THE EXPERIENCE OF DEPRESSION IN THE TOKELAUAN CULTURE IN TWO NORTH ISLAND COMMUNITIES

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ABSTRACT

Background and Aims: The Tokelauan language lacks a word that corresponds to the western term 'depression'. Furthermore, there is no research on the experience of depression in Tokelauans, and yet doctors continue to apply a western biomedical model of depression to Tokelauan patients and those from other Pacific cultures.

This research aims to describe the experience of depression in Tokelauans and provide insight into its management. Better awareness of the symptoms and signs of depression as experienced by Pacific Islanders will enhance diagnosis and treatment of the illness by general practitioners.

Method: Following extensive consultation with the Tokelauan community in Taupo, and using purposive stratified sampling, ten respondents contributed to this study. Semi-structured in depth interviews were performed and recorded verbatim. The transcripts of the interviews were thematically analysed using an immersion crystallisation technique, with further analysis to detect sub themes.

Results: There is no specific word for depression in the Tokelauan language but an illness involving extraordinary sadness does exist. Ordinary sadness is regarded as just 'part of life' but extraordinary sadness can be classified as "unwellness" or "a burden". Tokelauans use several indicators to recognise someone with extraordinary sadness. The main indicator is isolation and withdrawal from family and community activities as well as absence from work and church. Tokelauan men are more likely to hold their feelings in and may indicate their unwellness with increased alcohol use or violent tendencies. For Tokelauans, privacy and pride are important cultural characteristics and these may be barriers to recognising sadness. The shame and loss of status associated with displaying sadness may also cause a person to hide his or her feelings. Often the smiling Tokelauan face becomes the mask that hides sadness.

The main causes of extraordinary sadness are the changes caused by western influences on the Tokelauan culture and the stress of poverty and unemployment. The family, community and church are all important avenues for caring and for counselling the Tokelauan with extraordinary sadness.

Discussion: This research documents some of the features of depression experienced by Tokelauans that are different from those that doctors may be trained to detect and manage using a western biomedical model. This research demonstrates the complexity of relationships between the patient, their illness and their culture that impacts on how the illness manifests. Similarly, this research indicates that therapy must have a holistic approach that includes the family, the community and that accounts for the patient's spiritual beliefs. Te Vaka Atafaga is a metaphor for Tokelauan wellbeing involving a canoe. Its structure is representative of different components of health, and it provides a holistic model for the general practitioner involved in assessing and treating Tokelau Islanders with a possible depressive illness. The model does not exclude the use of western medical approaches, but it emphasises the need for social disharmony to be corrected to allow healing.

Conclusion: The presentation and management of depression in Tokelauans may differ from that of other patients in a general practice setting. The Te Vaka Atafaga model provides the general practitioner with a tool to assess the different components that comprise health in the Tokelauan. A holistic approach involving the family, spirituality and correction of social factors along with palagi medicine is then necessary for treatment.

PREFACE

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GLOSSARY

WORD	MEANING
Aitu	Spirits or ghosts
Fakanoanoa	Sadness
Fatu	Rock
Fatupaepae	Senior Woman
Fita	Exhausted
He fiafia	He is not happy
He malohi	Ill. Unwell
Ihati	Tokelau custom of sharing food and possessions
Kaiga	Family and extended family
Pakeha	Maori term for the white inhabitants of New Zealand. Origin is probably from word ‘pakepakeha;’ imaginary beings resembling men.(1)
Palagi	Person from over the sea, foreigner
Paopao	Outrigger type of canoe
Pepelo	To tell lies or falsehood
Sa	Sacred
Tauale	Sick
Tapu	Forbidden
Taulasea	Traditional healer

CHAPTER ONE
INTRODUCTION

1.1 Background

After completing the General Practice Training Programme in Tauranga in 1980 and passing the Part 1 exam for the RNZCGP, I travelled to the United Kingdom where I trained in both general practice and anaesthetics. By mid 1982 I was keen to return to New Zealand and applied for a position as a general practitioner at the Taupo Health Centre, doing part time anaesthetics at the local hospital. My application was successful and I commenced general practice in Taupo on 11 October 1982. I had purchased a practice with a population of some 2400 patients, and a large percentage was either Maori or Pacific Islanders. Further analysis showed that the majority of the Pacific people were Tokelau Islanders.

I quickly developed a close relationship with many of the Tokelauans in my practice and became interested in their lifestyle and culture. I also recognised their special problems with illnesses and reflected on this.

I wrote a formal essay for the Part 2 of the FRNZCGP in which I took the opportunity to develop my interest in the Tokelauan culture further. With the help of one particular Tokelauan, Mr. C, I learnt much more about Tokelau and its ways and included many of his insights in my essay.

About the time I submitted the essay, Mr. C died suddenly at an early age. His death was a message that made me question our effectiveness as doctors in preventing the preventable in the Pacific community.

In 2001 the surgery had extra money available to spend on their patient population. I ring-fenced some money to provide free medical checks for all Tokelauan patients attending the Taupo Health Centre. The plan was not explained to the whole Tokelauan community and I did not think through the cultural implications of a free check being offered exclusively to patients attending one surgery. The idea was met with suspicion: Why was it free? What was the catch? What about the community members who attended the other doctors in town?

Furthermore, many members of the Tokelauan community had been subjects of a ‘free check’ in the past when they first arrived in New Zealand. They told me that their cholesterol, blood glucose and many other blood tests were performed as part of this check. They then described the sense of betrayal they felt when the results of the tests were published without consultation with the community. Some community members felt that my free check was in fact more research. I learnt a valuable lesson from this venture regarding the importance of full and proper community consultation and communication.

In 2005 I studied Medical Anthropology as my first paper in the Post Graduate Diploma of General Practice at the University of Otago. For the main assignment, I performed a practice audit on some of my Tokelauan patients. I asked patients about possible barriers to primary health care attendance and concepts of ‘the meaning of health’ as well as the use of traditional massage.

I discovered that although western medicine promotes ‘health’ widely, there was in fact no word for it in the Tokelauan language. Furthermore, my investigation was made more challenging as many patients only spoke English as a second language. For them ‘health’ was simply the translation of ‘an absence of illness.’ It suggested to me that words commonly used in western medicine might not always have an equivalent in Pacific Island cultures.

However when I asked other Tokelauan patients what they understood by the word ‘health’ many replied that it meant the ‘ability to be active and to function.’ However, no one mentioned ‘mental’ or ‘emotional wellbeing’ as a part of his or her understanding of ‘health.’ This absence of mental disorder as part of the health experiences of Tokelauans alerted me to the fact that few of my Tokelauan patients ever presented with what the palagi classifies as a mental illness. Depression was rarely seen.

For the main assignment for the Mental Health Paper GENX710 that I completed in 2005, I had to write a proposal for a mental health service in my area. I furthered my interest in the health needs of the Tokelau Islanders and wrote a proposal for setting up a mental health service for the Taupo Tokelauan community.

I examined the findings of the New Zealand Mental Health Survey (2) conducted in late 2003 and 2004. It showed that Pacific Islanders in New Zealand had a prevalence of mental illness that was higher than the rest of the population.

This survey used the World Health Organisation Composite International Diagnostic Interview scale (CIDI) (3) which showed that 20.7% of New Zealanders fulfilled the criteria for having had mental illness in the previous twelve months. However the statistical analysis for ethnicity showed a marked variability. The prevalence rates became 29.5% for Maori and 24.4% for Pacific people compared with only 19.3% for the rest of the New Zealand population. The survey also showed a decreased use of mental health services by Pacific people with the usage rate of 1.8% compared with 2.2% for the general population. Furthermore, only 25% of Pacific people with severe disorders used mental health services compared with 58% of the rest of the population

While I was researching my assignment for the mental health paper, a Tokelauan patient told me that there was no word in the Tokelauan language for 'depression.' They had phrases such as *'fakanoanoa'* or '*having sadness.'* Alternatively they might say *'he fiafia'* meaning *'he is unhappy'.* There was, however, no actual word for *'depression.'*

As I continued my assignment I realised that applying the western constructed biomedical model of the illness '*depression'* to the Tokelauan culture might not be appropriate. I therefore became motivated to investigate the Tokelauan experience and understanding of the condition that the palagi calls *'depression.'*

1.2 The Tokelau Islands

The Tokelau Islands are actually no more than coral atolls, which rise sharply, directly from the seabed.(4) The land on top of this coral rises to a maximum height of five metres above its coral base and creates a narrow strip of inhabitable land surrounding a large central lagoon. Travel to and from the rest of the world is made difficult by the absence of any airstrip or harbour with a deep-sea anchorage for visiting ships.

The coconut palm dominates the dense vegetation that grows in this ground around the lagoon. The absence of rivers and streams is notable.

There are three very small atolls that are usually regarded as comprising the Tokelau group. Atafu, the most northern atoll, is also the smallest with an area of only 3.5sq km. Nukunonu, the largest with an area of 4.7 sq km, lies in the middle whilst Fakaofu is the most southern atoll and has an area of 4.0 sq km.(5) The atolls are separated from one another by a gap of 90km between Atafu in the north and the largest Nukunonu in the middle then another 60km between Nukunonu and Fakaofu in the south.

The islands are situated in the South Pacific some five hundred kilometres north of Western Samoa, six hundred kilometres west of the most northern of the Cook Islands and one thousand kilometres east of Tuvalu. They lie in an axis stretching one hundred and fifty kilometres from northwest to southeast.(5)

The 2011 Tokelau Census of Population and Dwelling (6) showed that the number of people usually resident in Tokelau was 1411, which was a decrease from the total of 1466 in 2006. In 2011, the census figures for Tokelauans normally resident in the individual atolls were 482 for Atafu, 490 for Fakaofu and 397 for Nukunonu. Forty-two Tokelauans included as normal residents were living in Samoa.(6)

After initial administration as a colony of Britain, the Tokelau Islands were transferred to the jurisdiction of New Zealand in 1926.(7) The Tokelau Act of 1948 (8) deemed Tokelau to be part of New Zealand and as a result of a further act of Parliament in 1949,(7) New Zealand citizenship was granted to all Tokelau Islanders.

Within Tokelauan society, upon reaching the age of 60, a man becomes an elder and a woman becomes an old lady.(9) Both are positions of authority and respect. Traditionally the community hierarchy saw the elders lead the Tokelauan community. The community distinguishes dramatically between youth and age. The young are considered "ignorant, physically strong, spiritually weak and irresponsible," whereas the elder is considered wise, physically weak, spiritually strong and responsible.(9) Traditionally, the youth was taught from an early age to "listen, obey and respect," while the elder's role was to "rule, reprimand, speak and decide."

Councils were present on each island that generated the edicts necessary for the running of the community.(10) However, in the mid-1970s, leadership organisation started to move away from this traditional structure with the establishment of a national council called a General

Fono. This council met twice a year and comprised a Faipule, or leader from each of the three atolls, as well as delegates from Apia and the Ministry of Foreign affairs in New Zealand.(11)

In 1996, the three Faipule were given power as an independent unit to enact policy. Power moved further away from the local community in 1996 when authority was given to the General Fono to make decisions that would further "peace, order and the good government of Tokelau."(11)

Economically, Tokelau had traditionally been a subsistence-based economy. Fish was the stable diet and copra production was the only industry. An increasing population caused an imminent food problem in 1966 and this was exacerbated by a cyclone – also in 1966, which destroyed many of the coconut palms. The New Zealand government responded by introducing a resettlement programme under which families were funded to move to New Zealand and resettled. Many of these new immigrants were re-housed in Taupo and given jobs working in the bush.

The migration of many of the young productive workers from Tokelau resulted in difficulties maintaining the subsistence economy. The country progressively came to rely on financial assistance from the New Zealand government and on monetary contributions sent home by Tokelauans working in New Zealand. With time it changed from being a 'subsistence-based' economy into an 'aid-driven' economy.(11) Production of copra has now almost completely stopped. Unfortunately, some of the monies from the aid have been spent on unhealthy food and activities including the popular overseas-based fast foods.(12) This has resulted in increased obesity and diabetes among the population of the Tokelau Islands.

1.2.i Summary

This section has briefly described Tokelau and the cultural change as it has moved from traditional governance and economical ways. These tensions were similar to the experiences, described in the results, of the Tokelauans who moved from the islands to New Zealand.

1.3 The Tokelau Islander In New Zealand

1.3.i Introduction

Following the cyclone in Tokelau in 1966, the government introduced an active resettlement policy (7) and by 1973-74, Tokelau Islanders comprised 6% of all people migrating to New

Zealand. They saw the country's economy as being in a much more exciting and profitable condition than that of their own island nation, and felt employment prospects in New Zealand were more positive.

They came in search of a better annual income and overall an improved life experience. They did find the life in New Zealand more stimulating than back in Tokelau but their expectations for wages were often not met. Furthermore the new skills that they learnt in their adopted country were not going to be useful should they decide to return to live in the islands.(13)

1.3.ii Tokelauan Demographics In New Zealand

By 1996 the number of Tokelauans in New Zealand had reached 4917, which comprised 2% of the Pacific Island population.(14) Census statistics show that by 2006, Tokelauans in New Zealand had increased their population to 6819, which made up 3% of the nation's Pacific Island population.(15) They were a young community with a median age of only 19 and an even sex distribution. Their median income was $19200. By 2013 the number of Tokelauans in New Zealand had increased to 7176.(16) The median age remained at 19.2 years and the median income had decreased to $18000.

1.3.iii Geographical Distribution

It is significant that the 2006 census lists 5% of the Tokelauan population (341) as living in the Waikato and 7% (477) as living in the Bay of Plenty.

Although there is a Tokelauan community in Rotorua, it is also very possible that members of the Taupo community might have identified themselves as being in the Bay Of Plenty. Certainly many of the 341 Tokelauans identified by the census as living in the Waikato will in fact be Tokelauans living in Taupo in 2006. Unfortunately the report on the 2006 census did not give detailed statistics on numbers of Tokelauans living in smaller urban areas.(14) The detailed residential figures for Tokelau Islanders from the 2013 census are not yet available.

1.3.iv Religious Affiliation

The 2006 census (15) reported that 86% of Tokelau Islanders living in New Zealand affiliated with at least one religious denomination compared with 61% of the rest of New Zealanders. Of those affiliated to a religion, 41% reported affiliation to the 'Catholic Church.' Another 41% identified themselves as 'Presbyterians' which was a generic term used in the census to classify all reformation and congregational denominations. The recently released 2013 census

(16) shows that the percentage of Tokelauans affiliated to a religion has dropped to 83.4% with just 34% reporting affiliation with 'Catholicism', 28% identifying as 'Presbyterians', 'Congregational' or 'Reformed' and 8.2% defined themselves as 'Christian' without further qualification. Four point one percent of respondents objected to giving their religious affiliation whilst 13.8% stated that they had no religion. This value was an increase from 2006 when only 10.6% of Tokelauans reported that they did not have any religion.

