, discourage meaningful changes, stop innovators and are a waste of human dynamic and constructive efforts. As it was for me, this thesis is an invitation for other nurses to write about their experiences in order to identify barriers within our health structures for nurses from non-dominant cultures. Changing the beliefs, attitudes and behaviours of health professionals is vital to removing those barriers and making the sector safe for minority groups. The central purpose of nursing is to work with all people in a safe way in order to improve their health outcomes and experiences. Nurses can have a strong influence as cultural advocates as well as act as agents for social change. The status of indigenous health is a global concern and occurs within a complex maze involving not only the impact of colonisation processes that continue to this day, but also social and economic deprivation and structural barriers within the society of which nurses are part. Without a good understanding of these issues, nurses may unwittingly be carriers of myths and misconceptions about indigenous people that inform their practice (Wilson, 2003).

In this chapter, I want to look at my past experiences relating to missed job opportunities as a direct consequence of my advocating for what I believe is a minority voice within Mental Health Services in Aotearoa/New Zealand. I selected aspects of my story that had resonance to Maori experiences, and then fully immersed myself in the re-living of my previous lived experience. I collected these stories in my diaries, where a lot of the ideas

were incubated, during 2002, 2003, and 2004. Illumination came slowly through the distilling, analysing, and theorising of all these thoughts, during long hours of being lost to the world in contemplation. Finally, the writing of my reflective autobiography started taking shape around April 2003, and I completed my first draft in July of that year. My stories will allow you to decide whether or not I was subjected to discriminatory practices within our Health system. It is my view that "discrimination" permeates our society and is transmitted across generations and manifested in individual behaviours, institutional norms and practices, and cultural values and patterns. As the American Psychological Association puts it, "racism serves simultaneously both to rationalize the hierarchical domination of one racial or ethnic group over other group(s), and maintain psychological, social, and material advantages for the dominant group" (American Psychological Association, 2001 p.1).

In the United Kingdom, discussions of institutional racism have appeared in nursing journals (Dhruev, 2002), and the Ministry of Health is making more efforts to ensure that all National Health Service Organizations become positively diverse. In Aotearoa/New Zealand, the Nursing Council of New Zealand has supported and issued guidelines and standards for cultural safety in Nursing and Midwifery Education since 1992 (New Zealand Nursing Council, 1996). However, my lived experience, as I shall relate, runs contrary to those guidelines. It is clear to me that the enduring strength of discrimination lies in its institutional and individual power, or the abuse of that power, which, as I argued in Chapter Two, has its basis in colonial times.

4.2. Review of four nursing job applications

Confronting institutional or individual power is not a comfortable or safe experience. After going to nine job interviews over a four-year period, I was rejected for every single one of them. This led me to lodge a complaint of discrimination through the Ombudsman's office and the hospital eventually granted a review by a third party acting as a mediator. The reviewer went back to interview the people on the panels, and I was not surprised with the summary of conclusions:

briefly, the clear majority of the evidence points to an absence of systemic discrimination in these cases. All but one of the interviewers on the four panels preferred other candidates to Mr Ramsamy at every stage of all interviews. But there is no evidence available as to the absence or presence of a general "intentional or unintentional disadvantage" for minority culture applicants.

The discrimination that I faced was robust, effective, and agile–by design, not by accident. However, proving it was another matter. It was covert and more like an invisible hand that was determined to hold me down. In my particular circumstance, it was determined to "keep me out," and went to great lengths to do so, as I will reveal later on in this chapter.

4.3. Maintenance of oppression in practice

I was meant not to question the powers that existed within the services that employed me. The perpetuation of the dominant relationship was based on the premise that the characteristics of those in power were the best that could be achieved. This belief pervades my position as an oppressed person even though it may be more myth than reality (Freire, 1971). Others from the dominant group were co-opted to enforce my subordination. Some staff were rewarded for proclaiming that the values of the dominant culture were correct, even though it meant degrading their own characteristics (Carmichael & Hamilton, 1967). There was clearly a threat of change, and their responses were to halt the momentum toward the change that I was advocating for.

Ten of the eleven people on the review panel were white, and the independent reviewer was unable to find any evidence to support my claim of discrimination. There was no racist language or behaviour, nothing overt, just the organisational process of human resources management. The punitive verdict was clear, and it was delivered in the guise of professionalism and fair-mindedness. This, I had no doubt, was a clear case of institutional racism. I knew that I was not the only one. Many people like me had had similar treatment dished out to them and retreated in silence or left the services. They are

the manifestation of institutional discrimination against those who dare to speak out; those who dare to have alternative views; those with vision and passion for the people trusted to their nursing care. Those new ideas unfortunately became a threat to narrow-minded people in authority who perceived us as an obstacle to their power. Their message was clear to me – "know your place." It was paternalistic, marginalizing, and pathologising. The review looked good on paper. It reinforced the organisation`s defensive action and its culture of denial. The real process for me was clear: first, ensure that the discriminatory action is covert; second, silence the evidence. The twist was in designing a system to maintain its institutional power, and selecting those that would not "rock the boat" and so preserve the status quo. The review simply reflected the organisational culture, and saw no further than the organisation's perception of professional practice – its corporate good and self-interest. It attempted to appear conciliatory while it was humiliating to me. I was a sacrificial lamb of little significance.

The review panel's verdict put the blame for my lack of success in finding work on my interview techniques. It also suggested that I did not have the necessary knowledge and skills. And finally, to add insult to injury, it insinuated that I should get collegial help and advice from some of those very colleagues that I felt had discriminated against me. In October 2002, it became known that many nurses currently working in psychiatric services were "not qualified to do so." (Daily News, 2002). The Nursing Council and the Ministry of Health were demanding that these nurses go back to school to gain full mental health registration. Several of those nurses were appointed over and above me as being better caliber nurses than me. I, on the other hand, with a full registration, over twenty years' experience in mental health, and a Diploma in Community Psychiatric Nursing from North East London Polytechnic, found myself constantly being rejected for jobs. Any community psychiatric nursing job would be internally advertised, thus excluding me. I would also be excluded from being put on the casual relief staff list – this when there was a shortage of experienced nurses throughout the country. Being treated unjustly made me want to fight back, and it took a lot of personal strength to rise above this feeling of powerlessness without any retaliation. That experience gave me new insight into the oppressive and cliquish nature of psychiatry.

4.4. Psychiatry as coercion- a psychiatric nurse's reflective lens

I have always reflected on my job as a psychiatric community nurse, and psychiatry itself as represented by the mental health system, as society's primary response to distress. Psychiatry is society's primary enforcer of the normative social order, when the enforcers cannot or do not want to apply the statutes of criminal and civil law. My experiences made me increasingly aware of the coercive elements within psychiatry. Much of this coercion is overt. People who are incarcerated are given drugs against their will. Even more so, however, coercion in the psychiatric field is subtle, rooted in the covert threat of involuntary "treatment." The core of psychiatry is therefore oppressive to the individual. As my own history is rooted in oppression, I have developed an acute sense of awareness, and believe in an individual's ability to transform his/her world. In so doing, a person moves toward ever-new possibilities of a fuller and richer life individually and collectively. Paulo Friere was convinced that every individual is capable of looking critically at the world in a dialogical encounter with others (Friere, 1972). Provided with the proper tools for such an encounter, the individual can gradually perceive personal and social reality as well as the contradictions in it. He/she becomes conscious of his or her reality, and becomes conscious of his or her own perception of that reality, and deals with it critically (Friere, 1972). Thus, I believe that a patient can educate a nurse and vice versa through mediation with the world.

4.5. Personal illumination through Freire's analysis

Freire asks the question in "Pedagogy of the Oppressed" of whether a human being can maturely contemplate overcoming the oppressive realities that lead to dehumanization and instead base human relationships on the ideal of love. Freire's premise for fighting oppression appears to be a synthesis of the Christian view of "love thy enemy," and the Marxist idea of worker solidarity, which I support, but have not until now been able to articulate. To Freire, since the oppressors have their "theory of action," so the oppressed must have theirs in order to overcome the internal and external structures that oppress them and inhibit concientizacao Freire (1970) refers to our perception of social, Political, and economic contradictions and to take affirmative action against our oppressive reality.

He counsels that the oppressed need to avoid seeing their predicament as unresolved but, rather recast it as a "limiting situation that they can transform" (Freire, 1970a, p. 33). This leads to the realisation that the oppressor cannot exist without the oppressed – a dialectical relationship. He further warns that this knowledge in itself does not constitute liberation, but only the necessary context in which a person or people will be able to join the struggle to free themselves. He defines *concientizacao* as the ability to perceive social, political, and economic contradictions, and to take action against the oppressive elements of reality. A basic element of *concientizacao* is another important term, praxis, defined as reflection and action upon the world in order to transform it. Freire describes a pedagogy of the oppressed as a pedagogy that "makes oppression and its causes objects of reflection by the oppressed, and from that reflection will come their necessary engagement in the struggle for their liberation. And in the struggle this pedagogy will be made and remade" (p. 33). Freire claims that the task of the oppressed is to liberate themselves and their oppressors: "only power that springs from the weakness of the oppressed will be sufficiently strong enough to free both" (p. 27). This notion may seem counter-intuitive since it is the oppressors who are in the dominant position and would therefore possess the key in the first place. Since both humanization and dehumanization exist, but humanization is the only true vocation of humans and "dehumanization is a distortion of the vocation of becoming more fully human" (p. 28). Freire argues that those who oppress others dehumanize themselves and engender the process that blinds them from seeing how this behaviour is self-destructive.

I have attempted to apply that knowledge by respecting and supporting each individual's right to "say his or her own world, to name the world" (Friere, 1972). As a person whose past has been marginalized, I am determined not to be a mere object, but instead to take upon myself the struggle to change the structures of society and to enter the modern world not as a victim but instead as master of my own destiny. I have refused to become submerged in this "culture of silence" and to subjugate myself even if it cost me my job. An example of a letter sent to the Chief Executive Officer that earned me the title of "a social activist" is included in appendix 2.

4.6. Sense-making through the Theory of Social Dominance

This letter is an example of what might have earned me the reputation of being a social activist. The review panel mentioned that there was

> a philosophical gap apparent between Mr. Ramsamy's interest in social activism and the requirements of the hospital. This interest is no doubt a useful strength when he is acting as an advocate for his clients. But it is also the prerogative of managers to regard such methods of advocacy as outside the parameters of organisational culture.

I had never considered myself as a "social activist" before, nor do I consider myself as one now. But my life thus far has often been experienced on the margin of society, and as a struggle for the right to be heard as an equal, and, consequently, I find it easy to empathise with the indigenous Maori people. In Aotearoa/New Zealand, cultural safety has provided me with a model of understanding of myself and the impetus to strive for improvement in the health status of indigenous people who have been subjected to past oppression. One of the founding fathers of sociology, Emile Durkheim, in his two great works "Suicide" (1966) and "The Rules of Sociological Method" (1961), showed the importance of social context in determining how an individual thinks, feels, and acts, and concluded that we do what we do because of the society in which we live and not because of the sort of people we are. Therefore, I have always viewed the structure of society through its institutions and artifacts and tried to understand the constraints it imposes in ordinary, everyday life.

During my nursing of tangata whaiora/patients, I had perceived "gaps" in the system, and I had already seen evidence that suggested that the system had failed to meet Maori needs. I personally attended several tangi , and was convinced that we could do better if only we were given the opportunities and resources. Furthermore, the review pointed out that "in order to bridge this gap, a somewhat uncomfortable activism would have to fall within the philosophy of the Mental Health Service (say, as a result of the appointment of a manager with a different range of preferred methodologies), or Mr Ramsamy would have to come to a determination to abandon such methods of work for the purpose of

fitting in with the Mental Health service goals and values." My "social activism" had been around wanting to improve Maori health, which was said to be a priority for the then Health Funding Authority. My response was to question that service culture itself as falling short of meeting that objective. I dared to ask pertinent questions, like "for years government policies and health funding authorities have made Maori health a priority. What had the Mental Health Services done so far?" In the area of Mental Health, I had dealt with many young Maori men and some of their deaths kept haunting me. I became relentless at asking further questions, like does the Mental Health service see Maori as a priority? If so, where is the evidence? Am I unsuitable for employment for raising these very issues? I knew that I was banging my head against a brick wall. I had dared to challenge the power base of some people within the organisation, and I had driven them into a reactive, retaliatory, and defensive mode. I needed to understand why people seek to dominate others. Pratto and Sidanius' (1999) theory of social dominance provided some illumination.

4.7. Illumination through the Theory of Social Dominance

My understanding this time came through Felicia Pratto and Jim Sidanius' (1999) theory of social dominance. In their book, they observe that all human societies with surplus wealth are group-based social hierarchies, in which there is a dominant group at the top and one or more subordinate groups at the bottom. The dominant groups are characterised by possession and control over a disproportionately large share of the material and symbolic goods people desire. Most forms of group conflict and oppression, from racism to sexism, are manifestations of humans' predisposition toward these hierarchies, they say (Pratto & Sidanius, 1999). I just did not fit in that hierarchy. The theory of Social Dominance also examines, for example, how both men's and women's gender roles in the family and in the workplace contribute to male dominance in the political sphere, to warfare, to ethnic oppression and racism, and to gender inequality both inside and outside the home. The same can be said to apply to age and disability. For me, it was clear that people who had status and power over me supported discriminatory practices and used covert means to ensure that they fell within the law, and even at times would breach the

law in order to wield those powers. Pratto and Sardanius also point out that racism severely targets subordinate men, who dominant men may see as potential threats and reproductive rivals. In contrast, discrimination against women of any group is endemic to all societies, they argue, and is driven by a desire to control them rather than to harm or destroy them (Pratto & Sidanius, 1999). This sense-making, however, did not bring me a job to sustain my own and my family's material wellbeing, and I had to step out of this oppressive situation for our own survival.

4.8. Stepping out of the psychiatric system

I began to realize that it was a futile exercise. I began to question the very essence of being a psychiatric nurse. I would pose more questions. Is the service self-serving? Who benefits most out of the system, tangata whaiora or staff? I did not presume to speak on behalf of tangata whaiora, but certainly as one of the staff that took home a pay packet, I knew that my livelihood depended on being a nurse. Yet the patients on the other hand are often reduced to a life on a sickness or invalid benefit, which provides a mere subsistence wage. How can I then say to those people that they have to budget better, and they have to live within their means? I have been party to running self-esteem classes, having the audacity to want to raise their self-worth as human beings, when society reduces them to a "mere mentally unwell patient."

The mental health workforce has necessary expertise and intelligence within it to change, yet I could not understand why it was so self-serving. What is it that stops us from looking outside of the square? Several questions remain open in my mind today. Like, is this the way it was meant to be? Should we be content with the status quo? Do we really care? Do we, when all is said and done, really only care about our own pay packet? Are we just a cog in the system, or can we reinvent it? Can there be another system that might provide tangata whaiora with a better chance in life?

These questions would eventually lead me and others to attempt to set up alternative services, such as "Kaupapa Maori," supported accommodation, and programs for at-risk Maori children in schools, and counseling and stop-violence programs for Maori men.

We struggled by with lottery funding, community organisation grants, Ministry of Justice money, and, eventually, a small amount of Health funding. After over six years of constant struggling for resources, we could not endure the personal sacrifices any longer. A supported residential care home and the prisoners' rehabilitation centre still remains to this day, however. Many more services have sprung up since resources have become available, although there still remain many more gaps. On the other hand, having resources available has also attracted one or two "self-serving" people who continue the cycle of discrimination and oppression. This is often done under the guise of "caring," in order to benefit our "Human Misery Industry" (a phrase coined by an ex-colleague of mine). I could not have gone to any learning institution to gain these insights.

What did all this teach me? Certainly, the service was community development in its true sense. Paulo Friere used the term *conscientizacao* to refer to a perception of social, political and economic contradictions, and unconsciously I was taking affirmative action against the oppressive elements of reality to a specific situation of injustice. I saw some of my colleagues taking refuge in an attempt to safeguard their own security. I would be dehumanized in my attempt to recover my lost humanity, and would now witness what Friere would call "the dispensers of false generosity" who had become desperate as I had posed a threat to its source of power. I was at the mercy of coercive actions. I would be called "not a team player," "a trouble maker," "a social activist," "a dog with a bone." I also had friends still working in the system, and word would get back to me that I was "black-listed" and would not get a job. I knew that the country was crying out for experienced psychiatric nurses and that there were few people that could match my expertise, locally or nationally.

4.9. My experience of oppression in practice

I felt alone and powerless in the world, as no one was prepared to stand up against such injustices – even one particular nurse who was a devout Christian and someone with a sense of justice. I knew that I had an inborn urge to wholeness and the unconscious aspects of myself relentlessly seeking to be made conscious. My faith in God kept me

sane, and I was determined not to be vindictive as this was a test of my inner spirit. My biological and current history bears no resemblance to the hurt of slavery. The challenge of facing and integrating these emergent experiences into consciousness was frightening and I felt overwhelmed. There I was, in the grip of an oppressive psychiatric service, and my life was disrupted by the relentless actions of the "kiwi clobbering machine." I understood then how psychiatry perverts the continuing process of individual and societal spiritual transformation, preventing movement to the next level of development. This was happening at a time when talk of transparency, consumer empowerment, and a recovery model was promoted within Mental Health Services throughout the country. I went through sheer agony and torture. I had many sleepless nights. I felt hurt, abused, rejected. I became angry and in my desperation, started having self-doubts, and would question my own ability. I knew that I had to do something urgent. For my own sanity and integrity, I needed to get out of the area. I applied for an out-of-region job. Despite tougher competition, I got the job on my first attempt. There was nothing wrong with me, or my interview techniques. This was a turning point, restoring my faith in humanity, and, more significantly, my faith in myself.

4.10. The impact on my family of my nursing advocacy

Taking this job meant having to leave my wife, who was committed to her own part-time General Practice, and this left her with our two little girls (a five-year-old and a three-year-old). During that time, I had to be away from our home and would travel five hours back and forth every two weeks in order to be with my family. This was forced upon me, and I felt that I had very little choice. I did this for about eight months, and the agony I felt each time I had to leave my family was excruciating. In my silence, I endured this pain and guilt alone. I knew that I had the easy option, and that it was worse for my wife and children, who indirectly became victims of my oppressive situation. My wife could not sell or give away her practice despite much effort to do so. Eventually, she told me that my absence had resulted in a remarkable change in our youngest girl. She was closest to me and would pine each time that I would leave home. It would have been easier on her if I did not come home at all. I knew then that this was destroying my family, and that

I had to come back home and be with them. My employer, having valued my contribution to their services in that short time, would not accept my resignation. They gave me six months' leave without pay in the hope that we could all move in that time. After a month back, I got a job with a local NGO (Non Government Organisation), and subsequently resigned from my other job. However, this oppression would follow me a year later when I applied for a position with a regional service. The people in power were prepared to use that power at all costs. I now want to write about this overt form of discrimination for the simple reason that it is so subtle that it inevitably goes without notice, and I believe is reasonably common in practice.

4.11. Professional abuse

I was short-listed for another community psychiatric nursing job, and I was accompanied by a Kuia to my interview. During the interview, I was questioned on several occasions about my relationship with the Mental Health Services and about conflict resolution. The Kuia and I intuitively knew that something was said to the panel. I did my best during the interview, and then traveled back home. A few days later, I received a phone call from the convenor of the interview panel. I was initially declined the job despite the panel being impressed with my interview and my range of skills. After putting up a fight, I was eventually offered the job.

I waited all day in agony and had given up hope, when, late that afternoon, I received a telephone call from the convenor of the interview panel. In light of new information, the panel were unanimous in their decision to offer me the job. However, I was asked what guarantee I could give the manager that he would not have to come to the local area in order to sort out problems every week. I was also told that the local service would not be happy with their choice and that I should just get on with my job and forget about the past. Not long after that, a colleague approached me and told me that he/she had witnessed how my other colleagues had been coerced into speaking to the interview panel convenor by phone. After having listened to what was said about me, the person did not feel that this was fair and wanted me to know this. However, he/she wanted me to "forget

about it and get on with my job" too. I am reminded constantly to forget about myself and my past and to passively accept my fate. If I speak up in a society that prides itself in being a democratic country that values freedom of speech, does that make me a "trouble maker"? The message is always the same – "know your place." Was it discrimination? Was it racism? Was it victimization? Was it legal? Was it right or wrong? Should I be writing about this at all, or should I just forget about it?

4.12. Illumination and sense making through Bugental (1976)

My sense-making of these events came from Bugental (1976):

> If I am to have a meaningful sense of my own being, I need to keep faith with my own life. So many of us have learned to desert our own views, desires, or values when important or numerous others seem to favour a different position. When I set aside my own genuine awareness of an experience for some present satisfaction or seeming safety, I am alienating myself from my own center. I can only be me if I am willing to stand by my own being. But I also recognized that in order to do so effectively, I must be willing to see others perspectives as well. (p. 188)

This incident also clearly fits Nelson's (2001) descriptions of damaged identity by oppressive means and points to the consequence of my advocacy and my attempt at what Mc Eldowney, (1995) describes as "critically resisting a situation of power-over" (p. 32). I want to end this chapter with a small extract from a web-page on lion-taming, which in my mind runs parallel to the experience of millions of people who have been and are still being oppressed in the world today:

> If you attempt to tame a creature that requires being subdued, or subjugated, you will receive a notification that you must subdue the creature before you can tame it! To tame the creature, you must first drop its health down past a certain point. Once its health drops low enough, you will receive another notification that the creature has been beaten into subjugation. If the creature

regenerates its health back above this point before a taming attempt is made, you will be informed that it still needs to be subdued. Upon taming, all creatures that require subjugation will lose 50% of all their stats and skills in addition to normal taming skill loss (Dae, 2003).

CHAPTER FIVE: Cultural learning in lived nursing practice

This chapter records my cultural learning in vivo during my nursing practice. I believe that this kind of personal effort is important for me as a non-Maori living in Aotearoa/New Zealand. A large number of nurses that I have encountered do not believe that such knowledge is of any value to them. I have heard dismissive – even racist – comments from some of my Pakeha nursing colleagues. This colonial attitude of assumed Pakeha superiority unfortunately still prevails in this country and in the nursing profession. My lived nursing practice is full of experiential learning of the kind that is not given enough attention in nursing. McEldowney (2003, p. 8) commented that "our lives are lived in particular ways and we bring the stories and the remembering, the reviewing, the interpreting." It is important therefore to capture and reflect on what was happening during those moments of practice.

Indigenous people generally have been and still are profoundly affected by the erosion of their culture, resources, and spiritual identity brought about by colonialism, and the consequent disintegration of family and community that have traditionally sustained relationships and obligations and maintain social order and control. The history of race relations in Australia, for instance, is one in which indigenous people have been subjected to forms of violence that were unknown to many non-indigenous Australians, and as a consequence, the atrocities inflicted against indigenous people have only recently been spoken about. Colonisation and dispossession were factors identified throughout the consultations as being central to the current alcohol and drug abuse, violence and dysfunction witnessed in Indigenous communities (Department of Aboriginal Affair report, 1999). These aspects are also common in Maori patients that I have nursed.

5.1. Data from lived nursing practice

I want to present this next story as an example of modern-day reality for one particular Maori man that I had the privilege to nurse as well as to get to know for a brief time prior to his death. Mr Kahurangi (a pseudonym to protect confidentiality) was a 34-year-old

Maori man living in supported accommodation with three other people. He had had numerous admissions to both the medical and psychiatric wards. His marriage had broken down as well as the relationships with his whanau. He was overweight with poorly controlled diabetes. He was slowly losing his vision and his kidneys were not functioning well. The hospital system had great difficulty managing Mr Kahurangi, who was described as being "obnoxious, unreliable, abusive and non-compliant" with his treatment. It struck me then that Maori faces were visible amongst the domestic staff but invisible within nursing and other health professionals.

After years of negotiation with the eight Iwi (tribes) of Taranaki (Ngati Mutunga, Ngati Maru, Atiawa, Ngati Tama, Ngati Ruanui, Ngati Ruahine, Nga Rauru and Taranaki) the hospital had finally employed a team of eight Maori Health workers. Mr Kahurangi's care was conveniently handed over to that team, who in time managed to negotiate his transfer to a "Maori Psychiatric Unit" outside of their region, as such a facility does not exist locally. It was a unit within a large psychiatric hospital.

5.2. How I became involved as a nurse

As part of a care plan, several Maori staff went to stay with Mr Kahurangi and support him. I was asked as a non-Maori to be a part of that team, and I volunteered to spend a week with Mr Kahurangi. Prior to this, I had become involved with Mr Kahurangi when he was being evicted from his boarding arrangement in town. Together with my Maori colleague, we negotiated a house where he could live. During my nursing training and previous nursing practice in England and Aotearoa/New Zealand, the idea of professional boundaries was constantly emphasised. Nurses' roles were strictly defined and social workers would deal with any social issues, accommodation, or finances. We had the luxury of focusing on the nursing care plan for an individual. However, the Maori team had to deal with any problem that Maori patients brought, whether or not those problems fell inside their training and experience. The term that I have heard used for this was "dial a Maori."

5.3. Professional nursing boundaries

I had often felt shielded by my professional label and my job description, and felt that these existed for my own safety. For me, the term "professional boundaries" identified a range of concrete and abstract concepts that in many ways serve to define who we are, where we can go, and what we can do as registered nurses. Professional boundaries are interpersonal in their construction and for many clinicians represent sources of continual struggle and reflection as they seek to do "good" for the patient and at the same time not to cause harm (Nurses Board of Victoria, 2001). Within mainstream services, these boundaries were clearly defined and at times restrictive. I would welcome any opportunity to safely expand them in order to respond to a human being in his or her hours of need and felt comfortable with this. I would herald this as a new way of working that was congruent with Maori aspirations. On a personal level, I have always felt restricted by some form of inflexibility within my nursing role. It was as if nursing had to be confined to my roster of duties. My response, therefore, was natural, and it fitted in with the way that I was brought up and my evolving life philosophy. I would also suspect that this contributed to my selection as part of the Maori team. I saw it as a privilege to be asked, and the way I was brought up in Mauritius made it easy for me to fit in and to be treated as part of the whanau. Although we did not have Marae, I can recall as a child having stayed at my uncles' and aunties' places, and we would all turn the house into our own 'Marae' and have mattresses everywhere on the floors in the rooms. The experience of staying on Marae in Aotearoa/New Zealand is therefore familiar to me. I am very comfortable on the Marae, and always feel at home there. Maori tikanga are also not dissimilar to the way I was brought up. I can fit in very comfortably in a Maori situation, and am always willing to learn while still being mindful of who I am.

5.4. Sharing a 'sacred' moment through nursing practice

My time on that unit meant that I could be with Mr Kahurangi and relate to him not as a patient but as a human being while maintaining my professional boundaries. The label "patient" itself is a way of de-humanising people and rendering them to a mere "subject." The unit was set up like a Marae – we all slept on mattresses together in a large

communal room. My time was therefore totally dedicated to Mr Kahurangi in liaison with the unit staff that focused on him as a Maori first. The environment was right for him and he felt that the staff treated him with respect. Previously, within the mainstream services he reported he had experienced a lot of condescending and paternalistic attitudes toward him from staff. The consequence of being on a marae meant that he responded positively and did not display any of the behaviour that he would have in the past. All the staff from the unit were Maori except for the doctor and me. A powhiri was arranged for me on arrival, and I immediately felt at ease and at home as a member of the whanau, and could therefore relate to Mr Kahurangi's feelings about the unit. I could emphathise with Mr Kahurangi because we both grew up in the midst of the Eurocentric discourse of the "other." These situations are too familiar to me and deeply embedded in my experiences. As a nurse, I am in a position of power and the patient is often objectified as the "other." Hooks likens these debates to re-inscribing patterns of colonisation: "When this happens … the 'other' is always made object, appropriated, interpreted, taken over by those in power, by those who dominate" (Hooks, 1990, p.125). In practice, I am always cautious about this notion of "otherness."

I spent seven days with Mr Kahurangi in a one-on-one situation, and that allowed me to get to know him as a person. Although he said he found it difficult to talk about his feelings, he readily spoke about the guilt he felt for "letting his whanau down" in the past and blamed himself for his marriage break-up. He intuitively knew that he was dying and that became the foremost subject on his mind. It was an honour to be there in his company and just listen. He was not afraid to confront death – I was also brought up to face death as a child, although our circumstances were different. Furthermore, I had read Kubler-Ross, (1973) book on death and dying and had an insight into the various stages of coping. Mr Kahurangi shared very intimate thoughts with me – fears of death and his attitudes toward death and dying. What was striking for me was the degree of insight he showed, especially for a man who had previously been labeled as difficult, un-cooperative, obnoxious, and abusive. He could trace all his behaviour to his initial denial of feelings, and the subsequent isolation and anger at himself that he felt he would displace onto others and the world around him. He went through the bargaining stage by

trying to make amends with his wife and grandfather, who he said rejected his efforts. He sank into depression and despair and "felt abandoned." However, he had come through to a point of acceptance.