1.4 The Tokelauan Community In Taupo

1.4.i Introduction

The cyclone that ravaged Tokelau in 1966 resulted in a large number of islanders being settled in New Zealand. Three main communities were established; one in each of Mangere and Porirua, and one in Taupo where the men were given bush jobs in the then booming forest industry. They arrived from Tokelau in the winter months and despite being poorly prepared for the conditions they encountered,(17) they soon established a reputation as hard and reliable workers in bush gangs around the Taupo area.

In 1982 when I entered general practice in Taupo the size of the Tokelauan community was approximately 800.(17) However over the next thirty years the economic situation changed; the price of milk fat increased and the price of wood products plummeted. Pine plantations were not re-planted after being cut down and the rate of dairy conversions increased. The local Carter Holt timber mill was closed and then disastrously the Fletcher medium density fibreboard plant was destroyed by fire. The unemployment rate increased markedly amongst the Tokelau Islanders who for so long had been the backbone of the forestry industry in the Taupo area.

A meat-packaging factory opened in the area and for a while provided employment for some members of the Tokelauan community but in time it also closed as a result of the changing economic conditions. As the job opportunities in Taupo shrank, Tokelauan families slowly moved away in search of work.

The Taupo community has shrunk significantly as the exodus away to other parts of the country and even to Australia has continued. However some three hundred Tokelauans still live in Taupo where they enjoy a lively and close-knit community.

1.4.ii Tokelauan Community Hall

The Tokelauan Community hall is the hub of activity for the community. It is the 'Tokelauan village' for Taupo where the community meets, celebrations take place and dancing occurs. Although the members of the community may be away from one another while they are working, they come together at the hall. Along with the church, it is the lifeblood of the Tokelauan community.

1.4.iii Tokelauan Diet and Health in the Taupo Community

A member of the community (now deceased) told me that the Tokelauans enjoyed a healthy lifestyle prior to European contact, using resources in their natural environment. Most food was eaten raw, baked in a stone oven or barbecued. The fish, turtles and pigeons were not fatty and were eaten fresh. Daily energy expenditure was higher and cigarettes and many infectious diseases did not exist. Tokelauans built shelters and worked to provide food without the assistance of machines thereby ensuring that they remained healthy and physically fit.(18)

This is in direct contrast to the observed lifestyle of the Tokelauan who lives in Taupo today. Introduced fatty palagi foods are often eaten instead of the fresh diet enjoyed traditionally back in the islands. Mechanised labour and petrol-powered travel have decreased the need for physical exercise.

The increased prevalence of diabetes and obesity amongst Tokelauans migrating to New Zealand from the islands has been well documented.(19) As a general practitioner, I have anecdotally noted the large numbers of Tokelauans with both obesity and diabetes in my practice although local data is not available for this period to confirm this observation.

1.4.iv Social Issues and Health In The Taupo Tokelauan Community

The Tokelauan family values are important in the culture. The word 'fatu' means rock and the Tokelauan woman is the 'fatupaepae' or rock of the family.(9) When there is conflict, she is the stabilising influence. She is treated with respect. Physical or verbal confrontation by a man to a woman is regarded as unseemly.

Traditionally, it was said of the Tokelau Islanders that "Happiness is plenty of coconuts and plenty of children."(18) The Tokelauan investment is not in the bank but in their children. In

general practice in Taupo, I saw large families from the Tokelauan community where the children were well loved and generally well adjusted. The main health problems were the results of poverty and over crowding.

Just as the Tokelauan parents take good care of the child when they are young, so the children look after their mother and father in later years. Thus in Taupo there are large extended families living together and only once have I seen a Tokelauan in a rest home.

1.4.v Housing and Health in The Taupo Tokelauan Community.

Often households will have several generations living under the one roof. There are many cultural advantages of living together. The younger generations have the opportunity to live with their grandparents and the cultural heritage including the language is passed down. The older generation also has the opportunity to influence and prevent some of the more risky adolescent behaviour.

There are also marked disadvantages to the overcrowded houses. The younger family members in particular find it cramped and medically the situation is perfect for the spread of illness. As a general practitioner, I have seen simple cases such as scabies and respiratory tract infections in children spreading through communities because of overcrowded housing.

1.4.vi Religion and the Taupo Tokelauan Community.

The 2006 census (15) reported the spiritual affiliations of Tokelauans as 40% Catholic and 40% Protestant but in Taupo, the majority of the Tokelauan community identify with the Catholic faith and attend the local Catholic church. A significant but smaller number of the community attends the Union Church (Methodist and Presbyterian) while there are some islanders who identify with other Christian churches.

1.4.vii The Concepts of "health" and "depression" in the Taupo Tokelau Islander

As noted above, my previous studies suggested that most Tokelauan patients equated *'health'* with the ability to be active and to perform expected social functions. This definition seems to have a direct relationship to life and the role- particularly of men – back in the islands. A Tokelauan saying states "The woman stays inside while the man goes in the path."(4) Thus the paths of men take them into public arena and out to sea whilst women remain at home. The strength of men enables them to protect and provide for others.

As already detailed, the definitions of health were confined to physical attributes (strength, activity and functioning). Mental and emotional health did not feature at all in any of the concepts of *'health'* described by Tokelauans. There was little mental illness seen amongst Tokelau Islanders and there was not a culturally appropriate mental health service in the area.

The western medical model diagnoses depression and puts labels on patients including Tokelauans – who do not even have a word for depression in their language. As doctors, we do not even know if there is an illness in the Tokelauan culture equivalent to *'depression.'*

1.5 Pacific Mental Health Treatment

The 2005 Ministry of Health Pacific Island Mental Health Profile (20) discusses the difference between the 'palagi' and the 'Pacific' peoples' approach to mental illness. Whereas the European uses a biological or chemical model to explain mental disorders, a holistic approach is more important in the Pacific Island community. Treatment may often be spiritually based and involve restoration of harmony throughout all realms of a person's life; spiritually, physically, emotionally and within the family.

It therefore seemed that the local Tokelauan community might be using a holistic self-care to look after their own mental health and be at least partially providing a very necessary health service.

We refer Tokelauans to Western-designed mental health services without considering whether they are the best treatment for the person requiring therapy. Is there evidence that safe and effective treatment already occurs within the Tokelauan community?

1.6 Objectives

My previous experiences in working as a general practitioner and studying led to my interest in this topic. The following objectives are distillations of the aims of my research: to explore depression among the Tokelauans of Taupo.

1. Does an illness equivalent to the palagi diagnosis of 'depression' exist in the Tokelauan culture?
2. If so, what are its symptoms and how is it recognised within the community?

3. If such an illness does exist, what barriers prevent a general practitioner from recognising it?
4. What are the main causes for this illness in the Tokelauan culture?
5. What are the implications for the way in which a general practitioner should recognise and treat depression in Tokelau Islanders?

1.7 Structure of the Thesis

I have structured the thesis in the following way. The literature review presents data showing that Tokelauans have high risk factors for the development of depression. It reviews the prevalence of depression internationally and in particularly in the Pacific Islands and New Zealand. It then examines cultural aspects of depression including Pacific models of mental health treatment.

In the methods chapter, I provide a rationale for the qualitative research design and the methodological decisions made regarding recruitment and data collection.

There are six results sections. The first presents evidence that an illness equivalent to depression does exist and also presents different words used by interviewees to name depression. The second section presents the symptoms and signs of an illness with extraordinary sadness as seen by Tokelauans in their culture. Evidence that Tokelauans hide sadness, often behind a smiling face is discussed in the third section. Section four presents evidence that cultural changes with resultant socioeconomic difficulties are the main causes of extraordinary sadness while section five discusses results showing that the family, the community and the church are involved in useful treatment of the Tokelauan with sadness. Section six presents the signs of recovery as well as the advice suggested to prevent extraordinary sadness. It also discusses gender differences in the presentation of extraordinary sadness in the Tokelauan community.

Finally, the discussion draws on key theorists in medical anthropology to interpret the findings. It makes key recommendations as to a culturally sensitive and patient-centred approach to the recognition, diagnosis and management of abnormal sadness for general practitioners serving Tokelauan communities.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

In this chapter I will initially present the known demographics on Pacific people in New Zealand. I will then review the biomedical diagnosis of "depression" and consider the diagnostic criteria that are used by doctors practising in western cultures and consider whether they were written with ethnic people in mind. Here I will also review the neurophysiology and treatment of depression.

The next section will examine the prevalence of depression internationally and in New Zealand specifically. I will also review the prevalence of depression presenting in New Zealand general practices and the disability that it causes and review what factors are important for diagnosis. I will then consider the implications for diagnosis of depression in the Tokelauan community.

Next, I will review the official prevalence of mental health and depression in Pacific people in New Zealand. In particular I will discuss the relevant findings of the New Zealand Mental Health Survey. There is little research into depression in the Tokelau Islands so this review will consider available literature on mental health in other Pacific nations. It will also consider Pacific models for treatment of mental health.

I will then turn to the effect of culture on the presentation and treatment of depression and present studies of ethnic communities overseas that support the concept of different experiences of depression in other cultures. Finally I review the presentation of depressive illnesses with physical symptoms.

2.2 Demographics of Pacific Islanders and Tokelauans in New Zealand

The New Zealand census 2013 (16) showed that the population of Tokelau Islanders in New Zealand was 7176 (2006 census - 6819) (21) which was 2.4% (3%) of the country's Pacific population of 295,941 (265,974).

The median age for the Tokelauan population was 19.2 (19) years compared with 22 (21) years for the rest of the New Zealand Pacific Island population and a median age of 38 (36) years for the whole of New Zealand.

Seventy-four percent of the Tokelauan population was born in New Zealand and 32% (40%) could converse in Tokelauan. Only 69% (63%) of the population had a qualification at secondary school or higher. This compared with 79% (75%) of the total New Zealand population.

Research data shows that Pacific people in New Zealand are economically disadvantaged when compared with the rest of the population.(22) The majority of Pacific people live in crowded housing in areas of high economic deprivation and work in low-skilled jobs. Such positions are, unfortunately, the first to be affected when unemployment hits.

Both the average hourly and weekly wage for Pacific people is significantly lower than the average for the rest of the population. This inequality is exacerbated because 85% of Pacific Islanders regularly send money overseas (22) as well as contributing to their local church.

The life expectancy of Pacific people in New Zealand is 4 years less than the "overall population". One in four have hypertension (22) and in the 12 months from 2006-2007, 10% of all Pacific Islanders over the age of 15 were diagnosed with diabetes.(22) Their rate of ischaemic heart disease and strokes is much higher than the general population (22) and more Pacific children are admitted to hospital with infections and respiratory diseases.(22)

2.3 Depression

2.3.i Diagnostic Criteria

The clinical diagnosis of diseases using the biomedical model generally requires a doctor to objectively note his or her findings when a patient is examined. These findings are reproducible in any one patient and can be compared against a list of criteria in order to make a diagnosis. In psychiatry, however, the depressed patient presents with many subjective symptoms and few truly objective findings that are reproducible for the next physician. This subjective quality to the psychiatric consultation would lead to disagreements in diagnosis and difficulties in communication unless universally accepted criteria were established.

In a chapter of the textbook, Psychiatric Diagnosis and Classification, Jablensky and Kendell (23) reviewed the use of illness classification in psychiatry.

They discussed some of the advantages of using diagnostic criteria and in particular cite Feinstein (24) who felt that classification has three important functions:

1. To allow the same names to be given to illnesses with the same or similar characteristics
2. To allow the addition of extra qualifications such as the age of onset of an illness or any gender differences.
3. To allow for assignment of predictions such as the predicted course of the illness, the likely outcome and its probable response to treatment.

The gold standard for diagnosis of depression is laid down in an internationally accepted classification known as the Diagnostic and Statistical Manual of Mental Disorders (DSM). The first edition, known as the DSM-1, was released in 1952.(25) This was followed by the DSM-II in 1968,(26) the DSM-III in 1980 (27) and the DSM-IV in 1994.(28) Although the latest edition, the DSM-V, was released in 2013,(29) the diagnostic criteria in the DSM-IV are currently the most universally accepted. Jablensky and Kendell (23) note that the DSM-IV criteria do not classify patients; they classify the illness that patients have.

The DSM –IV classification for a major depression disorder requires that a patient must have one of the following symptoms for at least two weeks (30):

1. A depressed mood – or
2. A markedly diminished interest or pleasure in almost all activities.

Also over the same period, the person must have at least four of the following symptoms:

1. Either an increase or a decrease in appetite,
2. Either insomnia or hypersomnia almost every day.
3. Psychomotor retardation or agitation. This must be observed and not merely subjective.
4. Fatigue or loss of energy almost all of the time.

5. Feelings of worthlessness or excess or inappropriate guilt. These feelings have to be beyond simple self-reproach or guilt for being ill. They might reach delusionary stages sometimes.
6. Decreased ability to think and concentrate. Indecisiveness.
7. Recurrent thoughts of death including recent suicidal ideation.

To fulfill the criteria, the symptoms must be causing significant distress in organisational, social or other important areas of daily function. There is not allowed to be any organic cause to account for the symptoms including a general medical cause or substance abuse. The criteria specifically state that the depression should not just be a normal grief reaction to the loss of a loved one.

The classification is open-ended and allows for the addition of new criteria or deletion of existing ones when there is agreement that these actions are supported by best international evidence.

However Hickie (31) notes that relatively few patients present to primary care with symptoms classical of the depressive syndromes listed in the DSM-IV criteria. Often their complaints are vague and include "mixed anxiety and depression" or "neurasthenia" which includes nervous exhaustion and chronic fatigue. These are only mentioned in passing under *"Undifferentiated Somatoform Disorder."*

It is important that patients presenting to general practitioners be questioned fully to ascertain whether they do have a mood disorder. Exclusion of suicidal ideation is an essential step in the interview.(32) Some patients attending the general practitioner have a depressed mood, rather than an actual mood disorder and do not need pharmaceutical treatment.(32)

2.3.ii DSM-IV Criteria and Culture

Jablensky and Kendell (23) discuss culture in their review of the DSM-IV classification. They note that the DSM-IV contains reference to the existence of different cultures in psychiatry. However they note that the criteria merely regard culture as a confounding influence, which might alter the presentation of one or more of the illnesses listed in the classifications. They also observe that the classification ignores the influence of indigenous languages in psychiatry. They comment that this limits the relevance of the classification in some cultural settings.