I doubt that Mr Kahurangi would have shared those "sacred" moments with me during a routine community visit. He expressed a lot of previous feelings: his guilt and envy, his anger, and, finally, his coming to terms with his "fate." We then moved on to his fear of being buried as a "pauper," and especially what this would mean for him as a Maori. He was aware of his culture, although he said that this became a source of conflict in his marriage, and in time he would "shut the door" on it and live in a "Pakeha world" that he did not feel he fitted into. Over a short time, we had developed a sense of intuitive understanding and mutual respect. He needed to detach himself for the world in order to make dying easier as he felt that he was running out of time. I had entered that "sacred" space with him and there was no turning back. This is what I would describe as one of my "epiphanies," or turning points. We were communicating at a deeper level: it was true knowing, knowing that something deeper was going on, knowing that something was going to happen. His death was near, although time had disappeared. There was understanding and connection between us – no pretence, no falsehood, just being there with him as one human with another. Watson (1985) theorises this discovery of nursing intuition as a "deep connection" in nursing care practice – an innovative way to view the transpersonal caring process. I remember thinking that, if I were practising in England, I would have been accused of over-stepping my boundaries and becoming over-involved. For me, it remains a simple rule to show respect in caring – sharing the beauty and privilege of partaking with other cultures and accepting our cultural differences.

5.5. A non-Maori nurse learning tikanga in practice

I had been to several tangihanga before and had gained some insight of the tikanga involved. My understanding then was that the tuupapaku should be taken home to lie in state on an ancestral Marae, or with members of his whanau. In Mr Kahurangi's case, his mother and two brothers were in Australia, and his European ex-wife and grandfather had

completely rejected him to the point that they did not want anything to do with him. I felt his anguish and witnessed the turmoil he was going through. It was not my place to pass any judgment on their past relationships. I knew that if he were part of his ancestral community and had taken an active part in his local whanau, that whanau would have almost certainly taken charge of the tangihanga. Since being in Aotearoa/New Zealand, I have read on a couple of occasions in the newspaper of some of the tensions that can arise at tangihanga. It is so important that contending parties will argue and ruthlessly assert their rights, even going as far as to remove the tuupapaku. On the other hand, they can choose to recognise the higher importance of aroha ki te tangata (Metge, 1995). What I was witnessing was contrary to that belief and also to tikanga. This is an example of long-term colonial impacts on Maori life and the turmoil it can bring today for individual whanau.

5.6. My contemplation: Cultural understanding through nursing practice

Despite being aware of my own tension, particularly around professional boundaries, without any hesitation I made Mr Kahurangi the promise that I would not allow his tuupapaku to remain isolated in a morgue should no members of his whanau come forward to collect it, and that I would stand in as his whanau. This was a great relief for him, and tears streamed down the sides of his face. It was, he said, like "the weight of the maunga coming off my shoulders." We sat in silence for some ten minutes. He had a sense of calmness that I had not seen in him before. I knew that he was at peace with himself and with the world. He shook my hand and said "thank you bro from the depth of my heart". We both shared a moment of karakia together. I knew that all he needed was the assurance that other human beings would not abandon him at the time of his death. It was not a false promise, as I had to make sure that I was prepared to carry it through. The most meaningful help that I could give him was to share his feelings before the event of his death, and to allow him to work through those feelings, whether they were rational or irrational. This, I instinctively knew, was a great step toward his making peace with the world and the final acceptance of his death and eventual preparation to join his tupuna. I was prepared to step outside any boundary for the common good of humanity. The week

went by very quickly and Mr Kahurangi was very happy. I remember going for a walk with Mr Kahurangi when he decided to have some raw oysters, which was detrimental to his health, and him making a comment about "dying happy." We bade each other farewell and knew that we would catch up on his return home.

5.7. The Tangihanga - closure

A few weeks later, Mr Kahurangi returned home and was subsequently admitted to the medical ward. I visited him on many instances. His mother managed to come over from Australia a few days prior to his death and spent some time with him at his bedside. She then had to confront the issue of his tangihanga. I was asked to accompany her to Mr Kahurangi's grandfather's house in order to talk with him about the tangihanga. Mr Kahurangi's mother had been away from Aotearoa/New Zealand for a considerable number of years and had diabetes herself with an artificial limb. She was in no position to organise the tangihanga. We spent a considerable amount of time trying to persuade the grandfather to assist, but to no avail. I remember thinking, "what could Mr Kahurangi had done that his grandfather could not bring himself to forgive him, even at his death?" Disappointed, we eventually left, and I took Mr Kahurangi's mother to my house without the faintest idea of what to do next. We pondered this over a cup of tea, and I reassured her that somehow something was going to sort itself out. I also reiterated to her that I fully intended to keep my promise to her son in the event that no member of the whanau was to come forward. Several of my Maori health colleagues had arrived and we automatically started making preparation for the tangihanga at my house. My wife is an exceptional Pakeha woman, and she supported me, as always. I visited my neighbours (all of whom were Pakeha) to let them know what was going to happen so that they would not be alarmed. When I came back, I was informed that we had two visitors who wanted to speak with me. The two visitors were an aunt and uncle of Mr Kahurangi, both of whom I knew, but without realising until then that they were related to him. They thought that they may have offended me by their offer of having the tangihanga at their house instead, as by now the preparation was well on the way. I felt relief and told them that I was only too glad for a whanau member to come forward at last, and that it was

their rightful place because I was a mere bystander. I went on to explain that I could not allow Mr Kahurangi to be buried as a "pauper"; a promise that I had made to him prior to his death. I was given the honour of standing in at the tangihanga as one of his brothers and to bid him farewell on behalf of those who could not be there on the day. What remains vivid in my mind even today was that moment at the graveyard when I lifted my head and saw his grandfather there in front of me and we looked at each other and smiled. This was a great moment of illumination and satisfaction for me. I felt the fusing of our souls, and knew that he had forgiven his grandson for whatever pain he might have caused him in the past. This was a healing moment which I feel Western nursing needs to find a way of incorporating into practice. This was an important step for Mr Kahurangi in order for his spirit to begin the ancestral journey on which he would one day be reunited with his grandfather. These are the kind of treasured moments that make nursing worthwhile for me, but I feel that they are sadly ignored and often dismissed in practice. I have kept this as my secret moment until now, as I know I can be the butt of ridicule by colleagues that have little regard for other peoples' beliefs. This will remain a sacred moment in my life.

5.8. Gaining cultural illumination through lived nursing practice

Nowhere in my experience does the nursing system value other cultures. The Western way is often the only way. I have had senior colleagues in England tell me "when you are in England you do as the English man." Throughout their histories of colonisation, other cultures have had British culture imposed upon them whether they liked it or not. Yet the British would never tolerate such paternalism from anyone else. I have been cautious in my life never to impose my beliefs upon any other person, and I have tried to reflect this in my nursing practice. I have tried to understand the whanau concept by reading and by asking questions of the kuia and kaumatua. From those respected elders, I learned that the function of the whanau is to organise hui (meetings) – occasional gatherings to mark crises in the lives of whanau members, or for the whanau as a whole. Hui are typically held on marae, and follow protocol. According to Ranginui Walker (1987), marae are

important today because "they provide facilities to enable us to continue with our own way of life within the total structure of our own terms and values," (p. 147).

5.9. A reflection from competing thoughts - insight

This thesis has given me an opportunity to grow and to explore the many unanswered questions in my career and in my life in general. I have posited that, as a nurse and a human being, I cannot separate the two and pretend to provide nursing care while ignoring the root cause of many of the problems that we are facing today. History cannot be ignored, as it is the doorway to the past and toward the future. Indigenous people have held tight to their belief that the world is but a dust particle in the universe and that we should be mindful of all the other elements within it. To ignore this will surely take us down the path of self destruction. Colonisation is a good example of the innate desire of people to dominate, subjugate, and exploit other human beings while paradoxically claiming to save their souls through conversion to Christianity. This often comes about through dehumanisation. For many indigenous people, the most essential part of health is the spiritual realm (in Maori, the "wairua'), which is expressed in many unique forms throughout the world, although Christianity has replaced the many traditional practices of indigenous people wherever it has gone. In India, the British wanted to create Indians that looked Indian on the outside but thought like English people. Perhaps, in me, they have partly succeeded. The dominant European powers continue to ignore and fail to acknowledge how embedded and pervasive Eurocentrism is in the everyday life of many "other cultures." The residual traces of centuries of axiomatic European domination inform the general culture, everyday language, and the media, engendering a fictitious sense of the innate superiority of European-derived cultures and people. The Eurocentric position does not take into account the power relationship between communities and their subsequent impact on health. Shohat and Stam, (1997) wrote "While the fashionability of the word "multicultural" might soon pass, the issues to which it points will not soon fade. These contemporary quarrels are but the surface manifestations of a deeper "seismological shift" – the decolonisation of global culture – whose implications we have barely begun to register" (p.5). I have witnessed during my nursing practice in

Aotearoa/New Zealand many of my Pakeha nursing colleagues recognising that Maori having a better way of dealing with death, and yet, at the same time, criticising their Maori colleagues who take time off to attend a tangi.

5.10. Summary and reflection

Death and tangihanga are a time when the whanau is at its strongest. Selby described her own experiences when she lived in Auckland and heard of a whanau member dying. She had to respond with support. Her primary obligation was to return home to support the whanau. Selby (1994) writes:

> That support is given in form of being there, to work in the kitchen, to prepare food for visitors, to support the immediate whanau of the deceased. Others support by sitting on the marae to formally welcome visitors to the marae. Yet other whanau members are the grave diggers. Others have specialist jobs of preparing the meeting house and maintaining it throughout the days of the tangi. It is a thoroughly well organised affair where all have an important part to play. The whanau is a living vibrant, demanding, supportive, active unit that plays an important role in the lives of each other. To be a part of a large whanau makes us rich. To be ignorant of our whanau makes us poorer (pp. 144–151).

This elegantly sums up the case of Mr Kahurangi. It illustrates the hole left by the breakdown of the Maori family system, to which colonisation, culture loss, geographic dislocation, assimilation, generation gaps, and the need to adjust to economic demands and the universal culture of capitalism have all contributed (Walker, 1990). Despite this, as I have written below, Mr Brash (current leader of the National Party) obviously gained traction with voters in the 2005 parliamentary election by claiming that Maori are being given preferential treatment in Aotearoa/New Zealand. Mr Kahurangi's death was a premature one. Maori premature death is ignored by the majority of the Pakeha population, but it is a reality for many Maori families today. As a witness, my job brings me closer to Maori reality as I watch many families struggle just to make ends meet on a

day-to-day basis. As an advocate, this prompted me to write a letter to The Daily News (Feb 28, 2005 p. 8) attached as appendix 4.

This letter is my way of advocating for social justice as a nurse and urging more nurses to do the same. In the next chapter, I will outline a positive development: the provision of Mental Health services for Maori by Maori as a joint venture between Maori iwi in Taranaki and the Taranaki District Health Board. This is not the creation of a separate system for Maori, but a necessary response at this time and place until such a time we can reach maturation.

We are a nation in the making and enjoy cultural uniqueness. The Maori aspiration for "tinorangatiratanga" (self-determination) is essential for the mental well-being of Maori people and everyone else living in Aotearoa/New Zealand. Colonisation took away the right to self-determination of many people and nations. I have showcased some of my cultural learning, which is not to be found in any books, but lay within what Maori refer to as "kanohi ki te kanohi" encounters between and amongst people. The next chapter describes the evolution of a kaupapa Maori service in Taranaki and my part in this pioneering service. It is groundbreaking, and as such, it offers me and other nurses, opportunities for new learning and the enhancement of our future nursing practice.

CHAPTER SIX: A non-Maori nurse working in a Maori service

In chapter six, I want to share my experience as a non-Maori working in a kaupapa Maori service. I find it a sad reflection on local culture that I continue to encounter Pakeha third-generation or fourth-generation New Zealanders, and who, while never having set foot on a marae and knowing little about Maori culture, are often highly critical of it. My insight and appreciation of the culture come from my willingness to be open to new experiences, and through having honest and direct contact with Maori people as my equals. Again, McEldowney (2003) helped me in using reflective autobiography as a research methodology when she described Maori as subjects, as "basically listening, hearing their own voice, hearing their own interpretation at that particular point in time, although they may re-interpret that again" (p. 8). That aptly describes the experiences I will describe in this chapter. As a cautionary word for other nurses, I take this opportunity to point out that I had to limit my information in order to maintain confidentiality and commercial sensitivity. This has provided me with an understanding of what constitute public and private information when being employed by an organization. However, I do believe that changes happen by stretching those boundaries also.

If we are to undo the wrongs of the past and even out current inequalities, it is crucial that Maori participate in true partnership at all levels of Aorearoa/New Zealand society, as guaranteed to them under the Treaty of Waitangi. Mason Durie (1997) advocated that good Maori mental health is more than just efficient health services. For Maori, he said, good mental health also requires access to the institutions of Maori society, such as te reo Maori, land, marae, and ready access to primary health care, education, housing, and employment opportunities. As depicted in previously chapters, like all colonised people, Maori have been almost unrelievedly subject to wrongs and injustices at the hands of the new colonisers (Sharp, 1991). At the time of the writing of this thesis, services were being developed for Maori by Maori alongside those within mainstream services that have been the traditional response to Maori mental health issues. Kaupapa Maori services offer a desire for self-determination.

Te Rau Pani is one such service. It is a natural quality that is fundamental to postcolonialism itself. It is a form of self-expression for Maori who find themselves on the margin of society, and who have a higher rate of poverty, poor housing, and unemployment than other ethnic groups within Aotearoa/New Zealand. The desire for services for Maori by Maori is an emotional expression of those who find themselves at the points of disruption and fragmentation within Aotearoa/New Zealand society and are still struggling for self-determination as a basic right.