Significantly, they made this observation some ten years ago in a psychiatric textbook.(23) Since that time, medical practitioners have continued to apply the DSM-IV criteria to many different cultures with little regard as to its appropriateness. Here in New Zealand, it is likely that doctors have used the diagnostic criteria of the DSM-IV classifications to diagnose depression in the Pacific people and more pertinently, in the Tokelauan communities without first considering whether it is meaningful in their culture.

2.3.iii Diagnostic Tools

The DSM-IV classification for depression specifies the criteria that must be met in order for a diagnosis to be made.(23) The doctor examining the patient has to ask appropriate questions to determine whether the DSM-IV standards have been reached. A number of important screening tools have been developed, which assist the assessment of a depressed patient. They are also suitable for administering as a screening interview by a trained lay person.

One of the most commonly used screening instruments is the Composite International Diagnostic Interview (CIDI).(33) It is a comprehensive fully structured diagnostic tool, which is used to assess mental disorders according to DSM-IV criteria. CIDI has been trialed and found to be reliable and valid.(33) It is often used in research involving screening populations for depression.

The General Health Questionnaire (GHQ) (34) is also commonly used as a screening questionnaire. It is not a diagnostic tool but asks how a person's current feelings and mood differ from normal. The GHQ-12 is quick, reliable and only has 12 questions while the GHQ-28 is longer and has sections for each of somatic symptoms, anxiety, social disorder and depression.

Patel who reviewed the effects of culture on depression,(35) looked at some of the commonly used screening tools. He felt they are generally accurate in cross-cultural settings but may need their cut-off adjusted. For example, he states that the GHQ cut-off varies between countries.

For example the Self-reporting Questionnaire, which is often used in non-industrialised nations, needed a much higher cut-off score in Africa. In India, however, a short GHQ with five simple telling questions was found to be as accurate as the long questionnaire.

2.3.iv Neurophysiology of Depression.

The neurophysiology of depression is complex and numerous theories have been postulated. Remwick (32) presents one of the most accepted in a review article on depression. The theory states that psychological stress has been shown to decrease the production of brain-derived neurotropic factor (BDNF). This decrease can cause hippocampal atrophy, which has been demonstrated on CT scanning in depressed people. Remwick cites Drevets (36) who says that the more severe the depression, the greater the hippocampal atrophy. It is possible that this cascade of reactions is more likely to occur in certain genetically susceptible people when placed in a stressful situation.

When patients are treated with antidepressants for 30 days or longer, there is a prolonged activation of the cyclic adenosine 3-5-monophosphate (cAMP) in the brain. The cAMP then stimulates protein kinase A to cause phosphorylation of the cAMP regulatory element binding protein. This protein activates chemicals including BDNF. The resulting increased concentration of BDNF causes hippocampal growth.

2.3.v Treatment of Depression

a) Tricyclic Antidepressants

The British Medical Research Council (37) confirmed the effectiveness of the tricyclic antidepressant (TCA) in 1965 and it remains a useful treatment for depression in 2014. A recent meta-analysis by Arroll, MacGillivray et al. (38) showed that low dose TCA therapy given in primary care is more effective than placebo. Treatment with a TCA does, however, produce unpleasant side effects and another review by MacGillivray, Arroll et al. (39) showed that treatment with a TCA was as effective as an SSRI but that more patients stopped the drug because of intolerable side effects.

b) Monoamine Oxidase Inhibitors

A review (40) of trials of the Monoamine Oxidase Inhibitor (MOAI) showed it was effective in depression with features of anxiety but its efficacy for endogenous depression remained unclear. Its use was limited as a potentially fatal hypertensive crisis could occur if it was taken with food containing a large amount of tyramine.(41)

c) Selective Serotonin Reuptake Inhibitors

For many years pharmacological treatment with a selective serotonin reuptake inhibitor (SSRI) has been the most common therapy for depression. The SSRIs have been found in most studies to be better than placebo and to reverse the hippocampal atrophy that occurs during a depressive illness.(32)

In other studies such as the research by Fournier, De Rubeis et al.,(42) the efficacy of SSRIs compared with placebo in mild to moderate depression has been found to be minimal. These authors did however agree it was significantly better in severe depression.

d) Cognitive Behavioural Therapy

A review (43) showed that Cognitive Behavioural therapy (CBT) is effective at relieving severe distress in acute illness and in decreasing the rate of relapse of depression. However, trials comparing CBT with medication are inconclusive at present.

e) Exercise

A 2013 Cochrane Review (44) showed that exercise therapy was "moderately more effective than no treatment." It was "no more effective" for treating depression than therapy with drugs or psychological therapy. However the authors noted that there were only a small number of trials.

2.3.vi Evolutionary Theory of Depression

There are many psychiatric disorders where a positive family history is a significant finding and there may be a genetic basis for the illness.

In a classic paper discussing the evolutionary basis of psychiatric illness,(45) Fabrega looked at some of the conditions that are thought to have a genetic basis in some people. He pointed out that the prevalence is far higher than the natural mutation rate. He postulated, therefore, that the conditions must have been naturally selected during evolution, either because they offered some advantage, or because they were due to multiple genes that were adaptive in other areas.

Fabrega ascertained that social functions are important in evolution. As a result, a fit person who has been successful and managed to survive in his environment often displays positive

sentiments such as happiness and satisfaction. On the other hand, negative sentiments, which include sadness, anxiety and anger, are a signal to a person that all is not well. They warn someone that his adaptation and fitness for his environment is poor and needs modifying for continued survival.

Fabrega therefore viewed depression as an emotion that serves as a warning that the person's coping functions are not working. There is therefore, slowing, withdrawal and conservation of energy before the person with the illness moves to a different environment where success is more likely.

Fabrega also cited Price, Sloman et al. (46) who stated that humans assume an "involuntary state of subordination" very like their primitive ancestors. In a depressive illness this adaptations means a person will yield more easily if there is fierce competition. It also places the victim into a "giving up" state, which prevents further aggression in a competitive world.

Depression is also seen as a cry for help. It gathers others around the ill person and sometimes can be designed as a manipulation to get others to provide resources.

2.4 Prevalence of Depression

2.4.i Prevalence Of Depression Internationally

Depression has been shown to be extremely common in all countries but with a prevalence that varies from country to country and from east to west.

Simon and Goldberg et al. (47) studied a sample of 5447 patients in fifteen different primary care centres in fourteen countries. Participants were interviewed using the CIDI. They discovered a marked difference between the countries in the study. The highest rates for prevalence of depression were found in Santiago (26.3), Rio de Janeiro (18.3) and Manchester (17.1). The lowest rates were found in Nagasaki (1.6%), Shanghai (2.5%) and Ibadan (4%). The mid-range from 5-10% included cities such as Berlin (5.3%), Seattle (6.4%) and Paris (13.5%).

The prevalence varied by a factor of 15 between the Asian countries and the South American centres.

The authors acknowledge the probability that these different rates are a result of differing cultural attitudes to depression. This becomes pertinent when considering the prevalence of *depression* in Tokelau.

A study in Korea in 2007 by Chang and Hahm et al. (48) interviewed 5329 participants aged from 18 to 54 years. They showed a prevalence of 4.1% confirming the low rates of Eastern countries found in the study by Simon and Goldberg et al.(47)

Castro-Costa and Dewey et al. (49) studied a sample of the population of ten countries of Europe. The participants were all aged 50 or over and they were interviewed using a questionnaire adapted from the Geriatric Mental State examination.

The study showed a high prevalence of 36.8% in Spain with a low rate of 18.1% in Denmark. France had a prevalence of 33.3% in this study of older people. However Simon, Goldberg et al. (47) only found a prevalence of 13.5% in Paris in their study of all age groups although there was a greater problem in the French elderly.

Williams and Gonzalez et al. (50) compared the prevalence of major depressive disorder in African-Americans, Caribbean Blacks and Non-Hispanic Whites. Once again their interviews were performed using the CIDI. They discovered a marked cultural difference in the prevalence with the Non-Hispanic Whites having the highest prevalence of 17.9%, the African-Americans having the lowest prevalence of 10.4% and the Caribbean Blacks being in between with a rate of 12.9%. Once again the low prevalence in the non-Western culture raises the question as to whether this was a true figure. It is possible that the CIDI did not have the right questions to cover the symptom of depression in that particular culture. Alternatively, participants might have given false answers when asked about depression, to avoid loss of face.

2.4.ii Prevalence Of Depression in New Zealand

The New Zealand Mental Health Survey (NZMHS) (2) was conducted throughout the country from late 2003 through to 2004. The CIDI was used as the screening tool to identify mental disorders in line with DSM-IV criteria. Interviewees aged 18 and over, were selected from permanent residents in private dwellings and the numbers were weighted to ensure adequate numbers of Maori and Pacific people. A total of 12992 participants were interviewed. Of these, 2595 were Maori and 2374 were Pacific people.

The results showed that the prevalence of having had *any* mental disorder at some time in their life was 46.6% for all New Zealanders. The prevalence for having had a mental disorder in the last year was 20.7% and the 1-month prevalence was 11.6%.

When the prevalence of mood conditions – which includes major depressive disorders – was studied the rates were 20.2% for the lifetime prevalence, 7.95 for 12 months and 2.3% for the 1-month rate.

The only breakdown of the results showing precise rates for depression per se rather than just *mood disorder* are for the 12 month period. This shows a prevalence of 5.7% with a prevalence of 4.2% in males and 7.1% in females.

There have not been any other full national studies into mental health conducted in New Zealand. However, mental health interviews were done as part of the Dunedin Multidisciplinary Child Development Study. This is a longitudinal study, which has followed 1037 children born in Dunedin in 1973 and 1974. The researchers used the CIDI to interview the participants at the age of 18.(51) They recorded a prevalence rate of 16.7% of major depressive disorder over the previous one-year period.

A similar study of children born in Christchurch in 1977 (52) used the CIDI as a screening tool to interview them when they were 18 years old. This study reported a prevalence of 22% for mood disorders, including depression, over the preceding 22-month period.

2.4.iii Prevalence in New Zealand General Practices

The MaGPIe Research Group studied the prevalence of depression in New Zealand general practices.(53) Fifty patients were selected from each of 70 randomly chosen general practices. The patients were screened using the GHQ questionnaire and also assessed by their GP for psychological health.

Patients with a high GHQ score as well as those assessed as having problems by their GP were assessed formally. The interview tool was an adapted version of the CIDI. Results showed a prevalence of 35.7% for any diagnosable DSM-IV disorder over the preceding 12-month period. When broken down into genders, the figures were 38.2% for females and 31.5% for males. Further results showed that 18.1% of all patients attending the sample

general practices suffered from a depressive disorder in the previous 12-month period. This further broke down to 21.6% for females and 12.1% for males. The study had a high response rate of 92% of general practitioners and 82% of patients, which the researchers felt increased its power.

However they admit it included the more wealthy areas of Wellington and there was no mention of inclusion of Maori or Pacific people. The prevalence of 18.1% for depression amongst general practice patients in New Zealand may have very little relevance when applied to a high density Pacific population. We need to know if depression actually exists in a population and if so, how it presents, before we match an ethnic group to the DSM-IV criteria.

The NZMHS showed a prevalence of 20.7% for having any mood disorder reaching DSM-IV criteria standards in the past year.(2) The MaGPIe study showed that the equivalent prevalence rate amongst patients attending a sample of New Zealand general practices was 38.7%.(53) Similarly the prevalence rate for having had depression in the previous twelve months was 18.1% in the general practice sample. This was much higher than the NZMHS, which only had a rate of 7.95%.

General practice does not, however see a similar sample of the population and comparison of the two figures needs to be done with caution. The population attending the doctor is ipso facto unwell and will include patients with secondary depression because of their illnesses. General practitioners are also consulted regarding social issues including alcohol and substance abuse, marriage breakdowns and adolescent adjustment disorders, all of which are associated with depressive mood disorders.

It is also interesting to compare this high rate found in the more affluent Wellington areas with the higher prevalence found by Simon and Goldberg et al. (47) in Santiago. The prevalence here was 26.3% and the CIDI interviews were also done on participants attending a primary care centre. It is possible the selected patients attending the centre might also have affected the Santiago rate.

2.5 Disability and Depression

Murray and Lopez (54) emphasized the importance of depression as a cause of disability in their Global Burden of Disease Study. They looked at the future predictions of mortality and disability in the years from 1990 to 2020. They took into account socio-economic factors and lifestyle habits such as smoking. The predicted disability was estimated in disability-adjusted life years (DALYs).

They produced a list that predicted the top ten causes of DALYs worldwide in 2020. This study showed that by 2020, unipolar major depression will be the 2nd highest cause of disability internationally, ahead of road traffic accidents, cerebrovascular accidents and Chronic Obstructive Pulmonary Disease.

The MaGPIe Research Group also studied disability and depression (55) in a sample of 775 patients attending general practitioners in the Wellington area. Patients were selected according to their score in a General Health Questionnaire (GHQ) and then interviewed using both the CIDI and the World Health Organization Disability Assessment Scale (WHODAS). The research team found that significant disability was associated with both diagnosable mental disorders according to DSM-IV criteria and also with sub-clinical mental disorders. There was no statistical difference in the significance of the disability between the two groups.

This study demonstrates, therefore, that significant mental disorder is a major cause of disability amongst general practice patients. In practical terms, it becomes a possible important factor if patients are missing days off work.

The previous MaGPIe study suggested that depression has a prevalence in general practice of 18.1% over the previous 12-month period.(53) Thus depression will be one of the important mental disorders associated with the high incidence of disability detected by the WHODAS interview.

The study of disability also showed that GPs are much more likely to diagnose depression in patients who are showing some disability. Conversely, they are much less inclined to detect depression in a patient who is not showing any suggestion of disability. If a Tokelauan patient

therefore was hiding symptoms of sadness with a perpetual smile and was also reluctant to show signs of disability, the doctor could miss the presence of a debilitating illness.

2.6 Prevalence Of Mental Illness and Depression In The Pacific Islands

Above, I have presented figures for the prevalence of depression in European cities, the Americas and the Far East. I also wanted to present comparable studies for the Pacific Islands. The New Zealand Mental Health Survey (2) provided a gold standard for other countries by providing clear and full statistics on mental health disorders for its population. There are however very few studies in the literature that give any information on the prevalence of mental illness in the Pacific Islands. Studies that are reported are not recent and are therefore only indicative. In particular, I was unable to find any evidence of research into the prevalence of mental disorders, mood disorders or depression in the Tokelau Islands.

In 1997, Allen and Laycock (56) wrote a review on mental health in the Pacific region. They cited Murphy (57) who was a transcultural psychiatrist. In "Mental Health Trends in the Pacific Islands," he noted that admissions to hospital for major mental illnesses in the region were only 20% the rate of that found in a fully developed society.

He initially wondered whether that meant there were many untreated patients out in the communities. However, after further extensive fieldwork he concluded that the prevalence of major mental illness in many Pacific island countries was significantly below that which was usually found in other parts of the world. Murphy wondered if this low prevalence of mental illness was the reason there was so little written about Pacific Island mental health in the literature.

Allen and Laycock (22) also cite Wilson (58) who studied admission rates to the psychiatric hospital in Fiji. He found that admission rates for Fijians were half the rate of Fijian Indians and less than half the rate of other ethnic groups.

Allen and Laycock (22) noted that little research had been done into mental illness in Samoa but Murphy (57) reported an analysis of admissions to Apia Hospital. The admission rates for psychiatric illness were 3.2/10000 for men and 1.9/10000 for women. He commented that this was considerably lower than American Samoa.

Murphy was also cited (57) as reporting a low admission rate for mental illness in Tonga where there was a rate of 2/10000 for males and a rate of 1.5/10000 for females. Murphy did a further survey of the island of Eua in the Tonga group in 1977 and again concluded that the prevalence of mental illness was very low.

There were also some few smaller studies, which provide information on mental disorders in the Pacific communities both in past years and more recently.

In 1981, Dale studied the prevalence of schizophrenia amongst the Pacific island population of Micronesia.(59) Schizophrenia was, at the time regarded as a universally, worldwide phenomenon with similar rates in all countries. Dale however, found that the prevalence increased in the islands as he moved from west to east. There were no cases in islands settled in prehistoric years by the Polynesian settlers. Some cases, with a prevalence of one case per thousand adults, were discovered in the remote eastern islands while the western islands had a higher prevalence of nine cases per thousand adults.

The original settlers of the eastern islands had been Pacific Islanders from as far away as Samoa and Tonga. It seemed as if the cultural isolation carried with it some protection against schizophrenia. In fact, Dale postulated that these original Pacific Island migrants might have been genetically protected against schizophrenia.

Also in 1981, Yamamoto et al. (60) studied recent immigrants to Los Angeles. They compared the psychological profile of American Samoans who had recently arrived in the USA with those who remained in Samoa. Unfortunately they did not use the CIDI as a screening tool but instead used the SCL-90R, which is a self-administered 90-item checklist. It tested for nine different mental health modalities including depression. Samoans back home scored significantly higher than those in Los Angeles for all the 12 items tested. Nine out of the 12 scores, including depression, were significant to $P<0.05$. The result of this study seemed significant as there does not seem to have been any obvious protective effect on mental health from living in a relatively isolated community such as American Samoa.

However, although these authors report this study, it is unfortunately only in a letter to the editor and the full details of the research are not given. Furthermore, although they state that they discovered increased rates of depression in Samoans still living at home when compared with those who had immigrated to America, no actual prevalence rates are given. It would

also have been useful to find comments on the cultural appropriateness of the SCL-90R when used in different ethnic communities.

2.7 Mental Illness and Depression Amongst Pacific People In New Zealand: The Mental Health Survey

Te Rau Hinengaro: The New Zealand Mental Health Survey (2) interviewed a sample of 12992 New Zealanders aged 16 and over in late 2003 and early 2004. It aimed to identify and describe major mental illnesses in the European, Maori and Pacific island populations of New Zealand. CIDI-3 was used as a screening tool. Unfortunately Tokelau Islanders were not specified as an individual ethnic group. However, the researchers felt that the demography of the Pacific people sampled was a close representation of all Pacific groups in New Zealand society.

To validate the sample of Pacific people in the survey, the number of participants was over-sampled, Pacific interviewers were used, a Pacific community reference group was set up for consultation and the group of researchers was also comprised of Pacific Islanders.

Two thousand three hundred seventy-four (2374) Pacific people were interviewed. The demographic breakdown shows that 49.2% of those interviewed were Samoan, 20.7% identified with the Cook Islands and 16.5% were Tongan. The Tokelauans would have been included amongst the 17.5% that made up the “other island groups.”

The *lifetime prevalence* described in the survey is the prevalence of a disorder in a group throughout their lifetime, up until the time they are interviewed.(2) The *12-month prevalence*, on the other hand is the “proportion of a population who has ever met the criteria for a disorder, and who has experienced symptoms or an episode in the past 12 months.”(2)

The results showed that the Pacific people in New Zealand have a lifetime prevalence of DSM-IV mental illness of 46.5% as measured by the CIDI 3.0. This compared with a rate of 39.5% for the whole New Zealand population. The 12-month prevalence for mental disorder was significantly higher for Pacific people with a rate of 25% compared with 20.7% for the New Zealand population.

Anxiety disorder was the most common mental illness with a 12-month prevalence of 16.2% amongst Pacific people. This compared with a 12-month prevalence of 14.8% for the total New Zealand population.

For *any* mood disorder, the Pacific people had a lifetime prevalence of 19%. This was actually lower than the rate for all of New Zealand, which was 20.2%. Similarly, the lifetime prevalence for major depressive disorder of 10.5% was lower than the rate of 16% for the total population. However the 12-month prevalence of 8.6% for any mood disorder was slightly higher for Pacific people than the rate of 8.0% found for the total population. Pacific people also had a significantly higher 12-month prevalence of major depressive disorder. Their rate of 5.7% compared with 4.9% for the New Zealand population.

However both the 12-month and the lifetime prevalence rates for anxiety for Pacific people were higher than the rates for the rest of New Zealand. For 12-months, the prevalence for Pacific Islanders was 16.2% compared with 14.8% for the total population and for the lifetime figure, the Pacific people had a prevalence of 27.7% compared with 24.9% for the whole population.

The survey also detected a 17% lifetime prevalence of alcohol abuse in Pacific people, which was also higher than the New Zealand population, which had a lifetime prevalence of 11.4%. Younger Pacific people were more at risk for developing mental illness than older people and were more likely to develop severe conditions. Females experienced more anxiety and mood disorders and their rates for major depression per se were 7.1% compared with 4.2% for males. On the other hand, males had a higher rate of alcohol and other substance abuse with a rate of 5.0% compared with 2.2% for females.

When looking at the lifetime prevalence of mental disorders, the survey also examined comorbidity in participants. It found that 53.5% of interviewees met the criteria for one DSM-IV illness whilst 12.4% satisfied the conditions for two disorders and 10.7% met the DSM-IV criteria for three conditions.

The comorbidity included an association between chronic physical conditions and mental disorders but the significance was poor owing to the small numbers of participants with significant illnesses. The association between depression and chronic illness is considered further in Section 2.8.

The frequency with which mental health services were utilised also varied significantly between Pacific people and the rest of New Zealand. Whereas 58% of all New Zealanders with a serious mental health disorder and 36% with a moderate mental health disorder used a mental health service, these were only utilised by 25% and 26.3% respectively of Pacific people.

When only mood disorders (including depression) are considered, 31.8% of Pacific people used a mental healthcare provider and 36.1% of those with a mood disorder visited some mental health service. Comparative figures for the whole of New Zealand were 55.1% and 51.7%.

This survey showed that Pacific people had a significantly higher prevalence for both anxiety and alcohol abuse than the total New Zealand population. However the lifetime prevalence for both any mood disorder and for depression was actually lower than for the general population. Furthermore the 12-month prevalence for major depression was only slightly higher than the rate found in the New Zealand population. This apparently low prevalence of depression appears to be the direct opposite to the findings of Yamamoto et al. (60) who found a higher rate of depression in Samoan migrants to Los Angeles than in Samoans who had remained at home.

This raises the question as to whether the prevalence of depression in Pacific Islanders is truly lower than the general population or whether there are other factors affecting the result.

The survey is regarded as being true for all Pacific Islanders and therefore the general principles of the results would be deemed to apply to the Tokelauan culture even if the actual figures varied.

The survey did not find any statistically significant link between prevalence and severity of mental illness in Pacific people and educational qualifications, income or living in areas with a high deprivation score.

The survey did, however, show significant differences between Pacific people who had been born in New Zealand and those who had immigrated to New Zealand after the age of 18. Pacific people who had been born in New Zealand had twice the rate of depression when

compared with Pacific people who had lived for at least the first 18 years of their life in the islands.

It also showed that these same young people are more likely to develop mental illness and it is more likely to be severe.

It is therefore possible that spending early years in the islands provides a protective effect against mental illness. This could be because of close contact with cultural values and customs. It is also much more likely that a young person will live under the influence of the extended family in the islands and will also be a regular church attendee and be influenced by the social and moral values of the congregation.

On the other hand, the Pacific Islander who has lived most of his or her life in New Zealand has been exposed to the cultural stresses of palagi society from birth. He or she will live in a family where financial and employment worries might be the norm and anxiety levels may be high. He or she might also be exposed to the materialistic influences of a commercial society that preaches wealth as the definition of success. Family, church and cultural values may have been pushed into second place resulting in increased levels of stress.

2.8 Chronic Disease and Depression Amongst Pacific People In New Zealand

An association between diabetes and depression has long been recognised but its extent has only more recently been appreciated. In 1993 Gavard et al. (61) reviewed 20 studies linking depression and diabetes. He found that the prevalence of depression was 14% in controlled studies using diagnostic interviews. The figure rose to 32.4% in controlled trials where a symptom scale was used. This prevalence was three times that observed in the general population. In 2006, Ali, Stone et al. (62) reviewed 10 controlled studies involving 51331 people. They confirmed a depression rate of 17.6% in diabetics and 9.8% in non-diabetics. Richardson, Egede et al. (63) showed that depression in diabetes was also associated with an increased mortality rate.

The reverse association of diabetes with depression has also been confirmed. Campayo, Gomez-Biel et al. (64) concluded that having significant depression may be associated with a 65% increased risk of developing diabetes.

This association of depression with diabetes is particularly significant for New Zealand Pacific people who have a very high prevalence of diabetes. The New Zealand Health Survey (65) performed in 2003/2004 showed that Pacific people have a 10.1% prevalence of diabetes and that this had increased from 8.1% at the time of the previous Health Survey in 1996/1997.(66) Furthermore, HbA1c screening showed that Pacific Islanders had a rate of undiagnosed diabetes more than four times greater than Europeans.(67)

Pacific people in New Zealand therefore have a significantly increased risk of depressive illness because of the high prevalence of both diagnosed and undiagnosed diabetes.

The New Zealand Mental Health Survey (2) supported this association between diabetes and depression. The 12-month prevalence of mood disorders amongst diabetics was 10.2% in Pacific Islanders. This was however about the same as the 12-month prevalence for the total New Zealand population which was 10.3%. Unfortunately the precise figures for depression per se were not given.

An increased 12-month prevalence of depression has also been shown to occur with coronary artery disease.(68) In the New Zealand Mental Health Survey, the 12-month prevalence of depression for Pacific Islanders with cardiovascular disease was 11.6%. This was higher than the 12-month prevalence of 10.7% shown for cardiovascular patients within the total New Zealand population.

The New Zealand Mental health Survey also showed an increased 12-month prevalence of depression in Pacific people with hypertension. Within the total population, hypertensive patients had a 12-month prevalence of depression of 9.1% whereas in Pacific people the rate was 11.6%.

2.9 Suicide In Pacific People In New Zealand.

The New Zealand Mental Health Survey (2) examined the prevalence of suicidal ideation, suicidal plans and attempts at suicide amongst Pacific people, who include Tokelau Islanders.

The rates for both lifetime prevalence and 12-month prevalence for suicidal ideation, planning and actual attempts were higher for Pacific people than for the whole of the New Zealand population.

For suicidal ideation, the lifetime prevalence of 16.9% for Pacific people was significantly higher than the population rate of 15.7%. Similarly the 12-month prevalence was 4.5% compared with 3.2%.

For suicidal ideation, Pacific Island females had a significantly higher prevalence than females in the general population with a lifetime prevalence of 19.3% compared with 17.4% and a 12-month prevalence of 5.2% compared with 3.7%.

The lifetime prevalence for suicidal planning for Pacific people was 6.4% compared with 5.5% for the whole population.

Although the lifetime prevalence figures for suicide attempts were still higher for Pacific people, the difference was not great. The prevalence for Pacific Islanders was 4.8% with a slightly lower rate of 4.5% for the rest of the population.

2.10 Suicide In Tokelau

The only paper that I found on mental health in Tokelau was one review on 'Suicide in the Tokelau Islands.' There is not any direct comparative study of suicide in Tokelau Islanders who have migrated to New Zealand.

Tavite and Tavite studied the rapidly increasing rate of suicide in Tokelau between 1980 and 2004.(69) They reviewed the prevalence of suicide throughout the three Tokelau atolls and collected data by means of a questionnaire from two sample groups. The first group was made up of individuals from the age range 15-45 years and the second group comprised suicide survivors and their close relatives.

They found that between 1984 and 2004 there had been six successful suicides in Tokelau. Of these, two had occurred on the atoll of Atafu, four on the atoll of Fakaofo and there had not been any successful suicides on the atoll of Nukunonu.

There had been a total of 40 attempted suicides between 1980 and 2004 with the statistics showing a definite increasing trend over that 25 year period. Attempts at suicides had first occurred in Atafu in 1980 with an increase in numbers thereafter. The first suicide attempts on

the other atolls were in the period 1996-2000 and further cases occurred on Fakaofo during the period 2001-2004.

The rate of suicide in Tokelau was 6/1500 with a rate for attempted suicide of 40/1500. More females committed suicide than males and of the six fatalities, four were under the age of 20 years and five were under the age of 25 years. This is higher than the rate of 22.6/100,000 in Western Samoa between 1981 and 1983. A report into suicides in Western Samoa by Bowles (70) reports that there were 106 deaths from the population of 156,349 during this period.

Twenty-seven percent of the respondents reported low self-esteem and 52% of these subjects were in the age range 15-25 years. Methods of dealing with their low self-esteem included praying (18%), talking to someone (16%), leaving to relax themselves (16%), attempting suicide (11%), turning to alcohol and smoking (3%) and "letting it go." Thirteen percent of respondents had previously had suicidal ideation and of these 53% said they had attempted suicide.

Important reasons given by participants for feeling low or for attempting suicide included

- Problems with relationships between parents and children. This included children not feeling they could express concerns and also corporal punishment. Sixty-seven percent of the fatal suicides were believed to be a result of beatings by the parents or guardians.
- Relationship difficulties within the marriage, including one of the couple having an affair and breakdown of the relationship.
- Relationship problems between boyfriend and girlfriend, including lack of parental approval and the breakdown of the relationship.
- Grief and bereavement
- The effects of gossiping and public humiliation.

These reasons are significant as some of them were repeated during the interviews for the present research. They are further discussed in Chapter 5.