Maori, as the indigenous people of Aotearoa/New Zealand, struggle to resist colonisation and maintain cultural authenticity. Most of the institutions in this country have failed to address the needs of Maori people generally. It is primarily because of this failure that Maori people have become committed to seeking alternative solutions to mainstream institutions, especially in the areas of health and education. The issues of Maori education have been contested by the media, by politicians, by education experts, and by Maori themselves. It is not surprising that, within health institutions, multiple tensions have developed, highlighting the struggles of Maori people and their attempts to use cultural institutions and frameworks as sites of resistance (Smith, 1993b).

Aotearoa/New Zealand is a former British colony where British modes of colonisation have structured the indigenous people out of their tinorangatiratanga, or status as a sovereign people, and into an inferior subject position within a European-derived society. It was the audacity of Western nations to believe that they could determine who in the world could or could not be a sovereign nation. Dominance by power over was the mode of operation throughout the history of colonisation worldwide. When we look at history, then we can understand the clear intention of colonial administrators to use all its institutions as instruments of colonisation and cultural annihilation. The suppression of Maori language, knowledge, and culture was regarded as a necessary condition for becoming civilised (Smith, 1993b). Today, we see a Maori society that has survived the onslaught of colonisation. It remains a culturally distinct society that has its own ways of defining itself, its members, and its universe.

6.1. Data drawn from active participation in Maori services

This chapter is presented as the data drawn from my lived experience, and describes the development of kaupapa Maori Mental health service Tui Ora in Taranaki. It looks at the Taranaki District Health Board, the background to Te Rau Pani, and its initial goals and objectives from inception, and then traces its developmental stages. It gives an account of my appointment to Te Rau Pani as the initial clinical coordinator and the roles I played in the organisation while also outlining some of the difficulties I experienced as a non-Maori working in a Kaupapa Maori service. It introduces a new employment pilot project for Maori with mental illness in Taranaki. This service was described by its project manager, at the Health Innovation Awards (2003) in Wellington as "an example of Treaty of Waitangi partnership in action." This has been the desire of the Maori people for years. Maori had previously unsuccessfully tried to engage the hospital in meaningful dialogue over the provision of heath care for the Taranaki Maori people through Te Whare Punanga Korero (an iwi-based group in Taranaki). The idea sprang from the needs of Maori clinicians working in isolation from each other and service users' desire for Maori Mental Health Services. The resulting Kaupapa Maori Services work alongside existing Mental Health Services in Taranaki. The District Health Board, Maori Health Development Organisation together with Maori providers were the initial partners in a joint venture. Te Rau Pani, is now established as a charitable legal entity with its own governance. This is far from Maori being given special privileges; it is merely an attempt by Maori to address the disparity in health that exists between Maori and the rest of the communities in Aotearoa/New Zealand. Such initiatives should be applauded and supported by nurses. It is my plea for nurses to support Maori health initiatives, directly or indirectly, as a contribution towards improving these disparities.

6.2. Tui Ora Limited – A Maori health initiative in Taranaki

Tui Ora is a non-profit-making company jointly owned by Taranaki Iwi and Maori Health Providers. Tui Ora Limited is a Maori Development Organisation (MDO) with a focus on developing a range of public health, primary health care, and specialist health services. Its key aims include building the capacity of service providers as well as the development of

information for analysis, planning and monitoring of health services. Tui Ora Limited is an umbrella group that contract out the delivery of services to several Maori organizations and includes Te Rau Pani.

6.3. Taranaki District Health Board

Taranaki Health is the leading specialist mental health provider in Taranaki as well as being the District Health Board. As a main health funding authority and health provider, it is responsible for a range of mental health services including acute, outpatient, community, and drug and alcohol services. Additionally, it is responsible for the provision of Child and Adolescent mental health services and psycho-geriatric services.

6.4. Te Rau Pani – An illumination of a Kaupapa Maori service

Te Rau Pani encapsulates the common vision and desire of many people – Tangata Whaiora, whanau, clinicians, Maori mental health workers, and service providers. These groups have expressed a desire for an integrated Kaupapa Maori Mental Health Service, in order to meet the needs of Maori who have a diagnosed mental illness in Taranaki. Historically, mainstream services have provided minimal dedicated clinical time to Maori issues and Tangata Whaiora. Specifically, there have been no psychiatrists, psychologists, occupational therapists, or social workers dedicated specifically to this area. Most Maori clinicians were structured to work in isolation from each other. As a result, many experienced difficulty in providing culturally safe and clinically appropriate interventions for Maori. In 1998, Tui Ora Ltd. secured a number of Kaupapa Maori Mental Health positions that were established under new provider initiatives in Taranaki. During this time, clinician positions such as Dual Diagnosis, Drug and Alcohol, and crisis workers covered a broad geographical area and it became apparent very quickly that there were a number of risks for clinicians and Kaimahi working in isolation (Health Innovation Awards, 2003).

Since July 1999, a range of clinicians from each of the three providers of Specialist Mental Health Services in Taranaki had met regularly in the Kaupapa Maori Mental Health Clinical Forum. This group discussed clinical and cultural issues relating to Maori in Mental Health Services. Mutual respect and peer support enabled this group to address clinical and cultural safety issues. However, the clinical forum model had major deficiencies, namely a lack of autonomy and the human resources and skill mix of clinicians available to ensure quality clinical care of individuals. Henceforth, further discussions between Tui Ora Limited and Taranaki Health became the catalyst for a Kaupapa Maori Specialist Mental Health Service proposal in May 2000.

The over-all vision for the service was to "achieve excellence in the provision of Iwi driven Maori Mental Health by enabling and empowering for Maori by Maori wellness." The mission of Te Rau Pani is "To provide an Iwi-based specialist Kaupapa Maori Mental Health Service to Whanau, Hapu, and Iwi in Taranaki." It became obvious, however, that Maori working in mainstream services felt that their jobs were more secure there, and subsequently many at first resisted the move to Te Rau Pani.

Te Rau Pani delivers a specialist Maori mental health service in Taranaki. It provides a Maori clinical and cultural assessment services on an outpatient based, as well as treatment and consultation liaison service within a kaupapa Maori framework for the Maori people in Taranaki who have a diagnosed mental illness. By providing an integrated Kaupapa Maori mental health service, which would include dedicated clinical time to Tangata Whaiora, and cultural assessment and care. Te Rau Pani has improved access to services and provides early intervention for Tangata Whaiora and whanau by involving the Maori community.

6.5. The initial proposal

The initial proposal sought 12 FTE (full-time-equivalent) staff composed of a consultant Psychiatrist, Kaumatua, Tohunga, Psychologist, Social Worker, Occupational Therapist, and 6 Community Nurses. Initially, after lengthy negotiations, a smaller proposal was accepted and active planning began. This is in line with the intention of the Treaty, as

mentioned in Chapter One, and protecting Maori rights to ensure Maori participation in the delivery of services that had been previously lacking.

Guidance was sought from Kaumatua, who gave the name Te Rau Pani, as a name was required for the unincorporated Joint Venture. His explanation for the name was that RAU is to represent Te Raukura (the three feathers worn by Te Whiti) representing its message: "Glory to God, peace on earth and goodwill to all mankind." Pani, literally translated to mean "orphan," was a way of defining the humility involved in forging this new venture.

In February 2001, the Joint Ventures were legally constituted. As a new provider, Te Rau Pani had an initial set up of 4 FTEs. A consultant Psychiatrist, Tohunga/ Kaumatua, a clinical co-ordinator, and a Project Manager formed the core of the main staff in the establishment phase.

6.6. A non-Maori nurse as kaupapa Maori clinical co-ordinator

Workforce Development for Maori remains at a critical crossroads, particularly in Taranaki. There is a small Maori Mental Health Workforce that has both clinical expertise and knowledge in Kaupapa Maori. When the position of clinical coordinator was advertised, I was already employed, but was approached by a Maori colleague to apply for the job the day before the job application closed. As a non-Maori, I had previously worked in a Kaupapa Maori setting, although admittedly in a practically voluntary capacity. The prospect, I knew, would be fraught with challenges and difficulties. Despite this, I made the promise that I would put in an application believing that there might not have been sufficient applicants – especially Maori. I was interviewed and the next day, offered the position. This key role was to co-ordinate the entry to and exit from the service of Tangata Whaiora. All referrals were to come to the clinical coordinator, who would then ascertain the pathway for referrals within the Te Rau Pani team.

My appointment raised some controversies. After accepting the position, I was faced with the dilemma of what to do when I learned that I had competed against two Maori. Declining the position would have been insulting to the two kaumatua and the other members on the panel. I knew that there would be some aftermath to the decision, but trusted the judgment of the interview panel and kaumatua. Several other people were against my appointment to the position as a non-Maori. However, I also knew that I had support from both Maori and non-Maori. I decided that I had to lend a helping hand in the establishment of this Kaupapa Maori service, but would make way for a Maori successor when the time was right. This was a commitment that I had made previously when in the position of manager of Te Roopu Tane Taranaki (a non-profit-making Maori organisation). At the time, I insisted that the organisation should be led by a Maori. Nobody would come forward within the organisation, however, and, in the end, I asked for a compromise – sharing the position with a Maori. I wanted to demonstrate what a true partnership could mean, and would often remind myself of Te Raukura's message: "Glory to GOD on high, peace on earth and goodwill to all people." This was the guiding principle that kept me focused and kept my ego and natural human greed at bay. The partnership had to be on equal footing: 50-50, no more, no less. Partnership is built on trust, and in view of what has happened historically in the past for both Maori and me, I instinctively knew that trust building was an important part of forming a relationship with Maori. The concept of partnership plays an important role in ensuring that processes are transparent and culturally safe. It has to be sincere, genuine, and absolute. I also believe in speaking honestly and truthfully from the heart, and I have attempted to do this most of my life. At times people are afraid to offend others, and, consequently, honesty is hidden behind so-called political correctness. Honesty was my way of navigating the new domain and proceeding cautiously as I went. I knew that the laying of a sound foundation was very important for the success of this new Maori service. I had to put the interest of the organisation first, as opposed to mine. Each encounter became a learning and illuminating experience, as I shall illustrate by describing my involvement in the recruitment of our kaumatua.

6.7. Recruitment of kaumatua and psychiatrist

I have always considered it an honorable privilege and humbling experience to be asked to be on the panel that appointed the kaumatua. The interview process went well and a full-time kaumatua appointed. The kaumatua co-ordinator was a role that would provide cultural assessment and therapeutic intervention for Tangata Whaiora and their whanau. The role also encompasses on-going liaisons with kuia and kaumatua throughout Taranaki in an attempt to include and empower whanau who had felt alienated by Mental Health services. The contracting of a Consultant Psychiatrist was considered a huge success for a brand-new service. This helped to demonstrate the validity of the service in terms of function and public perception. This assisted the transitioning of over 200 Tangata Whaiora to the care of Te Rau Pani in fewer than twelve months, and the service is well supported by both clinicians and whanau today. On-going planning and regular communication are important features of the kaupapa Maori service.

6.8. Planning and deployment of actions

The Te Rau Pani Strategic Plan was developed by the Board of Control in liaison with Tui Ora Ltd, a Maori Health Consultant, a Maori Lawyer, two prominent Taranaki Kaumatua. A number of hui were held during the affiliation process to help set the vision and goals for Te Rau Pani, and these were incorporated into the Strategic Plan. The hui explored Maori concepts of Mental Health, medical versus traditional healing models, and Te Tiriti O Waitangi, and attitudes to current legislation and the Ministry of Health.

6.9. Tensions in the transitioning of Maori nurses to Te Rau Pani

One of Te Rau Pani`s key goals was to consolidate service provision by increasing the capacity of the specialist clinical and cultural multi-disciplinary team, and to increase Maori autonomy in the delivery of mental health services in Taranaki. Taranaki Health had a team of four full-time equivalent positions, employing 3.8 FTE Maori nurses and a .2 Pacific Island nurse. Therefore, within the JV agreement, it was only logical to want to

negotiate the transfer of those positions, thus realising the iwi's dream and providing a step toward tinorangatiratanga.

However, this did not prove to be an easy transition. Both the Maori nurses themselves, and at least one other Maori provider, had concerns about the transfer. The nurses had mixed feelings about the process and felt that they were not adequately consulted. There was a feeling of being more secure with Taranaki Health than with Te Rau Pani. The nurses felt pressured into this new arrangement and believed that they were not being given any other choices. One provider questioned the relocation of the nurses to Te Rau Pani itself as their preferred choice. Several meetings were held with the nurses themselves, involving a New Zealand Nurses' Organisation (NZNO) representative. At one time, I felt that there was a real risk of one or two of the nurses leaving, and this proved accurate when two of the nurses left. This action put further strain on Te Rau Pani and the nurses who had been working in pairs. I, in my clinical coordinating role, did my best to offer support to the nurses. I felt the stresses that the nurses were under, and that there was a real possibility of losing more of the Maori nurses – key resources that we could not afford to lose. It was the time, when I decided to step down from my role as clinical coordinator and apply instead for the vacant Community Maori Mental Health job. This, I knew, would strengthen the front-line delivery of clinical work and make room for a Maori to fill in the clinical co-ordination role within Te Rau Pani. Negotiations are still unresolved regarding the full transfer of the resources from Taranaki Health to Te Rau Pani. The nurses, whom I was now one of, although physically located within Te Rau Pani premises, remain employed by Taranaki Health and "on loan" to Te Rau Pani in a climate of uncertainty. Competition amongst Maori providers had also created an atmosphere of suspicion about the role of Te Rau Pani and its future intentions. I did not want to be wasting my time and energy on the 'politics', and this was another contributing factor to my stepping down from the clinical coordinator's role. Devoting my time to Tangata Whaiora remains my central focus. Stepping down was also my way of creating room for a Maori person to step into the role. I knew that, by taking a community nursing position, I could strengthen and support those Maori

nurses who were less experienced, and thus reduce the risk of less-experienced staff having to make front-line decisions and minimising the risks to the organisation.

6.10. Clinical risk/quality

Initially, the lack of co-operation between providers posed a real risk, and threatened the potential development of key stakeholder relationships. However, with goodwill, regular liaison meetings were established, both with mainstream and with Maori providers. As most of the client base was already established at the Mental Health Service, it was planned to transition clients once key personnel were established. Access and support were initiated to ensure clinical notes, risk management plans, and internal policies and procedures were available for Te Rau Pani. Regular Multidisciplinary Team (MDT) meetings were established in South and North Taranaki with regular in-service training initially encouraged. Attending Inpatient Unit MDT was necessary in order to develop relationships and partnerships between the main stakeholders. This has allowed for a safer infrastructure within which Maori nurses can practice and a safer environment for whanau to receive care. Employment is a key issue for good mental health, and Te Rau Pani successfully won a contract to pilot this new initiative in Taranaki, as I describe next.