My own research developed from the discovery that there is no actual word for *"depression"* in the Tokelauan language. It therefore significant that Tavite and Tavite state in their

paper,(69) “the Tokelau communities have little understanding and awareness of depression thus limiting the ability of individuals to define and report symptoms of depression.”

2.11 Holistic Health

The approach to Maori health is a holistic one in which there are four components. These are te taha wairua or spiritual health, te taha hinengaro or emotional and mental health, te taha whanau or family health and te taha tinana or physical health. Cram, Smith and Johnstone (71) state that of these te taha wairua or spirituality is most important when caring for patients. The holistic approach of Pacific models of care is in fact very similar.

In their 2004 study, Suaalii-Sauni, Wheeler et al. (72) performed qualitative focus group interviews with Pacific people and obtained viewpoints on mental health from the perspective of service providers, families and mental health consumers.

Participants emphasised the manner in which Pacific models of mental health care are holistic in their approach. Focus group members also spoke of the important role of spirituality in Pacific models of mental health care. This included Christianity and indigenous spirituality including the principles of “love and compassion, respect and deference and family interconnectedness.”

Both immediate and extended families were also described as an important part of the therapy for the person receiving mental health services. However some participants noted that confidentiality and the stigma of mental illness might preclude the involvement of the extended family.

Mental health consumers engaged in various self-care activities including ‘spirit-lifting activities’ such as ‘Pacific Island group therapy,’ baby sitting and doing exercise. People acknowledged the usefulness of palagi medication as long as it was not overused.

The writers maintain that according to Pacific philosophy, there needs to be a balance in “mind body and soul” before there can be “health and wellbeing.”

2.12 Te Vaka Atafaga

Kupa (73) also defined a holistic model of treatment for mental illness basing it on Tokelauan cultural values and using the model of the Tokelauan canoe or *'paopao.'* The physical structure, the sails, the ropes, the navigator and the outrigger represent the physical body, the spiritual beliefs, the family, the mind and the support systems of the Tokelauan requiring treatment. In addition to the emphasis on spirituality and family for Pacific people described by Suaalii-Sauni, Wheeler et al.,(72) Kupa adds the important Tokelauan values of *'inati'* or *'fatupaepae.'* These refer to the communal sharing of resources and the privileged matriarchal position of elderly women.

Both the Porirua Health Collective and the Tokelau National Health Conference endorsed the Te Vaka Atafaga model in 1992.

2.13 Effect of Cultural Values on Depression

All cultures are different. They vary in their beliefs, their worldviews, their social behaviours and emotions and frequently their language.(45) The manifestation of psychopathology and the way in which a society reacts to it depends on all these cultural factors.

Lawrence, Banerjee et al. (74) looked at the beliefs about depression held by older people belonging to three different ethnic groups in the UK. The groups studied were Black Caribbean, South Asian and white British. They researched their attitudes regarding what treatment would help someone with depression and from whom they should get it.

The majority of respondents felt the main responsibility for treating depression lay with the individual. Often any other formal treatment was considered to be of secondary or minimal importance. They felt the depressed person should maintain a positive attitude and take strength from "inner resources." Other self-help recommendations for getting well included avoiding negative thoughts and "adjusting" your "attitude on life."

The second treatment recommended by participants involved seeking social support and the family was the most important resource identified. Close relatives were able to take the ill person out on trips. They also provided a listening post and were a source of encouragement. South Asian ethnic people in particular felt families were important in the treatment of

depression. Friends were also regarded as important – but often as someone who would stop and listen rather than being a source of advice.

Religion and the church were very important – especially amongst the Black Caribbean ethnic group. Prayer was a vital part of treatment, and without a personal relationship with God, depression would be difficult to overcome. Non-Christian groups felt that visiting the temple, meditation and praying all helped treat depression by promoting peace and calm.

Dr. Walters was a psychiatrist at Pago Pago in American Samoa. He noted that the mental illness burden was lighter than expected in an island with a population of 30,000. In his article,(75) he reviewed the reasons for the effectiveness of the indigenous treatments.

The local population were not Christian but had a strong belief in ancestral spirits or *aitu.* These *aitu* could possess a victim's body causing illness as a result of an indiscretion by members of the extended family or *aiga.*

Treatment involved family prayer and involvement of the folk healer or *taulasea.* The family would be united in sharing the guilt and seeking absolution through a group confessional and prayer. Faith in the magic of the healer, herbal medicine, as well as the "cathartic effect" of taking part in the family therapy all helped provide some stabilising treatment.

2.14 Social Influences On Depression

In his article, Patel reviewed cultural and social influences on the epidemiology of depression.(35) He feels that culture is constantly changing with the effects of globilisation. He sees cultures as being increasingly open to the influence of the media and marketing. As a result they are becoming more and more homogenous throughout the world instead of remaining geographically isolated with no effect from outside influences.

Patel submits that previously in non-industrialised nations, somatic symptoms were equated with the symptoms of depression. However in fact, somatisation is also very common in developed countries as well.

Patel maintains that acute depression is likely to present with somatic symptoms but with time the person will re-evaluate the situation and is more likely to have a psychological

presentation. In some cultures however, these may be suppressed as they carry such a social stigma that the patient does not show them.

Patel explains that the word '*depression'* came from ordinary English literature and was converted in one step into a medical diagnosis. Many cultures do not have an equivalent word for it. Frequently the term *depression* means sad and this might not always be a symptom of a depressive illness. In a similar way *mental* illness includes a word associated with the asylum, which in many cultures is associated with poor care and a bad outcome.

Patel feels that different ethnic groups need to look for words to describe depression in their own terms and cites the phrase *'neurasthenia'* in China and *'kafungisisa'* in Zimbabwe, which means, 'thinking too much.'

Patel also notes that the risks for depression are higher in women; he cites Bahar, Henderson et al. (76) as saying it is more common in the less educated and Todd, Patel et al. (77) who stated that the risk of depression was increased in the economically deprived. Women, he states, lack opportunities and are often oppressed. They are more likely to suffer violence and stressful life events and he cites Broadhead and Abbas (78) who showed these are associated with increased prevalence of depression.

Patel also discusses poverty and he cites Patel, Araya et al. (79) who showed that unemployment and a low standard of living increases the risk of depression.

Patel relates how increasing economic development results in decreasing expenditure on public health measures. There is also an increasing gap between the rich and the poor with a resultant increase in migration to urban areas in search of employment to resolve the problem. Urban squalor and poverty with all its sequelae causes increased depression.

2.15 Samoan Concepts of Mental Health

Tamasese, Peteru et al. (80) studied the perceptions of mental health amongst elders in the Wellington Samoan community.

This paper researches the Samoan concept of self and its relationship to mental health. It involves a different Pacific Island community from my study but some of the causes of

‘mental illness’ in the Samoan community have commonality with the causes of depression as described by members of the Tokelauan community.

Subjects in the study by Tamasese, Peteru et al. (80) explained that the Samoan perspective of *‘self’* had to be comprehended before the Samoan perspective of *‘mental health’* could be appreciated. The Samoan *‘self’* was a “relational being” and one participant was quoted as saying that there is

> *“no such thing as a Samoan person who is independent.”*

It was impossible to take a person away from the relational space that existed between members of his extended family, friends and the community.

If a mental health service attempted to treat a Samoan as an individual without taking into account the communal nature of his person then therapy was unlikely to be successful.

Samoan cultural protocol is well defined as is the respect and etiquette surrounding certain relationships. *‘Tapu’* or ‘*sa’* (forbidden or sacred) states how people should behave in a given situation or towards a certain person.

Members of the focus groups described how breaching the *‘tapu’* or ‘*sa’* was often the cause of mental illness.

The interviewees also explained that spirituality was very important in the maintenance of a healthy mental state. In pre-Christian times, Samoans had always been aware of spirituality and the Gods of the environment where they lived. Mental and spiritual health were so closely linked that successful psychiatric treatment was impossible without considering the spiritual component of health.

The whole person is made of physical, mental and spiritual components and a holistic approach is essential. If one aspect of the person is unwell then the whole person is unwell and it is impossible to treat any one of the physical, mental or spiritual aspects on its own.

The participants described the financial pressures on migrants to New Zealand as a cause of mental illness. They noted the need to give money to the church and the desire to continue sending monies home to Samoa.

They also singled out the cultural adjustments associated with migration as possibly causing mental illness. They spoke of the pressures on the young Samoan who was confused as to whether he belonged to the Samoan or the palagi culture.

Subjects in the study also identified older Samoans as being at risk for developing mental illness. They feel their status in society falls as they live in an environment where status is based on earning power and social recognition rather than family titles.

Drugs, alcohol, bereavement, isolation and disruption of extended family ties were all mentioned as causes of mental health problems.

2.16 Culture and Illness Presentation

Kleinman, Eisenberg et al. (81) discussed how symptomatology and presentation can be altered by the cultural background of a patient.(81) Seventy to ninety percent of all illnesses that patients recognise themselves are treated without health care services. Folk healers, cultural healers, neighbours, church groups and self-care groups are all consulted prior to help being sought from either the general practitioner or the hospital.

Kleinman, Eisenberg et al. (81) contended that often treatment by doctors does not succeed "despite effective pharmacologic action, when patients fail to follow through on the medical regime because they do not understand (or do not agree with) the physician's stated rationale for their actions."

He explained that physicians treat *diseases*, which are abnormalities in the organic structure and the physiology of the body. However patients present with *illnesses,* which are the human experience of sickness. It is the illness that patients want treated and they may often get more progress and improvement with a folk healer who gives them a more holistic approach and a better explanation.

In the article, Kleinman, Eisenberg et al. (81) describe how illness is culturally shaped and perceived. The culture of a patient will determine how he experiences a disease, the way in which he explains it, when he goes for help and to whom. The culture will also determine what type of treatment a patient will find acceptable.

2.17 Physical Symptoms In Mental disorders

Many patients who have emotional or social upset will often present with physical symptoms rather than having a classical psychological presentation. When this occurs it is known as "somatisation."

In a review article on somatisation, Katon, Ries and Kleinman (82) maintain that 25-70% of presentations to family doctors are because of psychosocial problems and most of them are with somatic symptoms. They cite Collyer (83) who studied patients in primary care and found that 28% of consultations involved patients suffering from some emotional illness. They also cite Goldberg (84) whose study of primary care showed that over 50% of patients with an emotional disorder would initially present with a physical symptom.

Presentation with physical rather than emotional symptoms is common in many traditional cultural societies where showing negative emotions is actively discouraged.

In his classic review of culture and illness, Kleinman (81) used the case of the Chinese as an example of somatisation in a depressive illness. He explains that in the Chinese culture, a person will lose face and status if he displays any signs of mental illness. As a result, even the smallest of mental disorders will present with a physical symptom. Depressive symptoms are often masked and physical symptoms that are more socially acceptable are substituted. A patient may therefore present with stomach pain, wind or saying he is "short of blood." However the disparaging response to emotional symptoms also occurs in many other ethnic groups.

Somatisation can also occur amongst working groups where having a physical symptom is more acceptable than missing work because of an emotional problem. As an example of this, Lock and Scheper-Hughes (85) discuss the Brazilian labourers in Alto de Cruzeiro. Their pay is a mere $1.00 a day and they collapse with physical symptoms known as *"nervos."* The physical presentation can include blackouts, facial and limb paralysis, seizures, trembling and

weeping. Lock and Scheper-Hughes however, describe this somatisation as a physical "metaphor" in which the workers express their disgust and inability to continue to endure the hunger, hardship and horrific conditions under which they are working.

In his 2006 article on Culture and Depression, Kleinman (86) explains that in some cultures, a patient might be "so stigmatised" by having a doctor diagnose him with depression, that the label becomes unacceptable and a euphemism is necessary. In some cultures, depression can be attributed to family conflicts such as occur between "parents' patriarchal attitudes and children's modern perspectives." He also points out that in different cultures, self-care might take place and complementary treatment might be given.

Katon, Ries and Kleinman (82) further discuss how physical symptoms can be used within interpersonal relationships to gain support or to express annoyance and resentment towards other people. It can also be used to avoid intimacy. Increased support and caring can develop within a family because of somatisation and be quite beneficial. The social support services can on occasions reinforce the physical symptoms to such an extent that they grow and even continue long after the original psychological problem has been resolved.

However, major problems develop when the medical profession do not recognise the physical symptoms as being secondary to psychosocial problems and continue to do multiple unnecessary investigations and even perform operations.

2.18 Summary

The 2013 New Zealand census accurately determined the population of Tokelauans resident in New Zealand. It showed that they are disadvantaged, have low-skilled jobs, a low income and tend to live in crowded housing. These were identified as risk factors for the development of depression as were unemployment, poverty, disruption of the extended family and alcohol.

Many cultures do not have a word for depression. The diagnosis of depression varies internationally between cultures and from east to west. In New Zealand the NZMHS obtained accurate figures for the prevalence of mental illness including major depressive disorder in Pacific Islanders. There were, however, no prevalence rates for Tokelau Islanders.

Studies show that traditional life in Pacific Islands seemed to carry some protection against mental illness and the NZMHS showed that Pacific people who were born in the islands and emigrated after the age of eighteen had a degree of protection from mental illness.

The Pacific model of mental health treatment is holistic and includes spirituality, involvement of the family and group therapy as well as use of palagi medication. Specific Tokelauan cultural values are added to the treatment model of Te Vaka Atafaga.

CHAPTER THREE
METHOD

3.1 Introduction

This chapter discusses theories that form the foundations of the different research methods and explains why qualitative methods were chosen for the study. It looks at different types of sampling and interviewing techniques before outlining in detail the data collection process for the study. Following this, it turns to the protocol for the interviews and considers their significance from a cultural perspective as well as examining the interview questionnaire.

It then considers important issues related to the interviews including the availability of a translator, a support person and safety issues.

Following this, it turns to engagement with the Taupo Tokelauan Community. It describes how there was liaison through a steering committee, how recruitment was undertaken and presents the demographics of participants. It then discusses the important issue of confidentiality in a small tight community.

It then presents the Information and Consent forms and discusses the procedures in place for feedback to the Tokelauan Community.

Following this, it turns to discussion of the main methods of data analysis used for Qualitative Research. It then outlines how the analysis was undertaken in this study.

Finally it considers ethics approval.