Nga Pukenga Hei Whai Mahi – Employ<u>able</u>

A more recent addition and innovation within Te Rau Pani has been the establishment of a joint project with the Ministry of Social Development: Nga Pukenga Hei Whai Mahi – Employ<u>able</u>. This was a two-year demonstration pilot aimed at placing Tangata Whaiora on an Invalid or Sickness Benefit into open paid employment. Real work for real pay is the motivation for the Te Rau Pani Kaupapa Maori Demonstration pilot. This contract allowed for a number of participants over that two years period. Within three months, the organisation exceeded that number. Several Tangata Whaiora were now in part-time employment and a number in full-time employment. The early success of the project has seen the project extended on an annual basis.

Under the guidance of a kaumatua, kuia, and psychiatrist, the employment workers have forged a successful union with clinicians and have been able to provide a comprehensive support system for Tangata Whaiora. The day-to-day processes for this project involve a daily review of caseloads, daily reporting and liaison from employers, regular reviews of participant progress, marketing with employers, placement of participants in WINZ (Work and Income New Zealand) and community training courses, a job club, liaison with psychiatrist and key workers, and liaison with whanau, support workers, and residential homes. Nga Pukenga Hei Whai Mahi as a pilot program has been under close scrutiny from the Ministry of Social Development and a Research Group. Both provide feedback and suggestions for further program enhancement. Due to its success in Taranaki, our pilot program was extended. It provided guidance and advice to the other pilots throughout the country. The project has since expanded and is still continuing.

Te Rau Pani has already had a significant impact on Kaupapa Maori Mental Health Services, systems, and care in Taranaki. It received an award at the 2003 Community Mental Health National Building Bridges Conference in Rotorua. The theme for that conference was " Dare To Dream – Creating New Opportunities For The Future." I was proud of the team achievement, especially as I was instrumental in submitting the initial abstract. The service was also nominated in the Health Innovation Awards 2003 – the only Maori group there.

6.11. Illumination about supporting kaupapa Maori services

My work in Taranaki has been an attempt to support Maori in finding solutions so as to counter the constant negative focus on Maori services, particularly when something goes wrong. Understanding colonisation has given me a heightened awareness of discrimination and oppression, and I am very aware of their lingering effects on the colonised people. I therefore support Ramsden's (2002) view that nurses need to understand the colonising process. I have described what it is like for me as a non-Maori nurse working in a kaupapa Maori service, and the mutual benefit that this brings. More non-Maori nurses will undoubtedly benefit from direct contact with, and being part of,

such services in the future. Mainstream services pay lip service to the Maori knowledge requirement which it is necessary to have in order to work in a Kaupapa Maori service. However, working for Te Rau Pani has opened doors for me to learn Te Reo Maori (the Maori language) through a Maori organisation, Te Ataarangi, which is supported by the organisation. Along this path, I see the language as an integral part of culture identity, and I am sad to say that a lot of my Maori colleagues have dropped out of learning their own language, as I did with my own native (Tamil) tongue.

Colonisation has created a subconscious controlling force. Nelson (2001) states that "some master narratives hide the existence of coercion by naturalizing an oppressive identity. Naturalizing an identity is a matter of making it seem inevitable that certain groups must occupy certain places in society" (p.162). I was living proof of this subconscious mechanism operating in real life, having internalised this generational oppression. In today's terms, I would explain this further as the impact of de-culturation and acculturation. By acculturation I mean the influence of the daily exposure to the English language and European values and beliefs, while on the other hand there being little or no exposure to Maori language, values, or beliefs. De-culturation, meanwhile, happened years ago, when Maori people was punished for speaking the Maori language. The language's very absence continues that process today, an interplay of assimilation as a process that exists as a shadow alongside us all.

6.12. A non-Maori nurse's reflection on Maori services

Te Rau Pani is an example of how a Maori perspective in health services is seeking expression in the Mental Health Service. There are still many problems and much resistance to the Ministry's attempts at coordinating a systematic approach nationally. The development of current Maori health initiatives within mental health services have been mostly brought about through the effort and energy brought to bear on the Health Board Authorities by Maori community pressure groups. There appears to be a lack of goodwill from the bulk of the non-Maori population in this country towards Maori determining for themselves their own paths toward improvements in Maori health. The

result has been the growth of an array of Maori initiatives throughout the country, many existing in some degree of conflict with mainstream services. By and large, mainstream services have kept the bulk of the resources, and continue to provide, through their staff, the greatest barriers toward the incorporation of Maori value systems in the health sector. Most staff continue to deliver care to Maori under the belief that Maori are just like Pakeha/Europeans, and therefore should be treated and cared for in the same fashion. This is evident in there being so few Maori initiatives like Te Rau Pani in the country, despite Maori health being a top priority by the Health Ministry.

6.13. Conclusion

On reflection, Te Rau Pani is about a team of people working in unity and co-operatively. It is not about what a Maori colleague of mine once described as a "mana buzz" (adding to an individual's ego), or gaining personal accolades or financial rewards. (I do accept that those in Maori services need a comparative salary to health workers in mainstream services.) It is not about setting up yet another hierarchical and bureaucratic organisation. This is perhaps what we were initially accused of – that is, following European values and approaches and trying to "fit round pegs into square holes." It is, rather, about developing services that meet the needs of clients in a culturally safe way.

My perception of Maori in the Taranaki region is one of a proud and humble people. Despite being dispossessed, Taranaki Maori can lead the way, just like Te Whiti and Tohu did, and, in recent times, Ngati Ruanui (one of the iwi of South Taranaki) in establishing the first Iwi-based social services in the country. One needs to work for the people, and for the right reason(s). It is therefore about restoring the Mana Tangata, which is an essential element for good mental health for all people. This must also be practised within organisational structures, between Tangata Whaiora and kaimahi, and among every citizen of Aotearoa/New Zealand. It is only then that we would be upholding the wise message of the Taranaki Tupuna Te Whiti O Rongomai and Tohu Kakahi, of Parihaka: "kororia ki runga rawa, maunga rongo ki te whenua, whakaro pai ki nga tangata katoa" ("Glory to GOD on high, peace on earth, and goodwill to all people.")

This message embraces Maori and Non-Maori alike. Generating opportunities for Maori to participate fully in the political processes within the health system is a positive way to close the gap between Maori and non-Maori in Aotearoa/ New Zealand.

It is better to light one candle than to curse the darkness. Faced with the seemingly impossible needs of this country and the world, we can easily give up and become despondent, depressed, angry, or feel powerless. "Yet, we can "light a candle" through our love, giving, karakia (prayers), and work. We can all make a difference" (World Vision, 2005). Those words of wisdom are also found in the many whakatauki (proverbs) that I use as my guiding principles. They mean nothing if they are not put into practice. The following is the one I have heard used most often:

He aha te mea nui o te AO –

Maaku e kii atu

He Taangata, he taangata, he taangata

("What is the greatest treasure on earth? It is people, it is people, it is people.")

While Maori are kept at arms' length by a Pakeha system where majority Pakeha voters want to maintain Maori subordination, the impact of Maori powerlessness can be seen in the increased number of Maori in our mental health and justice systems. Mirowsky and Ross (1983) have described a link in the general population between social positions characterised by powerlessness, the threat of victimization, and exploitation (e.g, in terms of gender, ethnic group, and socio-economic status), and paranoid beliefs. The role of experiences of victimisation in the development of paranoid belief is an important area for future research (Bentall 2003; Morrison, 2001). It is not surprising to see, years after the onslaught of colonisation, the increasing number of Maori in both the mental health and the justice systems in Aotearoa/New Zealand. Racism is a social disease that lurks within our society. It is a cancerous growth that has to be removed whilst it is still benign – before it becomes malignant. Racism, I believe, affects people of all ethnicities, and exists also in nursing.

6.14. Reflection of a non-Maori nurse on politics

To speak is to be political. Politics is the power that determines the fate of the people. Colonisation, as I have pointed out throughout this thesis, undermines that voice and takes away opportunity by rendering people powerless. Oppressed people can internalize their oppression and become oppressors themselves (Freire, 1996). Yet, the Bible teaches us that we are all equal human beings made in the image of God. Despite this knowledge, we have created a world of "dog eat dog." Not many people would stand up for their moral convictions as long as the status quo protects their sense of comfort. Westerners have also been witnesses to, and a cause of, the wholesale destruction of hundreds of unique cultures and the belief systems that accompanied them. "Today, advocates of 'Ethical Relativism' actually welcome and celebrate differences between cultures, and are critical of the naive arrogance of Eurocentric Moral Imperialism" (Robinson & Garratt, 1996, p.20). Most modern societies have embraced capitalism and consumerism. "There is no going back, as a postmodernist society demands variety, something capitalism is good at providing. Most political parties control its members through consumerist seduction in-order to retain power" (Robinson & Garratt, 1996, p.121). Nursing is also located in this framework of consumerism, where to be healthy is a commodity for a large number of people.

6.15. Reflection on illumination

This chapter has given me an opportunity to understand the many layers that constitute health for Maori people. Nobody can deny that Maori have genuine grievances, whose resolution will require sweeping social and political changes. There are attempts at concrete plans for the reform of thought and action to meet the Maori demands for justice and to rebut and avoid the Maori claim to absolute sovereignty (Sharp, 1991). Te Rau Pani is one such attempt, although it is fraught with challenges, as I have depicted. As a non-Maori and a non-Pakeha living in Aotearoa/New Zealand, I hope that there is going to be justice on both sides, as opposed to an instinctive reaction to uncomfortably recognized differences. Working together as nurses for the common good of all surely is a healthy start. This concept fits comfortably with Maori values, but is incompatible with

a Pakeha concept of capitalism. In this light, Maori desire to run services for Maori by Maori should be encouraged – supported and not feared. Sharp (1991) believes that there are Pakeha who simply refuse to consider that there could be justice in the Maori claims. Since 1840, Pakeha have used the legal system to favour themselves at the expense of Maori. Pakeha have created and serviced most of our institutions from the time of their arrival in this country. The challenge now is for them to step aside and accept that there are inherent values in other cultures too, which undoubtedly contribute in a positive way towards the advancement of Aotearoa/New Zealand and its people. This is applicable for nurses also, as I have demonstrated from my experience of working for Te Rau Pani. I started off being employed by Te Rau Pani as the clinical coordinator. Then, I was employed by Taranaki District Health Board as a community mental health nurse but on loan to Te Rau Pani. Now I am employed by Te Rau Pani as the "Assertive Community Worker," working in conjunction with a similar position held by TDHB. We have written a combined job description that can sit in both Kaupapa Maori and mainstream services. I have become a bridge to share in our common humanity, irrespective of the many barriers that we as human beings create. This, I believe to be the essence of my nursing, as I peel off the many layers of pretense and dare to look at the reality of my existence from the "gut." To ignore others' existence is to deny my own.

The Maori nurses' initial fears for wanting to remain with the District Health Board have been realised. The nurses employed by the District Health Board have already had two pay increments. By April 2006, there will be a net deficit of approximately $15,000 in my salary working for Te Rau Pani. This disparity, represents a quarter of my total current salary after a similar pay rise. This will affect Maori organisations future ability to retain and recruit staff.

In Chapter Seven, I pull together the many threads in order to create some form of sanity in the insane world we are all responsible for, despite our intellectual superiority to the other species on this planet. Asserting a common human value is better than generating material wealth. This sentiment is captured in Eiseley's (1969, p.39) sensitive observation

that "Men, unknowingly, and whether for good or ill, appear to be making their last decisions about human destiny." I am aware that I have tried to cover wide and complex issues in this thesis. I wanted other nurses to think more deeply about these issues of our very existence, in order to deliver meaningful nursing care at the primary preventative level, rather than at secondary and tertiary levels. I shall now present my final summations, recommendations, and reflections.

CHAPTER SEVEN: Conclusion

7.1. Introduction

This chapter is a distillation of what I have learned through writing this thesis. I was guided by reflective autobiography as a research method, as suggested by Johnstone (1999), which has been used by more nurses recently (Harker, 2000; Mc Eldowney, 2002). Colonisation and its impacts have been made more visible through that reflective autobiographical lenses of both my own history, and that of Maori in New Zealand since European settlement. Pulling the various threads together proved a tortuous exercise. I found it difficult to make sense of and come to terms with this obscure past in order to achieve self-illumination. I feel that I have raised some controversial issues that I know many of my nursing colleagues would rather ignore. In doing so, however, I believe that I have created new knowledge in the hope that, it would invite other nurses to do the same. I have provided my insights, along with their implications for me as a non-Maori working in a kaupapa Maori service. As a nurse, I am now more aware, that I am driven by a quest for equity and social justice. These issues impinge on health and are important issues for the nursing discipline to address at a primary preventative level, rather than at secondary or tertiary levels of care. I have now gained an insight into my own historical and Christian backgrounds, which I as a nurse, needed to come to terms with in order to become culturally safe. I present the significance of my findings with recommendations for nurses and nursing researchers. I reflect on "Reflective Autobiography" as a research methodology, and the overall significance of the study. I then end with a final reflection on my whole journey.

7.2. Implications of working in Maori services for nursing

As a nurse, I wanted to answer the initial question of whether a non-Maori can work in a Kaupapa Maori Service. The Mason Report (1988) notes that staff were then rarely educated in taha Maori (Maori Culture). Despite various attempts to reverse the position of Maori, there are still disproportionate numbers of Maori coming into contact with mental health professionals (K. Brady, 1992; Lawson-Te Aho, 1994; Durie, 1998), who

are largely ignorant of Maori Mental Health perspectives (Durie, 1986). My own lived experience in Aotearoa/New Zealand confirms that not many non-Maori nurses see the relevance of Maori culture to their jobs. For example, when I wanted to learn the Maori language, I was told by the manager of the Mental Health Services that, "it was irrelevant to my job." In order for me to learn anything about Maori culture, I had to do it at my own cost and in my own time, with no support from the mainstream services that employed me at the time, despite this being a prerequisite to the job itself. The deprived state of Maori today cannot be remedied by Maori alone, because, so much of the alienation and deprivation was imposed by Pakeha attitudes and processes, they must also be addressed by the Pakeha community, which nurses are a part of. Each nurse has a responsibility to practice in a culturally safe way, and must reflect on what that actually means, both in individual practice and collectively.