3.2 Research Paradigms

3.2.i Introduction

A paradigm is the interpretive framework upon which the researcher bases his or her work.(87) It is the collection of beliefs that guide the research. It encapsulates the ontological, epistemological and methodological principles that form the foundation of the researcher's inquiry.(87)

3.2.ii Quantitative Research and the Positivist Paradigm

Early scientific research was objective and dealt with measurable data. This was *'quantitative'* research. It was clearly defined by what became known as the *'positivist paradigm.'* Besides clearly stating the objectivity and measurable nature of quantitative research, the positivist paradigm required researchers to use fundamental scientific laws to find causes for events. They also developed informed guesses or hypotheses, which could be tested by research. In the positivist paradigm, all observations are reduced to the simplest events. By using reason, the positivist can differentiate truth from falsehood.(88)

Devers (89) lists five basic principles as making up the positivist paradigm. These may be summarised as:

1. That the observer is separate from the recorded data and as such does not influence the results.
2. Only facts that are measurable and are discernible by the senses can be regarded as knowledge.
3. True scientific knowledge occurs when many facts are put together to form laws.
4. Scientific theories are used as the basis for hypotheses, which are then tested.
5. Researchers do not have any values that affect their objectivity (Science is value-free).

Devers (89) describes the positivist philosophy as "if a concept cannot be observed and measured, it does not exist."

Positivistic research is driven by its opening prediction or hypothesis and is always orientated towards its end outcome.

3.2.iii Social Science and the Positivist Paradigm

Devers (89) further explained how social scientists initially tried to combine positivist principles with qualitative research. They did studies that resulted in the definition of new social laws which they thought would predict behavior in the future.

By applying the principles of the positivist paradigm to qualitative research they hoped to obtain results that would be more acceptable amongst their scientific peers and would stand up to the challenges of publication.

3.2.iv Post-Positivist Paradigm

During the 1980s researchers using qualitative research methods defined the *'Post-Positivist Paradigm.'*(89) Whereas the positivist paradigm maintains that knowledge can only be based on a *true reality* that we must measure, the post-positivist paradigm maintains that this reality can only be approximated and can never be accurately obtained.(90) Methods must, however, still be systematic and rigorous.(91)

In differentiating this approach from the positivist approach they described a framework that encapsulated research in disciplines such as social sciences, health sciences and economic sciences. Much of this research uses qualitative methods to study people and their behaviours.

Devers (89) describes research based on the post-positivist paradigm as being "phenomenological, theory-building, holistic, case-based, subjective and process-orientated."

3.2.v Interpretivist Paradigm

Researchers working in cultural and social fields realised that data that they were obtaining was always influenced by social and cultural factors. They also understood that the background and values of the researcher influenced the understanding of what was observed. Researchers recognized that the full meaning of what they saw could only be fully appreciated if it was interpreted in its context. These principles did not fit either the positivistic or the post-positivistic paradigm and resulted in the elucidation of the *'Interpretivist Paradigm'.*

In defining the Interpretivist Paradigm, Peck and Seeker state (92): *"Reality does not exist; knowledge is constructed through the research process and interpreted through the researcher's own values and assumptions."*

Whereas research based on the positivist paradigm gathers statistics, research based on the interpretivist paradigm recognises the influence of social issues on the subject under investigation. When considering a subject's personal experiences, interpretivist-based research also considers culture and the environment.

In research using interpretivist methods there is observation of the way in which the subject interacts with the observer. The display of the relationship between the subject and his or her

family can become important. Similarly the researcher looks for important interactions of the subject with his or her society or culture.(93)

Language – including tone, volume and inflections of voice become important in interpretivist research and body language might also become noteworthy. This can include seating arrangements, clothing worn, eye contact and facial expressions.(93)

Research based on the positivist paradigm identifies patterns and laws then makes the assumption that the findings are applicable in other similar settings. However studies using the interpretivist paradigm observe and record experiences from one situation only. That particular observation is not necessarily reproducible elsewhere but the study might identify general principles that have a wider application and require comment.

When doing research using interpretivist methodology, the data collected changes depending on location and is different for every culture and every person. Furthermore the interpretation of qualitative data is influenced by the values and thoughts of the researcher. Increase in knowledge occurs through an interaction between the observed person and the observer.(93)

The important characteristics of the interpretivist-based research methods include consideration of social, family and cultural issues and how these affected the subject's feelings.

These characteristics make interpretivist research methodology the most appropriate method for this research project. It studies people's individual experiences and also looks at how those experiences are affected by interaction with the Tokelauan community and with the larger palagi or European community. The research was not collecting figures and data, which would have required a positivistic-based quantitative study.

3.3 Purposive Sampling

A true randomly selected sample for a study is appropriate for quantitative studies where large numbers of cases are being chosen. A representative sample is selected and from the results, generalisations can be made and applied to the larger population.(94)

However, when the researcher has identified the characteristics of the population that he or she wants to investigate and seeks out people with those criteria, the sampling method used is known as *'purposive sampling.'*(95)

Once the specific group with the required characteristics has been identified, some randomisation is still possible as the exact choices of subjects is made. Guarte and Barries (96) defined Purposive Sampling as the "random selection of sampling units within the segment of the population with the most information on the characteristics of interest."

By using purposive sampling and targeting a specific group, the researcher is much more likely to be able to collect information, which is full of detail about the chosen subject. He or she is also likely to be able to spend more time with each participant than would be possible in a large randomised trial.(94)

Purposive sampling was chosen for the current research question. It is a qualitative study and the community under consideration is well described.

3.4 Stratified Sampling

In stratified sampling, a number of people are chosen from different subgroups of a population to ensure there is as diverse representation as possible in the study.

3.5 Structure Of Interviews

An interview is a conversation between the researcher and a subject, which is guided intelligently and empathically by the researcher. He or she does this in a manner that keeps the subject at ease yet obtains as much information as is possible. Bogdan and Biklen (97) described the interview as a "purposeful conversation" whilst Grbich (98) stated that interviews gained "information on the perspectives meanings and understandings constructed by people regarding the events and experiences of their lives." She feels that a good interviewer is able to listen attentively and intelligently, displaying appropriate empathy when the respondent is happy or sad and can remain focused, handling all presented data, regardless of the complexity.

The interview in qualitative research can be structured, semi-structured or unstructured.

3.5.i Structured Interviews

Structured interviews are organised and rigid.(99) The participant is presented with a questionnaire that has been carefully prepared beforehand. This questionnaire is read in a strict manner with the questions being presented in the same order in a like way to every participant. The format allows more objectivity in the results with minimal objective bias.(99)

It does, however create a situation where the researcher is in a position of power and the respondent is in the weak position and this may curb the flow of useful information.

Structured interviews are as close to the positivistic paradigm and quantitative research as qualitative research is likely to come.(97) Consequently, a problem with them is that the ability to capture free speech rich in unanticipated or de novo data is curtailed.

3.5.ii Unstructured Interviews

Unstructured interviews are very like an oral history in that following an initial prompt they are largely guided by the informant. There are no set questions at all. The researcher is an attentive listener and will develop appropriate questions in response to the narrative as time proceeds. Crabtree and Miller (100) describe unstructured interviews as "guided everyday conversation."

3.5.iii Semi-structured Interview

In a semi-structured interview, the researcher has a pre-prepared list of open-ended questions guided by his or her known research topics. However these introductory questions are often merely a 'kick start' for the interview. They are simply to give the researcher a general guide as to what line the interview should take and which issues should be dealt with to help answer the research question. The researcher then guides the conversation with 'probes' and further open-ended questioning as he or she endeavors to elicit further relevant information.(99)

The conversation within the interview is free flowing and each participant is encouraged to add his or her individual perspective and colour to the topic. The open-ended nature of the questions ensures that the semi-structured interview will develop very like an ordinary conversation. As it proceeds, the subject is given a chance to fully enlarge on and develop matters, which he or she might feel are relevant.

It is often important to slow down the speed at which information is collected when sensitive issues are covered and with the conversational approach, the researcher is able to vary the speed of the interview appropriately. He or she is also able to show appropriate empathy and respond as necessary to situations as they develop.(99)

In contrast to structured interviews where the questions are fixed, the researcher can change the questions in semi-structured interviews. This allows him/her to address topics in much greater depth than in structured interviews. The researcher can also spend extra time on an issue particularly relevant to an individual participant or else try to get another approach on an important question.(101) The semi-structured interview also allows the researcher to test emergent themes as they develop during the interview.

Semi-structured interviews allow the researcher to enter into the world of those whom he/she is trying to study. In a review article on qualitative research, Shaw (94) says the researcher needs to be able to have an "empathic understanding" of the stories being told when studying people in a societal setting. Attentive listening that shows such empathy is possible in the semi-structured interview. This makes the format particularly suitable for dealing with a sensitive topic such as depression in another culture.

The relaxed, conversational free-flowing approach of the semi-structured interview where the questions are guides rather than absolutes also make it ideal for this study.

3.6 Sample Numbers

The numbers required for qualitative research are small in contrast to the large numbers necessary to reach significance for a quantitative study. The number in the study depends on the information received. Interviewing continues until no more new information is being gathered by doing further interviews. This is known as the saturation point.

Crabtree and Miller (100) state that five to eight samples are often needed to reach saturation point in homogenous populations.

3.7 Data Collection

For the reasons outlined in the previous sections, this research was performed as a qualitative study with purposive one-to-one, face-to-face, in depth, semi-structured interviews with open-ended questioning.

The target community chosen was the Taupo Tokelauan Community and initially the group was stratified into four groups in order to provide as diverse representation as possible. The proposed groups were:

Males – Recently arrived in New Zealand
Females – Recently arrived in New Zealand
Males – Long time New Zealand resident
Females – Long time New Zealand resident.

It was intended that there be four people in each group and that at least one of these should be an elder (over 65 years of age).

Interviews continued until the point of saturation where no further new information was being obtained.

3.8 Developing an Interview Guide

I developed the questions for the interviews after consultation with my supervisors. I have since become aware of the 2006 work by Kleinman and Benson which validates my questions.(102) The questions used in the interviews are listed in 'BOX ONE.'

3.8.i Question 1: Existence and Name of Illness

Western medicine has the expression 'depression' to use as a label for a person who fulfills certain diagnostic criteria. Although there does not seem to be a word for the condition in their language, we also use the same label when diagnosing Tokelauans, often without first stopping to inquire whether that illness actually exists in their culture.

In the introduction I described that although a word for 'depression' probably does not exist in the Tokelauan language, there are words such as *'fakanoanoa'* which means '*having sadness'* and *he fiafia'* meaning *'he is unhappy.'*

The research questions therefore avoided the term 'depression' and in its place spoke of sadness, extraordinary sadness and unhappiness. The interview schedule began with the question: Is there an illness in the Tokelauan culture where a person becomes very very sad? If such an illness does exist, is there a specific Tokelauan name for it?

3.8.ii Question 2: Symptoms of Illness

If an illness characterised by sadness did exist in the Tokelauan culture, it was important to establish what symptoms were predominant. I was aware of the strong family ties in the Tokelauan community, which have already been discussed in Section 1.4.ii I thought that family members might be the first to notice changes in a relative with a depressive illness and decided to ask them how they might recognise when someone was getting such an illness.

3.8.iii Question 3 and 5: Treatment of Illness

I wished to discover whether there was treatment within the Tokelauan family or community for an illness characterised by sadness. Question 3 asked how the participant might deal with a family member who had such a disease.

3.8.iv Question 4: Cause Of Illness

In the palagi culture, the onset of depression can be a result of external factors or in some people it is regarded as an intrinsic illness.

I was keen to discover if illnesses with sadness in the Tokelau culture were associated with specific causes or whether they occurred de novo.

3.8.v Question 6: Signs of Recovery

It was important as part of the study to see if family members could recognise when a person was getting better. Were there signs that would constantly indicate that a sad person was finally heading towards recovery?

3.8.vi Question 7: Prevention of Illness

What do members of the Tokelauan community know about avoiding an illness dominated by sadness? Were they able to outline preventative strategies to someone just arriving in New Zealand from the Tokelau Islands?

3.8.vii Question 8: Coping with Sadness

I suspected that a Tokelauan newly arrived from the islands may be susceptible to sadness induced by the culture change. I wondered what coping strategies he or she would use.

3.8.viii Question 9: Gender Differences

I wanted to discover whether males and females coped differently with feelings of sadness.

BOX ONE

1. In your language you say fakanoanoa or having sadness, and he fiafia, or he is unhappy. Sometimes a palagi can become so very very sad that it becomes an illness. Sometimes the sadness can become too much to bear and life does not seem worth living.
   - Is there an illness like that in the Tokelauan culture?
   - Does it have a name?
2. If there was someone in the family with that illness or getting it, how would you know?
3. If there was someone in the family with that illness, how would you deal with it?
4. How do people get this illness?
5. If someone is sad, how can you make him or her well?
6. How do you know when someone is well again?
7. What advice would you give to someone who had recently arrived in New Zealand so they can stay well?
8. How might a newcomer cope with feelings of sadness?
9. Do women cope or deal with feelings of sadness differently from men?

3.9 Support Person and Translator

Although I was trying to study a genuine topic within the Tokelauan community, I recognised that for some participants, the topic and the interview process had the capacity to become quite personal. I appreciated the need to proceed with extreme sensitivity at all times. The consent form specifically offered each participant the opportunity to have a family member or other support person with him or her during the interview.

A senior member of the Taupo Tokelauan community was available to be a translator for interviews if needed. He was a professional person and because of his career choice had a full understanding of the importance of confidentiality.

3.10 Safety Issues

Further to the issues raised in Section 3.9, I appreciated that some participants who were suffering from an illness with significant sadness might volunteer for the study. I knew that as a general practitioner who had been in practice in the community for thirty years it could become a very blurred boundary between researcher and doctor if a participant suddenly needed help.

I therefore spoke to one of the community mental health nurses in Taupo who was happy to be available if I needed assistance. The Taupo general practitioners also have free access to an excellent counsellor and using my medical hat I arranged for the counsellor to be available for any subjects should they need assistance.

3.11 Length Of Interviews

Qualitative interviews can be as short as half an hour or continue for a number of hours. However, whilst discussing research methods and the ideal length of interviews, Barhuizen, Benson and Chik (103) cite Richards as suggesting that both "interviewer and interviewee may experience tiredness after an hour of interviewing" and this can affect the quality of the interviews.

I therefore determined that no interview would go on for longer than sixty minutes maximum, and informed all volunteers for the study that the interview length would probably be about forty-five minutes and no longer than one hour.

3.12 Engaging with The Tokelauan Community

In 2001, when I talked to some of my older patients about the idea of a "free check," (see Section 1.1), they immediately became very suspicious. They spoke of tests that were done on them and blood that was taken when they migrated from Tokelau at the time of the cyclone. They told me how no one really explained that it was for research and no one said it was all going to be published.(104, 105) They told how they felt their blood had been used without their consent. Both spiritually and emotionally they felt betrayed.

Laverack and Brown studied health issues in Fiji and subsequently wrote an article on the cultural considerations necessary when doing qualitative research in a cross-cultural context.(106) They emphasised the importance of flexibility and observing cultural protocol when doing research.

They also cited Seefeldt (107) who stated that qualities needed for a cross-cultural researcher included "patience, adaptiveness, capacity for tacit learning and courtesy."

It was essential to ensure that I did not make the same errors that had obviously been made – albeit inadvertently- by researchers at the time of the initial migration. I needed to explain the study in detail to a full meeting of the Tokelauan community. Furthermore, I personally needed cultural guidance at every step of the study to ensure that I did not upset any community members.

3.12.i Tokelauan Steering Committee

I approached three members – two men and one woman - of the Tokelauan Community and asked them if they would form a steering committee to guide me through the active phase of the project. They all agreed and the committee met and discussed the study. All members were enthusiastic about the project and agreed to approach the Tokelauan community leaders to coordinate my attending a regular monthly Sunday meeting to fully explain the proposal.

3.12.ii Tokelauan Community Meetings

I attended two Sunday meetings of the community; initially to explain the study and again to talk about the project once more as attendance had been poor the first time. Mental health was becoming more topical in the wider Tokelauan community with some suicides having occurred in New Zealand. There was suspicion from some community members about *research* being done but generally the community gave its full support for the project.

3.13 Recruiting

3.13.i Local General Practitioner as Researcher

I had been in general practice in Taupo since 1982 and was well known in the town. When I first arrived, there was a very big Tokelauan community and the majority of the families came to me as their doctor. Although the number of Tokelauan patients in my practice had

decreased substantially as families migrated away from Taupo, I still cared for many people from the community.

I was very aware that choice of interviewees had to be done with care, as there might be Tokelauans who would agree to an interview in order to please me when they had no desire to be part of the study at all.

Ethically, I therefore did not feel able to approach members of the community looking for volunteers to participate in the study. I presented this problem to the steering committee and the members agreed to take responsibility to coordinate recruitment for the study.

As the researcher, I had nothing to do with the finding of appropriate members of the community for the interviews. One particular member of the steering committee took on the job of identifying suitable participants. I noted that having just one person from the steering committee involved in the choice of subjects helped prevent breaches of confidentiality.

3.13.ii Shortage of New Arrivals

There was no problem finding volunteers for the study within the Taupo community and three males and three females were quickly recruited and subsequently interviewed.

However all six participants had lived in New Zealand for many years and two of the interviewees had actually been born in New Zealand. They were however, all deeply involved in the Tokelauan community and extremely knowledgeable about its culture.

I realised that when I first arrived in Taupo, the job situation had been different and the Tokelauan community had been growing with new families frequently arriving from the islands. Now, the jobs in the bush were gone and unemployment in the Taupo area had grown. Tokelauans were no longer coming to live in Taupo and the community was shrinking. The steering committee member who had identified the interviewees told me that there were not any *"new arrivals"* within the Tokelauan community in Taupo. I realised that if I was going to interview Tokelauans who had arrived in New Zealand more recently, I would need to have recruits from outside the Taupo area.

3.13.iii Auckland Interviews

I was lucky to have been introduced to Rev Linda-Teleo Hope (this is her actual name and is used with her permission) by one of the members of the steering committee. Rev Hope is a Tokelauan minister who lives in Auckland and who has done research on suicide in the Tokelau Island population. The member of the steering committee spoke to Linda on my behalf and subsequently I contacted her. Linda kindly offered to help me find suitable participants for the study. She gave up a full day during which four interviews were completed with one male, one female, a husband and wife together and a group interview of a family comprising two males and two females. Although none of these interviewees could be classified as *"new"* arrivals in New Zealand, they had all arrived much more recently than any of the Tokelauans I recruited in Taupo.

3.14 Transcription

The interviews were taped and transcribed word-for-word by a local typist who had signed a confidentiality agreement.

3.15 Termination of Interviews

In accordance with the process of conducting qualitative interviewing outlined by Crabtree and Miller,(100) the point of saturation was reached when no further new information was being obtained.

In this study the point of saturation was reached after ten interviews.

3.16 Demographics of Participants

Whilst doing the four interviews in Auckland, there were two occasions when more than one person was interviewed. I arrived for 'Interview G' and found both the husband and wife expecting to contribute to the interview. At 'Interview H,' there was a Tokelauan family of four comprising an elderly man who only spoke Tokelauan, along with two other women and a younger man. Although there were only ten interviews, there were therefore fourteen participants, comprising seven males and seven females. The age range of the participants was between '25-30' and '60-65.'

The demographics of both the husband and wife who participated in interview ‘G’ are recorded in BOX 2 on line ‘G.’

The demographics of all four family members who contributed to Interview ‘H’ are recorded under ‘H’ in BOX 2. Interview ‘H’ therefore required two lines of BOX 2 in order to detail the demographics of all four participants.

A summary of the demographics is provided in Box 2.

BOX 2

INTERVIEW	GENDER OF PARTICIPANT(S)	AGE OF PARTICIPANT(S)	YEARS IN NZ
A	Male	55-60	46 yrs
B	Female	40-45	43 yrs
C	Male	55-60	40 yrs
D	Male	55-60	36 yrs
E	Female	25-30	25 yrs
F	Female	60-65	61 yrs
G	Male and Female	40-45 and 25-30	4 yrs
H	Male and Female	60-65 and 35-40	3 yrs and 4 yrs
H	Female and Male	55-60 and 20-25	20 yrs and 4 yrs
I	Female	30-35	1 month
J	Male	45-50	8 yrs

NOTE: The line ‘G’ includes all the demographics for the husband and wife who contributed to ‘Interview ‘G.’ The two lines labelled ‘H’ includes all the demographics for each of the four members of the family who contributed to Interview ‘H.’

3.16.i Translation

The man’s daughter provided translation for the interview of the participant who did not speak English. She did not have special training, but the translation was constantly verified by the other family members in the room. Only the English translation was typed and there was no transcript made of the Tokelauan version of the interview.

3.17 Locality of Interviews

3.17.i Taupo Interviews

From the outset I had stated that I would hold the interviews at a place and time convenient to the person being interviewed. I expected participants to nominate their home and if there was

difficulty, I knew I could organise a community room through Waiora House, which is administered by the Lakes District Health Board.

However, only one participant elected to be interviewed at home and the steering committee member suggested that I use the pipe band hall for the remainder of the interviews. This hall is comfortable and is in the same club-hall park as the Tokelauan Hall. I accepted this suggestion for the interviews as it was a very convenient place and always available. However I acknowledge my own association with the pipe band.

3.17.ii Auckland Interviews

Three of the Auckland interviews took place at the residence where the interviewee was living and one interview was done at the residence of Rev Linda-Teleo Hope.

3.18 Confidentiality

3.18.i Problem and Recommendations

Damianakis and Woodford (108) reported on the problem of maintaining confidentiality whilst doing qualitative research in a small, connected community where everyone "knew" one another. They felt that the researcher should practice constant "reflection" on the subject of confidentiality whilst doing the study.

They noted the possible additional risk to confidentiality that arose when the research was written up and presented. They felt that the risk of breaking confidence was so great that there was a case for not identifying the community at all when documenting the study. They specifically recommend checking all narratives and quotations to ensure that there is nothing in them that can identify any participant.

Damianakis and Woodford (108) suggested that the consent form acknowledge that this was a "small community" and specifically state how participant's identification will be protected when transcribing quotations in the writing of the presentation.

3.18.ii Confidentiality in Taupo Study

Problems

The issues outlined in the article by Damianakis and Woodford (108) were very relevant in Taupo. The Tokelauans, who make up the Taupo community, know one another very well,

which means that news travels fast and it was important to be discreet when talking to participants. There are also many large families, meaning that most Tokelauans in Taupo have many relatives in extended families within the community and could easily identify a participant if a narrative was not reviewed carefully. Furthermore, most of the Tokelauan community worship at the Catholic Church and many of the remainder attend the Union church. These are also close communities and this further compounded the challenge of confidentiality for the study.

Actions

It was important to be able to retain as much anonymity as possible when interviewing participants. Using the pipe band hall, proved to be ideal. No one else was ever around and the arrival and departure for the interview was not observed. This was therefore a confidential interview location where participants felt at ease to speak freely about their experiences of sadness.

In presenting this research I have maintained confidentiality by ensuring no one is identified in the write-up. Confidential IDs have been allocated to all interviewees when listing the demographics and when acknowledging the quotations. However I am troubled that in a small society the size of the Taupo Tokelauan community, even listing a person's age, sex and the number of years he or she has been in New Zealand might be enough to allow identification.

The risk of unauthorized access to the interviews is another area where the researcher has to reflect on confidentiality. In the case of the Taupo study only the typist, the researcher and his supervisors have had access to the transcripts. When not being used, they have remained securely locked away and will be destroyed once the study is fully completed.

The recordings of the interviews have been locked in a safe where they will remain for ten years in line with regulations. At the end of that time they will be destroyed.

Damianakis and Woodford (108) recommended that the consent form specifically acknowledge that the study involved a small closely knit community and outline the steps that would be taken to preserve anonymity in the write-up. On reflection, I feel this would have been an excellent idea, particularly with the small size of the Taupo Tokelauan community.

They also suggested withholding the identity of the community when doing the reporting. However this would not be practicable. In a small country such as New Zealand, the characteristics of the island community along with the local employment history would make Taupo easily identifiable.

3.19 Expenses

I paid petrol expenses to all participants who travelled. I gave a koha to other interviewees after following the cultural advice kindly provided by Rev Linda-Teleo Hope.

3.20 Information Sheet and Consent Form

A full "Information and Consent Form" (see Appendix A) was prepared and given to all recruits prior to their partaking in the study. The information sheet clearly explained the aim of the study as well as the hope that it might lead in the future to a better model of mental health care for Pacific people. It detailed the interview process and explained what line the questions would take. The information sheet also reassured participants that they did not need to answer a question if they felt uncomfortable. Furthermore, they were able to withdraw from the study at any time if they so desired. The sheet clearly explained that the interviews would be taped and then transcribed. The security and confidentiality of their interviews was explained. The information sheet confirmed the paying of the petrol expenses. Before the interview started, all participants signed a consent form that acknowledged that all the particulars in the information sheet had been read. The format of the consent form was taken from the New Zealand Ethics Guidelines.(109)

3.21 Feedback

As noted, some of the older members of the Tokelauan had told me of bad experiences of research (see Section 1.1). I know that ongoing communication and feedback is vital. If it does not happen, not only will my credibility be lost, but also the credibility of any further palagi researchers endeavouring to improve the health of Pacific people.

3.21.i Participant Feedback

At the individual level, I have returned the individual transcripts to interviewees. They have been able to check them for correctness and make any comments. In one case, I was not able

to arrange a meeting with the participant and had to return the transcript in a sealed envelope using a steering committee member as an intermediary.

3.21.ii Community Feedback

When I spoke to the Tokelauan community meeting, I outlined the study and promised to return to tell them the findings when I had completed my work. They voted to approve my research and it will be essential to keep my word and return to another meeting to detail my findings and any implications.

- I will first attend another meeting of the steering committee and present my results to the members and receive their feedback.
- I will subsequently provide results to a full community meeting and answer any questions that members might have.
- I also intend to discuss any proposed publication or presentation of the study with the community and obtain their prior consent.

3.22 Data Analysis Theory

Malterud writing in the Lancet (110) identifies three different methods that are important in the analysis of qualitative research. These are:

- Immersion Crystallisation
- Editing-based Analysis which has its foundation in Grounded Theory
- Template-based Analysis

3.22.i Immersion Crystallisation

In Immersion Crystallisation, the researcher immerses him or herself totally into the subject being studied. The researcher reads the qualitative interviews slowly a number of times over several days, looking for important themes and reflecting on the findings. During interviews, the researcher carefully observes the subjects he or she is studying. With time, there is an 'intuitive crystallisation of meaning.'(111)

In their chapter on Immersion Crystallisation, Crabtree and Miller (112) discuss the need for this type of analysis to start during the preparation for the project – before any interviews take place. They say that a researcher has to have 'time and patience,' before he or she can

immerse him or herself successfully in data. The crystallisation of theories does not necessarily occur whilst the researcher is reading the interview transcriptions. It can happen at any time during the day or night as long as the researcher is keeping his or her mind 'open and receptive.'

3.22.ii Editing-Based Analysis

This is an analysis in which the researcher identifies similar units within the interview transcriptions and labels or codes them. He/she uses these units as a basis for re-organising the text so that the meaning can be seen more plainly.(110)

Spiggle (113) describes this type of analysis as one in which the researcher identifies chunks or 'passages of text' as 'belonging to, or representing an example of some more general phenomenon.' These chunks or 'categories' are given descriptive labels.

They are taken through a process of further interpretation and further selection into another rank of categories and codes. This process of looking for deeper properties and characteristics of categories continues and gradually during the analysis process there is the evolution of a new theory. This resultant new theory is a result of the 'interplay between data collection and analysis.'(114)

3.22.iii Template Based Analysis

The Grounded Theory and the coding format of the edited-based analysis is quite rigid in its application. Waring and Wainwright (115) feel that although template-based analysis does indeed have its origins in grounded theory, it is less restrictive. Whereas in the editing-based analysis, codes are developed as the data is analysed, template analysis allows the use of *a priori* codes in the analysis.

Crabtree and Miller (116) explains that the "initial codes are refined and modified during the analysis process."

King (111) says that codes can be identified in three different ways:

- A priori codes that are theory-based and determined before any data collection begins.
- Codes that are identified after some initial data analysis has taken place.

- An intermediate position –with some initial codes and further development after some data analysis.

Waring and Wainwright (115) feel that template-based analysis is good for analysing and identifying codes in "large volumes of texts." It enables multiple chunks of interview relating to one specific topic to be gathered in the same place in preparation for more interpretation.

3.22.iv General Inductive Approach To Analysis

Thomas (117) describes a variation of the analysis and coding system which he calls 'General Inductive Analysis.' He comments that it has been used successfully in both social and health sciences.

In this method

- The researcher reads the data multiple times and interprets it. This is what Thomas calls the *'inductive'* phase of the approach. He identifies the main topics, which need further investigation.
- The researcher develops a model that contains all the main topics and themes, which he has previously identified. These themes are described in the model as *'categories.'*
- The data is coded and analysed. The researcher has to prioritise the data according to its importance.
- Within each category there might be sub-topics.
- One segment of text can be coded into more than one category.

3.23 Data Analysis Tokelauan Study

I took a pragmatic approach to the analysis of data for this current study and used the most salient aspects of more than one method. The result was a thematic analysis that was consistent with the principles of Immersion Crystallisation and Grounded Theory but also of Template-Based Analysis and General Inductive Analysis.