7.3. Reflection on cultural safety

Cultural safety is about being and feeling safe within oneself in any particular encounter with Maori or other cultures. Ramsden states that cultural safety is not about tangata whaiora/patients, but that it is about nurses, their behaviour and attitudes toward tangata whaiora/patients and their ability to create trust. However, she says that some nurses want to make it about ethnicity, about Maori (Ramsden, 2000). She believes that they are always looking for simple stereotypes or a cultural checklist. This is Leininger's (1991) transcultural nursing and not cultural safety. Ramsden gave an example in a Samoan community, those raised in Samoa and those born here can be profoundly different, and making generalizations about them would be quite dangerous. Ramsden observes that nurses do not enjoy being stereotyped themselves, yet they often seem quite happy to do it to others. Nurses assume that people trust them, she says, but in fact people do not always do so – particularly indigenous people, those who have been colonized (Ramsden, 2002). I believe that the experiences I have related here further corroborate these sentiments through my lived experiences in this thesis.

Cultural safety is about the balance of power. Knowledge is power, and the construction of knowledge takes place throughout all of our educational institutions. Knowledge is deliberately constructed to control or to influence the behaviour of others (Yon, 1999). During the British occupation of India, many of its young and upcoming Indian leaders were educated at Oxford and Cambridge, where the Indian knowledge-base was replaced by the British one, so that the British could influence India through the Indians themselves. Cultural safety is concerned with teaching nursing students about power relationships in the context of nursing practice. Power and resistance are different sides of the same coin (Wilkinson, 1999). Cultural safety addresses power in the context of relationships and differences, especially with people who are marginalised within systems because of race, gender, class, or ability (Hall, Stevens & Meleis, 1994). Cultural safety also addresses the impact of structural and institutional power on the health outcomes of all people using health care services (Polaschek, 1998).

In writing this thesis, I have examined my own history of colonization and that of Maori and Pakeha in order to understand and answer my research question – can an ethnic, non-Maori nurse work with Maori? (I realise, though, that this is a retrospective question, as I am already working in a Kaupapa Maori service.) Whilst I share points of similarity with Maori (like colonisation), there are also points of difference: for example, culture and life experiences (Carryer, 1995c; Hooks, 1990; Smith, 1999). Ramsden believes that when our general education system improves and people address the issue of colonization, then cultural safety will be understood. Until then, it will only be taught and understood well in patches. I have brought to light some of these issues, and invite other nurses to do the same. She further states that our education system is still designed to support and reproduce the status quo and that people are still not being taught to think critically about their own attitudes and resulting practice (Ramsden, 2000). Cultural safety education can therefore include both complimentary and conflicting discourses. Discourses can be described as commonly accepted assumptions that explain reality and in explaining this reality form the basis of knowledge development (Wilkinson, 1999). I have attempted to make visible the invisibility of my reality in my attempt at improving human relationships amongst nurses.

Fook (1996b), on the other hand, emphasises the need to reflect, especially in areas relating to interpretations of meaning in different situations. On reflection, I do not believe that I have been immunized against the shocking state of Maori health statistics. However, I believe that I have been blocked on numerous occasions in my attempts at doing something about it. I believe that the politics of the health system are today the biggest waste of energy and resources. Generating opportunities for different groups to participate fully in the political processes within the health system can be a way of creating a health system that meet the needs of diverse groups (Fuller, 1997). I fear that, by increasing the Maori nursing workforce, which I wholeheartedly support, we risk loading the entire problem onto Maori health workers. Many people who identify as Maori do not wish to work in Maori health, nor do many non-Maori, either. The Maori health workforce is only four percent of the total, and Maori need to be accommodated further without the resentment of non-Maori. All nurses must take responsibility for improving negative health and social indices (Ramsden, 2002). Cultural safety teaching is concerned with a teaching-learning process that critically analyses and reflects on discourses impacting on the client's health and illness experience (Richardson, 2000). This thesis presents an example of how a non-Maori can work effectively and safely in a kaupapa Maori service, despite the inevitable tensions, the reality of a lower salary, and the failure of the mainstream system to recognise the skills and expertise one must possess in order to carry out such work.

7.4. Reflection on some insights as a nurse

To date, Te Rau Pani is making a difference in starting to bridge the gap in health between Maori and non-Maori in Aotearoa/New Zealand. As a non-Maori, I support this initiative, and I am proud of the service. There is talk of dual clinical and cultural competencies. Writers like Hall, Stevens and Meleis (1994), and Traynor (1999), have taken up these arguments for the compelling reason that nursing's place in health care as a marginalized "other," with regard to "mainstream" medicine, acts as a vivid embodiment of societal relations between women and men, black and white races, upper and lower classes, rich and poor, cultural differences, and the multitude of artificial

differences within a society. This is especially challenging to nurses, because they will be expected to deliver care that encompasses these differences. As Aotearoa/New Zealand becomes increasingly multi-cultural, the demands on mental health services to be able to respond in an appropriate manner to the many cultures that make up society will rise. The question will still remain about how we bridge those divides, and how we go about accommodating each other in this country. These will have other future implications for us all as nurses. I will now consider some future implications for nursing research.

7.5. Future implications for nursing research

This research project explores and describes my nursing journey and the direct personal impacts of working in a Kaupapa Maori service. The insights have been portrayed through lived experiences and narratives. I have looked at many emotional issues and given an account of my unique experience as an ethnic colonised (Mauritian) nurse in historical context. My experiences are presented in a story form in order to reflect critically and to give meaning to my clinical nursing practice. While the study is unique, it is also derived from the reality of practice, and thus has the potential to inform others by generating new knowledge. Ethnocentrism must be countered by building bridges across cultures and transgressing the many divides of our profession. Nurses have the capacity to enrich and to be enriched by their encounters in practice. Cultural awareness is presented in this thesis as a way of being that considers the individual, family, and wider issues within our society and globally. I have advocated a revised form of cultural safety, in which an understanding of both "others" and the self is equally important. I realise that there are critiques of both the concepts of "self" and "others." However, I feel that the ravages of colonization on colonized people and their decendants are real, with enduring effects even today.

The themes that have emerged in this thesis as being relevant for indigenous people – religion, internalized oppression, subjugation, racism, slavery, indentured labour, colonization, cultural safety, the Treaty of Waitangi, and discrimination – need further investigation in nursing research. The use of history, as advocated by Ramsden, has been

my attempt at linking the past to the present. Both are fundamentally intertwined, and have a bearing on the well-being of people, as well as determining their futures. A cultural safety model has been pivotal in influencing the direction, and some of the findings, of my research. The past's biggest impact on me has been the damage to my identity and the deprivation of opportunity caused by colonialism, and the way this has infiltrated my consciousness (Nelson 2001, p.21). I now realise that I have been conditioned by colonisation, and I have in the past acted automatically, without thinking reflectively. I had taken on the "master narrative," which contributed to the construction of an oppressive self-identity. The writing of this thesis has been a way to self-empowerment through "narrative repair" by creating a different discourse. I am now able to reclaim my free "moral agency" (Nelson, 2001) as an autonomous human being. I cannot reclaim a lot of what I have lost in the way of cultural heritage. Now, simply the act of knowing itself will allow me to forge a new, stronger, and more intelligible sense of identity. For instance, I now feel that I can choose – or not choose – Christianity.

7.6. The shift in my Christian beliefs

Christianity – originally an instrument of colonisation – paradoxically provides a shelter for oppressed people by promising spiritual salvation for the powerless. My position on Christianity is now open for a personal intellectual questioning. Colonisation has deprived the colonised of both material resources and their own spiritual contents, and replaced that spirituality with Christianity. Thus, if Christianity at its introduction was corrupted by the inclusion of aspects that made it the ideal religion for the colonisation of people, nowadays it is the ideal religion for maintaining the subjugation of the same people. Missionaries played an important part during colonisation in conquering the hearts of the colonised.

Nursing is fundamentally a moral and ethical undertaking. Both "ethical" and "moral" are used interchangeably in common usage. For my own position, my understanding of "ethics" refers to the systematic study of morality and the sources of moral knowledge, norms, values, and the applicability of moral norms and values in real life. In any society,

morality refers to a social institution with a code of rules that has profound social importance for the way we conduct our lives as members of a given society. Religions such as Christianity, Buddhism, Hinduism or Islam, are for many people a way of life. To be faithful to the tenets of those religious traditions is, for them, to live an ethical life. Colonisation is morally and ethically wrong in the sense that it is far from the tenets of most religious beliefs. Yet, Christianity was used as one of the instruments of colonisation itself, and most European nurses that I have worked with come from a Christian background.

7.7. Significance of the findings for nurses

As nurses, we are often the beneficiaries or the victims of history. Our individual philosophy of life, whether it is consciously articulated or not, is the foundation of our behavioural norms. A philosophy consists of those principles underlying our conducts and thoughts. Thus, the performance of a nurse is influenced by his or her personal philosophy. Each philosophy generates values that are demonstrated through behaviour and ways of thinking. There is a strong relationship between our conscious decisions and actions and our unconscious beliefs, attitudes, and values. Therefore, our ability to give optimal, sensitive care requires knowing and owning our feelings, beliefs, and attitudes and recognizing their influence. One of the novelties of cultural safety is its insistence that an analysis of power relations within health care must take account of the historical and social contexts of the persons involved (Ramsden & Spoonley, 1993). In other words, there must be a critical understanding that reaches beyond the appearance of relationships in clinical and community contexts (Dyck & Kearns, 1995). I have attempted to discover my own colonised past, and have provided that account, with my own critique, as an example for other colonised nurses.

7.8. Recommendations for nursing researchers

I assume that this reflective autobiography will spur other nurses to tell their stories. In time, those different narratives can become the basis of new knowledge that could bring

about better understanding and promote safer nursing care. Nurses belonging to dominant groups must support those on the margins of our profession, who need to feel safe and nurtured before they will do their own exploration and research, which has the potential to reveal a great deal more about our profession.

Future research could look at, for example, the correlations between colonisation and any of these variables: oppression, suppression, powerlessness, depression, subjugation, discrimination, racism, global poverty, or poor health. An examination of racism within the nursing profession itself in Aotearoa/New Zealand could provide new knowledge that would inform our future nursing profession. Do nurses from the dominant group believe that racism and discrimination exists within our work environment? If it does, what shape or form does it take? These are but a few suggestions, as the list is, potentially, endless.

7.9. Recommendations for nurses

The following recommendations are made on the basis of improving Maori Health in general. Firstly, the developments of Maori Services ought to be supported by non-Maori, whether they are directly or indirectly involved. Non-Maori nurses must examine the mechanisms of colonisation in order to understand its impact on indigenous people. On a personal level, every nurse should become familiar with aspects of her or his culture within a historical context if she or he is to avoid "victim-blaming." Nurses in Aotearoa/New Zealand need to have an insight into Maori culture, as they will invariably encounter Maori people during their nursing. This knowledge can only be acquired through personal encounters. This will increase their own understanding and go a long way towards creating the trust that is essential for practice as well as co-existing in a society. If we are to mature as a profession, then a regular forum to look at uncomfortable issues such as colonisation and racism should be encouraged within the nursing community. Clinical and cultural competencies need to be expanded to multiple competencies, which are clearly identifiable as quality processes, as opposed to public relations exercises. Nurses need to understand the effects of assimilation and ethnocentric practices which are embedded within people and our institutions. The Treaty as a

founding document should be a point of reference to unite us as a nation instead of creating division. Commitment to Te Tiriti O Waitangi needs to be translated into more positive actions. With regard to a health obligation, the responsibility to close the "Health Gaps" between Maori and non-Maori should be shared equally. Lastly, the development of a Maori workforce and services should be advanced as a positive development, as opposed to creating resentment amongst Pakeha and other ethnic groups in the country. Nurses should recognise that kaupapa Maori include multiple dimensions beyond the physical and medical models, and involve a Maori-centered approach with the whanau at the centre.

7.10. My reflection on writing a reflective autobiography

The concept of epistemology, for me, is more than a way of knowing – it extends to a way of being. My way of being has been forced upon me and my ancestors throughout our history. An epistemology is "a system of knowing" that has both an internal logic and an external validity (Ladson-Billings, 2001). Euro-American world-views have established that the individual mind is the source of knowledge and existence. This is contrary to my own belief, which places more emphasis upon relationships with others and the environment as fundamental to knowledge and our existence. Gramsci (1971) describes these two traditions as not merely matters of "alternatives" or "preferences," but rather representing a deliberate choice between hegemony and liberation. Despite the abolishment of slavery, indigenous people remain under Western influence and domination even today. This is a position that no one in the Western world would tolerate.

Continued Euro-American domination has resulted in a rationalist discourse, and has legitimised the aggressive manner of Euro-American epistemological traditions (Ani, 1994). Therefore, for me, different discourses and epistemologies can serve as both counter-knowledge and liberating tools for people who have suffered historically, and continue to struggle, against the Euro-American "regime of truth" (Foucault, 1973). The

hegemony of the dominant paradigm makes it more than just another way to view the world – it claims to be the only legitimate way to view the world.

Neo-Marxist post-colonialist criticism and cultural studies shed greater light on the workings of power in everyday life (West, 1993). Semali and Kincheloe (1999) have explored the power of indigenous knowledge as a resource for bringing about social change. They further argue that critical researchers should analyse such knowledge in order to understand emotions, sensitivities, and epistemologies that move in ways unimagined by many Western knowledge producers. In today's post-colonial context, we are slowly becoming better informed by indigenous knowledge in order to challenge the academy, its "normal science," and its accepted notions of certified information (Semali & Kincheloe, 1999). These authors have moved the debate about critical research in new directions. They have shown an ability to understand the conceptual inseparability of valuing indigenous knowledge, developing postcolonial forms of resistance, academic reform, the re-conceptualisation of research and interpretation, and the struggle for social justice.

In order for me to move beyond my assimilated experience of colonisation, I need to gain deeper understanding and be able to expose the way ideology constrains my desire for self-direction. I also need to confront the way power reproduces itself in the construction of human consciousness. Lather's (1991) notion of catalytic validity gave me an insight into how research can provide deeper insights to the researcher in understanding the world they live and subsequently in transforming that world. She states that "research that possesses catalytic validity will not only display the reality altering impact of the inquiry process; it will direct this impact so that those under study will gain self-understanding and self-direction" (Lather, 1991, 1993). Furthermore, for me as a nurse to adopt the principle of partnership with Maori, I have undertaken an examination of my own cultural and health values, life experiences, beliefs and practices and how I interact with Maori, both as tangata whenua, colleagues and as tangata whaiora.

7.11. Reflection on and evaluation of the research process

Research is unquestionably the key to a more informed delivery of quality nursing care in the future. For that purpose alone, the discipline urgently needs more studies undertaken from a wider variety of approaches in order to answer the many complex questions confronting it today. Both qualitative and quantitative methodologies have valuable and unique contributions to make. In order to explore historical context, historical research should be accorded scholarly recognition within the profession of nursing (Sarnecky, 1990). In line with Ramsden's call to know the past, historiography is an important methodology that nurses should embrace. Abdella and Levine (1986) concur with this conceptualisation of historical research, stressing that this method transcends the mere collection of dates and facts by focusing on the relationship of past occurrences with present day issues.

All autobiographies – like all narratives – tell one story in place of another (Cixous, (1993). It is my political right to be an authorial subject, a position which I must protect (Barthes, 1968; Lucinda, 1984). Autobiography has been recognised since the late eighteenth century as a literary genre, and, as such, an important ground for critical controversies about a range of ideas, including authorship, selfhood, representation, and the division between fact and fiction. Many literary critics have described autobiography as slippery, and have sought to control it within disciplinary boundaries, stamping their academic authority on what they saw as an unruly and even slightly disreputable field. Lejenne considered these problems, and in 1982 produced the following judicious and widely quoted definition: "A retrospective prose narrative produced by a real person concerning his own existence, focusing on his individual life, in particular on the development of his personality" (Lejenne, 1982, 9:193). This aptly describes my position in this thesis.

7.12. Emancipatory reflection- The human core of a nurse

Writing this thesis has forced me to reach deep down to the very core of my being, and to be in touch with my "soul." But before experiencing those inner depths of joy, I had to do

some inner cleansing, which was not at all cathartic, as I had initially thought. Although I had not lived the physical trauma of colonisation directly, I have felt its lasting effects, especially in others' attitudes towards me. However, the worst thing was the attitude that I had constructed towards myself. My work with stopping violence with men had made me realised that I have been carrying a lot of anger, hurt, and bitterness, and that I needed to let go of these negative emotions, which had the potential to eat away at the inner core of my "soul." My denial of being Indian or Asian or "other," was based on an historical displacement as well as not wanting to belong to "a Third-world nation." This negative image of myself, derived from colonialism, was prominent especially while living in England and Aotearoa/New Zealand. Suppressing my own identity was a subconscious survival mechanism, and therefore inevitable. I had internalised my oppression and hated my very being. It was easier to forgive others than to forgive and accept myself for being who I was. I have seen the power of the White men, and I had lived in a Western state all my life, where I have learned to modify my behaviour in the presence of Western people, who have power over me (although indirectly). I had internalised this covertly, out of fear, and carried it within me. I had a tendency to feel resentment, and, over time, this internalised oppression had evolved into a hatred of the self. Yet, I had no logical reason for hating myself. I had the potential for either a psychological disaster or a psychotic breakdown. Again, while doing anger-management with men in prison, I saw this in many others from an oppressed background. They also presented with an unexplained internal rage, and this often resulted in depression, social alienation, and/or the acting out of that anger on others. When externalised, the anger resulted in alcohol and drugs being misused, resulting in violence against others or themselves. This internalised oppression, and all the underlying repressed feelings, unsurprisingly make people oppressors in their own homes, against their own families and against society. Aggression within oppressed persons may be vented in an even more self-destructive way. Fanon has described the tendency of native groups to be in constant inter-group conflict, often spending most of their energy killing and maiming each other. He explains that this behaviour, which he terms "horizontal violence," is the "native's" way of setting free the tension that had built up because of the inability to attack the oppressor (Fanon, 1963). Freire also alludes to this explanation:

> The oppressed suffer from the duality which has established itself in their innermost being. They discover that without freedom they cannot exist authentically. Yet, although they desire authentic existence, they fear it. They are one and the same themselves and the oppressor whose consciousness they have internalised. (Freire, 1971, p.32)

I am lucky that I have not gone down that destructive path myself. The little education I had when young, my life-long learning, and my inquiring mind saved me from that possibility.

Psychiatric nursing has been another vehicle of salvation. It has served as a mirror that has allowed me to reflect on my past and has been a positive influence on my life journey. I am surprised to have got as far as I have in life carrying all that "garbage." I had sought refuge in Christianity, which taught me that I needed to forgive as a matter of saving my soul. I began to realise that I would gain more by letting go of the past, so that it never comes back to haunt me ever again. I knew that, by doing so, I would move from being a victim to a victor. I have even posed the question of whether it is a genetic trait in Pakeha men to dominate others. However, I believe now that it is a human trait, existing in all of us if given the opportunity for action. In recent times, the former Yugoslavia is a good example of the untold misery and pain that can be caused by peoples' unwillingness to forgive, and their subsequent need for revenge. Oppression of others always involves an abuse of power – the powerful over the powerless. The balancing of this power involves the powerful being willing to allow the powerless to share in that power. Nowadays, in a globalised world, we have recourse to the United Nations to ensure that, whenever an individual or nation offends another, the offender gives up a certain degree of power, with the power being giving over to the offended. However, in real terms, I know that this takes time, and often it may not happen at all. From my position, as an oppressed person, I had to focus on myself in order to make the changes in my own life that I felt were necessary. This is a personal commitment, a choice, and a daily struggle.

Learning the history of Mauritius and the East India Company has allowed me to acknowledge, understand, validate, and accept my feelings of hurt, anger, and shame. I

know that in future there is a whole new dimension to life that awaits me. By beginning to learn the history of New Zealand, for both Maori and Pakeha, I believe that I will be in a better position to understand and seek compromises in the future. I have learned that "the first person who gains from forgiveness is the person who does the forgiving" (Enright, 1998). Forgiveness is a conversion of the heart, and by forgiving, I have experienced inner healing. I am able to move on with my life the way I want it to be. My pain must never be passed on to others, including the offender. I have chosen the message of Parihaka – "glory to God, peace on earth, and goodwill to all mankind" – instead. If I want something for my child, I must want the same for everyone else's children. I know that I am now released from the burden of grudges, and I feel the joy that this brings me already. Forgetting the past, as I am often told to do, is difficult – the past can rarely be wiped out of one's awareness. Remembering instead allows me to seek meaning in that suffering to ensure that I do not make the same mistake. Forgiving is not forgetting as a cheap avoidance of justice, a plastering over of wrong, or some sentimental make-believe. If forgiveness is a whitewashing of wrong, then it is itself wrong. Nothing that whitewashes evil can be good. It can be good only if it is a redemption from the effects of evil, not a make-believing that evil never happened.

The concern for the marginalized has been a theme throughout Christian history. English and American evangelicalism are famous for their concern for social justice, although little has changed in practical terms. Postmodernist Christians are trying to redefine the relationship of faith to knowledge, arguing that "instead of coming at the faith rationally, true knowledge requires the Holy Spirit to work an ontological change in the human heart" (Crouch, 2000). Despite this new openness to hearing marginalized voices, such as those of women, the poor, the disabled, the working class, ethnic minorities, and so on, we are a long way from moving forward into action. It is the people in power who control who speaks – on radio, on television, in print, and in the media – and they have a vested interest in maintaining the "status quo." The same is true within our health services, as I have indicated in Chapter Four.

7.13. The overall significance of this study

The nursing profession, and indeed society as a whole, need to ask why so many indigenous people are in our prisons and mental institutions today. Ramsden alluded to the need to consider history, and how it has impacted upon the lives of indigenous people worldwide. Colonisation is an important part of that history, and will not be erased from it, whether we choose to forget about it or not. If we fail to remember this, then we run the risk of victim-blaming (Ramsden, 2002). Colonisation was the means by which one race exploited another by subjugation. Paradoxically, the Bible tells us that Christians are born in the image of God, and that God granted freedom and tinorangatiratanga. In this thesis, through reflective autobiography, I have attempted to expose the forces that prevent individuals like myself, and groups like Maori, from shaping the decisions that crucially affect our lives (Denzin, 2000).

I want to reflect on my psychiatric nursing from an ethnic-minority point of view. Psychiatric nursing in the Western world derives from the broad stream of Euro-American culture, which generally is traced back to Greek and other Mediterranean cultures. Its present form has antecedents. Clearly, it is the product of particular historical developments and structuring of concepts of etiology, diagnosis, and treatment (Hughes, 1976). As a practitioner of Western psychiatry, which forms the basis of my own nursing training, I want to warn other nurses of its shortfalls, as well as invite them to explore other possibilities. It does not make sense that the bulk of psychiatric funding goes to inpatient facilities when primary prevention is spoken of, and little is changing in practical terms. Examples include the impact of physical, sexual, and emotional abuse in homes that I have witnessed here in Aotearoa/New Zealand, and the ineffectiveness of the main agencies – the Accident Compensation Corporation (ACC), Children and Young Persons' Services (CYPS), and the Justice system – in dealing with it. This breakdown in the social and economic structure for indigenous people I have traced back to colonial times, although the Western world would want us to forget about that past. It is directly linked to the subsequent long-term impact on mental health and costs to the justice system in this country. As early as 1982, Lin provided a "Chinese Perspective," and his

comments on the limitations of western ethnocentric vision of modern psychiatry are as follows:

> Modern psychiatry was born in the West, and as it grew it was moulded by specifically Western philosophical and scientific traditions; it developed as a child of Western Culture. Consider then the prevalence of ethnocentrism and the untested presumption of clinical universality in modern psychiatry. It is not difficult to understand why unfamiliar psychiatric phenomena or folkloric healing practices aimed at mental disorders in non-Western cultures are regarded as foreign, primitive, uninteresting or even inferior. Quite simply they are considered as phenomena and practices isolated from the totality of the cultural contexts which shape them and serve to define their real significance. It is the challenge of the cultural psychiatrist to overcome the inertia of ethnocentrism while helping modern psychiatry to step beyond its boundaries, enriched by new materials, new perspectives and new insights (Lin, 1982, p. 235-245).

7.14. Final reflection

Inequality and inequity are two of the signature characteristics of our species, and they affect how many people live, yet they are largely invisible in nursing. This thesis has enabled me to realise that I do live in an unequal and an unjust society. It has made me more aware of the processes that contribute to that inequality, and how I participate in them. I feel more determined to do something about inequality now, and to combat it in my daily life, joining forces with others in order to overcome discrimination and oppression.

This study has assisted me to uncover the many layers of history, and history's impact on me the person, the nurse, the father, the Indian, the Mauritian, the Briton, and the husband that I am today. I hope that it will provide a different view for other nurses who read this thesis. Colonisation is the central theme that emerged from my research, and I attempted to give insight into its impact on a colonized non-pakeha person and a psychiatric nurse.

Many sub-themes were explored as being significant in shaping and giving meaning to my lived experiences. It was a daunting and at times overwhelming experience, but it proved therapeutic also. Colonisation left me devoid of culture.

> "Colonial domination, because it is total and tends to over-simplify, very soon manages to disrupt, in spectacular fashion, the cultural life of a conquered people. This cultural obliteration is made possible by the negation of national reality, by new legal relations introduced by the occupying power, by the banishment of the natives and their customs to outlying districts by colonial society, by expropriation, and by the systematic enslaving of men and women" (Fanon, 1963 p.236).

As the descendant of a colonised people, I feel it is necessary to establish a more equitable bicultural and multicultural society in this country. The nursing profession, as well as the wider society, needs to look at the pathological view of "ethnic" people based on conceptualisations anchored in racism and transmitted through a historical concept of deprivation and maladaption to the existing social order. This is reflected through the over-representation of oppressed people in psychiatric and justice institutions. I explain this by its association to the historical tradition, framework and elements which govern the relationship between the colonised and the coloniser. Having done this project, I am now more aware of my history and how it has evolved through colonisation. As such, I can identify with oppressed groups that have been and are still controlled by forces outside themselves. The dominant groups have greater prestige, power and status, have exploited and continue to exploit the less powerful groups. I am aware of the degree of my success at being assimilated in the Western world, which nevertheless comes at the expense of being "marginal." By this I mean, living in a Western society, it is difficult for me to pass as a Westerner due to my obvious genetic characteristics. I now realise that I do not belong to either the Western or the Indian groups, but that I am rather on the fringes of both Indian and Western cultures. As such, I am unable to be a member of the dominant Pakeha group. This marginality leaves me without a cultural identity, leading to my struggles in a dominant Western society, whilst I have developed a greater sensitivity when it comes to oppressed groups, and can readily identify with the struggles of Maori

people. Previously, this inner conflict had led me into a process of internalization leading to oppressed-group characteristics of self-hatred and low self-esteem (Lewin, 1948). My taking on of the dominant European culture was a result of my assimilation, resulting in what Carmichael and Hamilton (1967) called "submissive aggression syndrome" (an example is found in Chapter Four). Fanon (1967) allowed me to understand how colonialism, with its explicit conceptual underpinnings of white racial superiority over non-white peoples, has created a sense of division and alienation in my own self-identity as a colonised person. I accepted as universal, normative and superior the culture, language, customs and beliefs of the British colonisers. This created a strong sense of inferiority in me, and led to my adoption of the language, culture, and customs of the colonisers as a way of compensating for these feelings of inferiority. This created a divided sense of self, leading to a sense of alienation from my culture of origin. Living in the West, the freedom for me, as a colonised person, to reclaim and reconstruct my own history and culture can only come from myself. It will not be freely granted by the dominant group (Torres, 1961). Fanon understood well that it is important for post-colonial nations to develop new forms of social democracy, rather than utilise existing colonial institutions and simply fill existing administrative positions with indigenous people. Fanon also suggests that these colonial institutions are inherently racist (experiences that I commonly experience in practice as well as my every-day life in the West), as they reproduce the concepts and ideas of the colonisers.

I want to end this thesis by drawing from the wisdom of Kahlil Gibran, a non-European poet and philosopher, whose works are world-acclaimed and has been translated into more than twenty languages. This is what he wrote about self-knowledge, pertinent to me as a "colonised nurse":

Your hearts know in silence the secrets of the days and the nights.

But your ears thirst for the sound of your heart's knowledge.

You would know in words that which you have always known in thought.

You would touch with your fingers the naked body of your dreams.

And it is well you should.

The hidden well-spring of your soul must needs rise and run murmuring to the sea;

And the treasure of your infinite depths would be revealed to your eyes.

But let there be no scales to weigh your unknown treasure;

And seek not the depths of your knowledge with staff or sounding line.

For self is a sea boundless and measureless.

Say not, "I have found the truth," but rather, "I have found a truth."

Say not, "I have found the path of the soul."

Say rather, "I have met the soul walking upon my path."

For the soul walks not upon all paths.

The soul walks not upon a line, neither does it grow like a reed.

The soul unfolds itself, like a lotus of countless petals.

(Gibran, 1980, pp. 65-66)

APPENDIX 1

Taranaki Regional Ethics Committee Letter

Taranaki Regional Ethics Committee

P.O. Box 555
New Plymouth
C/- Stafflink
Phone (06) 758 9086
Fax (06) 758 9278
Email: ethics@stafflink.co.nz

24 June 2002

Mr K Ramsamy
C/- Te Rau Pani
PO Box 5131
NEW PLYMOUTH

Dear Mr Ramsamy

Maori Culture: From novice to insight. The lived experience of an ethnic nurse from 1986 to 2002 through critical reflective topical autobiography.
Investigator: Krishnasamy Ramsamy
Ethics Reference: 02/06/009 Taranaki

Our Committee thoroughly reviewed your application at the meeting on Wednesday, 19 June 2002 and in our view you do not require Regional Ethics Committee approval as there is no participant.

If such is required by your administration, we will assist. Please advise if required.

In the meantime we wish you well with your study.

Yours sincerely

Pauline Maxfell

pp Catherine Quin
CHAIR

APPENDIX 2

Advocacy letter

Dear Mr/Mrs/Ms

I am writing this letter as I have been extremely concerned with what is happening within the Mental Health Services as an Ethnic Nurse. I have experienced those services as being "Monocultural."

It is my view that employment decisions are made which limit ethnic individuals' opportunities for employment and that selections are based mostly on western values. The complexities of cultural knowledge, belief, art, morals, law, and custom and any other capabilities and habits acquired by a human being as a member of our society have not been understood by the main players within the organisation. Subsequently, this is affecting the deliveries of care to people of non-European origin. At the very least, this constitutes a form of cultural abuse or neglect.

Culture influences who we are and who we can become in a number of ways. It influences what we perceive or do not perceive, how and what we feel and so on. Our genetic inheritance is passed to the next generation through our genes and DNA. Just as we pass on a biological heritage so too do we pass on a social heritage through the process of socialisation. This socialisation process is dependent on the particular historical time and the particular culture in which we are born. Culture is a shared part of socialisation. Culture is a factor in many aspects of our lives.

The Mental Health Services' failure to recruit enough ethnic people as core staff demonstrates the organisation's poor understanding of culturally different people. I have often heard statements from staff that "this patient does not want anything to do with his or her culture." Does that individual have any choice? Especially when the dominant culture is doing the asking, and after years of being assimilated into the dominant culture.

With the setting up of Maori providers, it is my impression that the Mental Health Services are now seeing those new providers as having to address all Maori-related issues, while the bulk of the funding remains trapped within mainstream services. It is somewhat ironic to hear non-Maori staff saying that they are now culturally safe to interact with Maori after attending a "Treaty Workshop." Many of the job descriptions require that "staff have knowledge and appreciation of Maori Culture, Tikanga and Te Reo, or alternatively give an undertaking to acquire such knowledge as soon as practical following appointment." The questions that this begs are: (a) How many of the staff have actually bothered to acquire such knowledge? (b) How committed is the organisation to such development? and (c) What evidence is there to demonstrate such commitments?

The HFA (Health Funding Authority) draft service requirements of February 1999 require providers to ensure interventions are culturally appropriate and that provision be made for access to cultural services in accord with the needs of individual service users. This must include cultural advisers, and the need for cultural safety in delivery of services must be recognised. The encouragement for ethnic people to join the workforce is therefore paramount if we are to achieve those objectives. There are a few non-Maori that have demonstrated the commitment and acquired some of the understanding necessary in order to work with ethnic groups and could play an important role in bringing the changes necessary to improve outcomes for ethnic groups, particularly Maori.

In order for us here, to adopt an additive Multicultural focus, one must be able to (1) Increase awareness of the extent to which our thoughts, values, and behaviours are the products of our own culture, and not necessarily functional; (2) increase our ability and skill in interacting with people who have different norms, values, ways of thinking and perspectives and ;(3) increase the ability to control our own behaviour so as to be optimally effective in relating to those of different cultures. To be able to achieve these

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three skills, there must be a shift from an ethnocentric to a culturally relative point of view. In human development, it is necessary to adopt a culturally relative position, which means being able to see and accept as valid others' perceptions of their own culture.

Many areas in this country are making greater efforts at addressing the delivery of services within our pluralistic society; that is, one that values and gains from the appreciation of cultural diversity. Ethnocentrism is as detrimental in a society as illiteracy. Additive "Multiculturalism" challenges the majority of the population to see the value of what the minority has to offer, and to learn from them, as well as the minority having to learn from the majority. At a time of financial constraint, there is even more need for us all to work collectively in order to achieve positive health outcomes for every group within our society, and to learn from every culture about the uniqueness and the universality of what it means to be human.

Yours sincerely

K. Ramsamy

APPENDIX 3

Land history in Aotearoa/ New Zealand from 1840

Sydney Land Act 1840: This act declared all purchases made directly from the Maori invalid till validated by a Commissioner of Land Claims.

William Spain in 1842 appointed commissioner. Many of his recommendations and findings were never acted upon. For example, the site of Wellington was shown to have been an invalid purchase, but the area was not returned to the Maori who had consistently refused to sell, nor was compensation paid.

Governor Fitzroy in 1844 broke the Treaty by allowing settlers to buy land directly from Maori people.

1846- Governor Grey changed the Law back.

Constitution Act 1852: This was the first major breach of the Treaty. Self- government began with this act. So the Treaty disappeared legislatively because it was signed between Britain and the Chiefs, and was not made binding on the new settler government. Adult European males who owned a small amount of property got the vote and were eligible for election, but equal rights of Maori males were denied because their land was owned communally.

1856- Settlers turned to sheep farming, which needed larger areas of land, and pushed for ownership of their illegally leased plots through their government.

1858- Many Maori began to dig their toes in, and land sales were banned in many areas. After a series of inter-tribal meetings, the Maori King Movement was formed, based in Waikato.

1859 Only seven million out of twenty six million acres in the North Island had been "acquired", and the Governor Gore -Brown reported to the Colonial Office in London about the feelings of the settlers. " The European covet these lands and are determined to enter in and possess them- recte si possint, si non, quocunde modo- rightly if possible. If not, then by any means at all". War was seen as the likely means. Now that the Europeans outnumbered the Maori and had the backing of the British imperial army, they wanted to provoke the Maori into rebellion, so they could then confiscate the lands off the "rebels". The excuse for war was not long in coming- the sale by the Government of disputed land

at Waitara. The Taranaki Maori fought back for eighteen months.

1861- Grey replaced Gore-Brown as Governor. The settler business community would become richer if the Waikato lands (their sale blocked by the King movement) came onto the market. Governor Grey was the meat in the sandwich between the British Colonial Office, who wanted him to prevent this expensive war from growing, and the settlers, whose greed for land led to more war. To keep the Colonial Office on his side, it was in Grey`s interest to convince them that the Maori were the aggressors. Though greatly outnumbered, and with inferior weaponry, the Maori fought back heroically. They asked three times for peace. However, anybody opposing the war would have his or her lands confiscated. So their offers of surrender were rejected twice to prolong and spread the war. This meant the settlers could benefit from greater confiscations.

Even the general of the British troops, Cameron, was disgusted at the job he and his troops were being ordered to carry out. He wrote to the War Office in Britain stating his objections bluntly. He was allowed to resign in 1868. Thereafter the conflict was led on the Pakeha (European) side by settlers without the restraint of Cameron.

Native Lands Act 1862: To break up communal ownership which was making Maori land hard to buy, a land court was set up to individualize Maori land ownership. An amendment allowed Maori owners to sell land to whomever they wanted. The Crown's right of sole purchase was cast aside.

Suppression of Rebellion Act 1863: Based word for word on the Irish Act of 1799 (used to put down the rebellion of Irish people to British rule) it withdrew the right of trial before imprisonment. Military courts were formed to deal with offences and threatened "death or prison" to those brought before the courts. The wording of the act clearly states its intention to punish "certain aboriginal (Maori) tribes of the colony" for rebelling against the crown.

New Zealand Settlement Act 1863: This allowed confiscation of any district where a "considerable number" of natives were believed to be in rebellion. As a direct result of this act, more than three million acres of Maori land were confiscated.

Native Reserves Act 1864: Before leaving power this Government introduced an act, which placed all remaining native reserves under settler control.

Native Land Act 1865: This required Land Court hearings to determine ownership, a

lengthy and costly business. Maori owners had to spend months at a time in towns where the court was sitting. If they did not appear, their right to the land was taken away. During this time, they built up huge debts, which the local land agents and businessmen then extracted from the land the Maori had just won claim to. Many Maori owners sold rather than go through a Land Court sitting.

Maori Representative Act 1865: This act set up the four Maori seats, as we know them. Pakeha(European) were becoming alarmed that, as a side effect of individualization of title, Maori who could vote because they had land might come to outnumber the settlers in certain electorates. The seats were therefore born out of settler fear and greed, and have restricted Maori representation in Parliament.

1877- Legislation was introduced to allow direct purchase of Maori land. This went against the Treaty.

1879- George Grey, now Prime Minister, amended the Native Land Act to make it easier for small farmers to get Maori land.

Peace Preservation Bill 1879: This Bill provided for one years hard labor for Maori people who refused to "withdraw from their abodes".

Maori Prisoners` Trial Act 1879: This Act was rushed through in August because the Parihaka ploughmen who had been arrested might be "liberated by the Supreme Court" if brought to trial. According to this new law, they were to be brought to trial within 30 days of the opening of the next session of parliament.

Confiscated Lands Inquiry And Maori Prisoners` Trial Act 1879: This said that while commissioners investigated West Coast (North Island) land grievances, "the ordinary course of the law should be suspended". So the trial of the ploughmen was put off till after yet another parliamentary session opened.

Maori Prisoners Act 1880: This act said that it was not necessary to try the ploughmen and undesirable to release them- this was a year after the arrest. This law went far beyond simple suspension of habeas corpus- one of the keystone rights of British subjects.

Maori Prisoners Detention Act1880: The arrested fencers of Parihaka were now held in detention like the ploughmen.

West Coast Settlement (North Island) Act 1880: This created a great variety of new offences whereby the Maori could be arrested in Taranaki without warrant, jailed for two

years with hard labour, after which he was to be released only by paying a surety of whatever the court decided. This entire burst of legislation tried to help the settler occupation of land whose title was in dispute.

1881- November the 5th when "the equal rights and privileges" guaranteed under Article Three of the Treaty was smashed when the squatter government of Bryce and Rollestone used 2500-armed troops to push the peaceful followers of Te Whiti off the land.

Native Land Act 1887: Direct purchase of Maori land was again the order of the day. Under this legislation, even the reserves began slipping away into Pakeha (European) hands.

Native Land Purchase Acquisition Act 1893: Though the Crown's right of sole purchase was reintroduced, power taken to declare any area of Maori land "suitable for settlement". When suspicious Tuhoe Maori pulled up the surveyor's pegs, Seddon quickly dispatched heavily armed troops to put down the "resistance". As a consequence of such stand over tactics, another 2,750,000 acres passed out of Maori hands between 1893 and 1900. The Maori response was the Kotahitanga Movement, trying to regain control over their lands and live hoods. But their efforts only made the small farmer population even more determined to grab more of the land.

Advances To Settlers Act 1894: This act specifically excluded Maori, but provided low - interest loans to white settlers to buy land from the Government and develop it. It was not till the 1930`s that Maori landowners gained access to government development finance.

Native Land Court Act 1894: This provided for the declaration of names on certificates of title to be called trustees or beneficial owners.

Validation Of Invalid Land Sales Act 1893: By this piece of legislation unjust deals could be made valid and therefore legal.

Maori Land Settlement Act 1904: Maori land was compulsorily placed under land councils, with no Maori representation if it " was not required or suitable for occupation by the Maori Owners".

Land Laws Amendment Act 1912: This freed up land restrictions. So between 1911 and 1912 land owed by Maori in the North Island fell from seven million to four million acres. The South Island had already gone except for a few thousand acres. From owning 66 million acres in 1840, the Maori had seen their land reduced to four million acres.

In 1932 a petition calling for the confirmation of the Treaty of Waitangi, and signed by more than 30,000 people, was presented by Ratana MP`S to Parliament. It sat gathering dust for 30 years during the depression. Maori received only half the unemployment benefit given to Europeans single -single Maori 7s 6d, Single European 15shillings a week.

In 1943 the four Ratana MP`s won all the Maori seats.

In 1945 Labour legislation allowed some Maori land to be returned to Maori owners after leases expired, but continued European control of all land transactions.

Maori Affairs Act: The National Government introduced an act setting up the Maori Affairs Department to act as the Maori land purchase agent for the Government. Now the state could compulsorily buy land at state valuation if it was " uneconomic". If the owners couldn't or wouldn't develop the land, European trustees could insist that someone else use the land. Land was leased at its unimproved value, and the owners were made to pay compensation for any improvements. As many Maori could not raise the capital to pay back European land developers, many were unable to get their land back. Incorporation was the Maori response to this act. Titles were kept separate, but interests pooled. As more Maori land went into incorporation, supplies of Maori land began to dry up. This was unacceptable to the National Government ands so new laws were passed.

The Maori Affairs Amendment Act 1967: This allowed anyone to get up to an Incorporated Trust Board. Land owned by fewer than four people had to go under one title. Unless it was done through the Land Court, this piece of land was then kept out of the incorporation. Today 50% of the land is owned by the Crown or reserved for public purposes. 47% is freehold land under European definition and title and only 3% is Maori land.

APPENDIX 4

Letter to editor

Race justice

I am sick of race being used as a political football by fuelling fear and ignorance. Common sense tells us that we need to establish a more equitable bicultural-multicultural society in this country and deliver social justice for all.

The polls confirm for me that this country needs to look at the pathological view of " black people" based on conceptualisations anchored in racism and transmitted through an historical concept of deprivation, oppression and mal-adaptation to the existing social order.

Christian values mean nothing if they are not applied in their true sense. Victim-blaming and further oppression can lead only to more conflict and division.

Kris Ramsamy

(New Plymouth)

The Daily News (Feb 28, 2005 p.8).

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