I had the topic of *'depression'* to investigate before the study was developed and it proceeded with some preset questions about the topic. There were, therefore, some *a priori* ideas or

themes based on the research questions. During the interviews I was very open to the development of further unanticipated themes.(116)

After obtaining the full transcription of the interviews, I waited until I was assured of sufficient undisturbed time and read the text through slowly and carefully according to the protocol described by Crabtree and Miller for Immersion Crystallisation.(112)

After reading the text a number of times, I then searched for main themes. Some of the large obvious themes were indeed related to the a priori ideas I had initially but others developed de novo. I grouped together all the passages of text that had the same theme in one electronic folder. I repeated this process for each interview. As a result of this process I identified 13 categories. I went through all the categories, further analysed all the quotations and allocated sub codes to each of them. I then prioritised the sub codes according to their importance (117) and performed further analysis, reporting on those with most relevance to this study.

3.24 Pacific Research Protocol

The University of Otago Pacific Research Protocol was introduced after the study began. However the design of the study aligned itself with the broad principles as laid out in the protocol. The Methods chapter has detailed full consultation with the local community and how advice was obtained from a local steering committee. The committee will also ensure that feedback to the community occurs in a culturally appropriate manner and will advise in the further consultation that takes place before there is any publication or conference presentation.

3.25 Ethics Approval

Ethics Approval was sought from the Northern Y Ethics Committee in Hamilton. The steering committee in Taupo supported the application by sending a letter of support. A copy of this letter and a copy of the ethics approval letter are included in the appendix.

CHAPTER FOUR
RESULTS

4.1 Introduction

In this chapter I present the results of the thematic analysis of the interviews with the Tokelauans who participated in the study.

The results are presented in themes, which correspond to the research questions that guided the entire project. I start with the issue of whether 'depression' or the equivalent is recognised by the participants. I then progress to the signs and symptoms of this equivalent illness, its causes, management and the gender differences in the presentation.

SECTION ONE
NAMING 'DEPRESSION' IN THE TOKELAUAN CULTURE

4.2 Does the Illness Exist?

In this section I present evidence that there is an illness in the Tokelauan culture where the affected person becomes extremely sad and displays the symptoms seen in the palagi condition of 'depression.' The quotes below show that most interviewees affirmed the presence of the illness and only two participants did not think it existed.

> *I do understand that people do suffer from not being happy or sad.* (Female 40-45 yrs, 43 years in NZ)
>
> *In the olden days there wasn't any illness like that. But nowadays it is.* (Male 55-60 yrs, 36 years in NZ)
>
> *I think people have been like that.* (Female 25-30 yrs, 25 years in NZ)
>
> *I am sure there is. I am sure there is illness like that in the Tokelauan culture. As we live here in New Zealand, we have seen comparing our people to the palagi people and I am sure there is an illness like that in our culture.* (Female 60-65 yrs, 61 years in NZ)

> *From my point of view I think depression is there in Tokelau.* (Female 25-30 yrs, 4 years in NZ)
>
> *Me, myself, yes I do feel there is.* (Male 35-40 yrs, 4 years in NZ)
>
> *I believe there is – as what my Mum says most of the kids do suicide and apparently it comes from depression and stuff.* (Male 35-40 yrs, 4 years in NZ)
>
> *I thinks so. We are human, even the Tokelauan. There is a sickness. A lot of Tokelau went through a lot of difficulties within the family and there is a lot of confusion. Yeah, yes there is a lot of – there is a disease depression in Tokelau.* (Male 45-50 yrs, 8 years in NZ)

One of the participants who answered that there was not such an illness was in fact very unsure.

> *Not that I know of. I don't really know but you can see like especially the young ones and some old people, like they got that depression but we got no word for that. I have no idea, we can't see if it is an illness or just, they just can't – I don't know what to say.* (Female 30-35 yrs, 1 month in NZ)

And only one interviewee gave a definite answer that the illness did *not* exist.

> *Not really – They don't talk about that.* (Male 55-60 yrs, 40 years in NZ)

These quotes establish the fact at the start of these results that an illness characterised by extraordinary sadness does exist in the Tokelauan culture. All further results follow on from this finding.

4.3 Naming The Illness

Although the Tokelauan language has a word for 'having sadness' (*fakanoanoa)* and a term for 'he is sad,' (*he fiafia*) it was unclear as to whether there was a term in common usage that was the equivalent of the palagi word 'depression.'

In this section I present the findings from the interviews of the terminology that participants assign to an illness that involves extraordinary sadness.

My analysis suggests that there is no name for an illness that is equivalent to depression and furthermore, some members of the Tokelauan community do not even acknowledge the existence of the illness. Similarly, sadness is covered under the umbrella term of unwellness

and extraordinary sadness is just part of life. I conclude with the views of participants who used the word for a ‘burden’ to describe depression.

4.3.i No Word For Depression

None of the interviewees was able to tell me a Tokelauan word that identified an illness exactly equivalent to depression in the palagi culture. Many participants then went on to give their thoughts on how extraordinary sadness fitted into the Tokelauan culture. Some had Tokelauan words, which they felt were appropriate to describe the condition but there was not any consensus.

Four out of the 10 participants were quite definite and specifically stated that such a word did not exist. As the quote below demonstrates, one of these went on to say that the community did not acknowledge illnesses such as this. He said that a person who stopped work and became withdrawn would be more likely to be regarded as lazy rather than being recognised as having an illness.

Another person noted that other Pacific cultures similarly did not have a word for depression and gave examples of the Samoan and Tongan languages as examples.

> *there is no word for it.* (Female 25-30 yrs, 25 years in NZ)

> *As we said, you know back home in the island, we never heard of any depression like this aye?* (Male 45-50 yrs, 4 years in NZ)

> *but you can see like especially the young ones and some old people, like they got that depression but we got no word for that. I have no idea, we can’t see if it is an illness or just, they just can’t – I don’t know what to say. Oh yeah, we got no word for that depression, Tokelau word.* (Female 30-35 yrs, 1 month in NZ)

> *I think people have been like that but I don’t think they have acknowledged it as an illness. I think some people are saying that it is laziness or, yeah, or that they are too shy to come out of their room or too shy to acknowledge people. But really I think that it is the sadness that is making them not be open or the sadness they are going through is making them not be open to other people.* (Female 25-30 yrs, 4 years in NZ)

> *There is no word in the Samoan culture for depression or cancer, or the Tongan or the Maori. I was even talking to someone in Turangi about whether they have a word for depression – no, no. It is just mamai which is sore or unwell.* (Female 40-45 yrs, 43 years in NZ)

4.3.ii Depression is just 'Part of Life'

When asked about an illness involving sadness, one participant said that the Tokelauan culture did not treat sadness in any special way. He did not feel that the culture treated it as an illness at all and said that as an emotion sadness was no different from happiness – it was just '*part of life*.'

He was aware that specific signs characterised the illness 'depression' in the palagi culture. However in the Tokelauan culture they did not see these signs as characteristic of a disease. There was no classification of sadness that transformed it into *'depression'*. Respondents expressed an understanding that there are situations that result in the experience of happiness and sadness. One participant quoted below suggests that it is only when a person talks about suicide and the palagi word depression that they become aware that their sadness is extra-ordinary. *"They don't talk about that."* To them he fiafia and happy are all part of life.

> *They don't look at it as a sickness is what I am talking about. You know, they don't look at it as sickness, it is all part of their life growing up.* (Male 55-60 yrs, 40 years in NZ)
>
> *It is part of life, oh he is sad, there must be something wrong, or they very happy there must be something that makes them happy.* (Male 55-60 yrs, 40 years in NZ)
>
> *I am thinking of the word 'depression'. We never talk about a word depression but when somebody is sad, sometimes it takes a while for them to know what is the sign – the sign, when you talk about suicide and depression, you know in the pakeha sense of the word, there is always a sign that tells you there is something wrong with this person, but in our culture when somebody is sad, we just call it sad, or if somebody sad, there must be something wrong with him. But, they don't classify this as something, you know, 'this person is depressed', 'this person is sad', you know.* (Male 55-60 yrs, 40 years in NZ)

4.3.iii 'He malohi' or 'Unwell'

The Tokelauan language has an expression *'he malohi'* that simply means 'sick' or 'unwell.' It is a non-specific phrase that encompasses all illness from the flu through to cancer. Just as one participant said that sadness was "part of life," similarly, another three interviewees said it was just a form of unwellness or 'he malohi.' One of these participants noted the difference between 'sadness' when it was just 'unwellness' and 'sadness' when it became 'depression.' He noted that 'sadness' was something that improved whereas 'depression' went on and on. In daily life this is best illustrated by the sadness experienced during a grief reaction, which is generally self limiting and not usually long-lasting. Depression however can be much longer

in its time course unless therapeutic intervention occurs. Another interviewee used *'tauale'* rather than *'he malohi'* as a word to describe unwellness.

> *I do understand that people do suffer from not being happy or sad and depending on what happens in their families I would know that they would all just call it 'unwell' in the palagi version – there would be no specific name for an illness but unwellness.* (Female 40-45 yrs, 43 years in NZ)
>
> *I don't know a Tokelauan word for it. You know, even if you have got the flu or if you have got the asthma, there is a Tokelauan word for every sickness 'he malohi.' Yeah. It mean if you are really sick or you just got the flu, we just say 'he malohi'.* (Male 55-60 yrs, 36 years in NZ)
>
> *The difference is you know if you are sad, it takes a week, three or four days and you get over it, your sadness. But depression is carry on, you know.* (Male 55-60 yrs, 36 years in NZ)
>
> *Yes, I can only think of, like at the moment I can only think of tauale – which is sick.* (Female 25-30 yrs, 25 years in NZ)
>
> *Yeah, unwell, not themselves........that's another word for it.* (Female 25-30 yrs, 25 years in NZ)

The Tokelauan culture has similar features to other Polynesian cultures and one interviewee identified another feature. She noted that Maori also have a universal word – mamai for unwellness, which covers depression as well.

> *I was even talking to someone in Turangi about whether they have a word for depression [in Maori] – no, no. It is just mamai which is sore or unwell.* (Female 40-45 yrs, 43 years in NZ)

4.3.iv 'FITA' or A BURDEN or EXHAUSTING

I asked participants to be explicit in describing the signs of sadness that is extra-ordinary from sadness that is relatively self-limiting.

When palagi patients suffer from the illness 'depression,' they will often feel tired and lacking in energy. Everything seems an effort and they often seem weighed down by the responsibilities of life.

These palagi symptoms fitted in well with two participants who described depression using the word *'fita.'* The syllable "ita" was given to me as meaning more or too much and when the consonant "f" is added, the word "fita" can mean tired, heavy, exhausting or a burden.

A third interviewee, whilst not using the Tokelauan word 'fita' – still used the analogy heavy and overloaded to describe depression.

> *I was thinking of the word 'fita' People used to say 'fita' - - - - 'fita' is sort of like a burden but not – 'fita' is a word they can say whenever they want to say it, you know? But 'fitaga' that means something that you are not very happy of and something that you are worrying about.* (Female 60-65 yrs, 61 years in NZ)
>
> *The other word in Tokelauan for tired is fita and you know people in their everyday lives "Oh fita" I am tired, and probably not physically but it is just a word that they sort of hang on to. Tired from doing this and doing this and it could be that it doesn't go deep down but at least they expressing it. You know, I am tired, it could even be to the extent of depression, who knows, but they are admitting it, aye.* (Male 45-50 yrs, 4 years in NZ)
>
> *I can't help explain the word in Tokelauan but hopefully someone will come up with the word in Tokelauan for depression but depression to me, in English I understand, is had enough, too much, overloaded, disadvantage, no money, left out there, nobody to help.* (Male 55-60 yrs, 46 years in NZ)

4.3.v Summary

In this section the evidence has shown that an illness in which a person becomes extremely sad, does exist in the Tokelauan culture. Evidence was also presented which showed that none of the interviewees could give a specific Tokelauan word for an illness with the clinical features of depression.

Some participants suggested that some community members did not acknowledge extraordinary sadness as an illness and another participant said the Tokelauan culture treated sadness as part of life in the same way as happiness.

Participants used two different words to describe depression. Although these were quite different they were all logical. They showed recognition of sadness as unwellness (*he malohi*) and of the symptoms of depression as being tiredness and a feeling of a heavy exhausting burden (*fita*).

SECTION TWO
SYMPTOMS AND SIGNS OF DEPRESSION IN THE TOKELAUAN CULTURE

4.4 Symptoms

Because I strongly suspected from my clinical work with local Tokelauans that there was no word for 'depression' in the Tokelauan language, I avoided using the term during the interviews. I elected instead to talk about an illness in which someone became intensely or extremely sad.

In this section I present the two main symptoms that were prominent in the answers given during the interviews. These were isolation and sadness.

I also present other symptoms described by participants who had personal experience of an illness involving intense and extra-ordinary sadness.

4.4.i Isolation

In a depressive illness patients often become withdrawn. The quotations below show that isolation was a recognized and important feature of an illness involving extra-ordinary sadness amongst the Tokelauan people.

Typical descriptions of the withdrawal were of the person physically locking him or herself away in the bedroom or shutting the family out emotionally and becoming non-communicative.

The withdrawal not only involved the person becoming isolated from the family but also involved a withdrawal from the community and its social activities.

This was an obvious event as the Tokelauan culture is centred round its local community and a sustained absence by an individual very quickly becomes obvious.

> *But when I am feeling down I just lock myself in my room, tell everyone I am not home or just don't answer the phone.* (Female 25-30 yrs, 25 years in NZ)

if everyone is home you just go lock yourself in the room. (Female 30-35 yrs, 1 month in NZ)

You don't want to go anywhere, you just shut everybody out and that's about it. (Male 55-60 yrs, 36 years in NZ)

We laugh and share, you know, but people – when you don't see a person who usually goes to the hall for those gathering, that they don't feel like coming to the hall anymore. They stay home. (Female 60-65 yrs, 61 years in NZ)

I didn't see him for, like, ages. He hide himself from people. (Female 25-30 yrs, 4 years in NZ)

Some interviewees also described other symptoms that are typically found in a depressive illness. For example, a depressed man often presents with loss of temper and one interviewee described a sad person who displayed anger along with isolation.

Other participants described people losing weight, having sleep disturbance, lack of morning motivation and loss of optimism.

he is not happy, he is not normal like before, aye? He could easily get angry. He doesn't want to be involved with other people. He want to be by himself, by herself and he started to think that he is not supposed to do – make – start not to come to the family. (Male 45-50 yrs, 8 years in NZ)

It makes people down-hearted, withdrawn, lose weight, lose sense, you know? (Male 45-50 yrs, 4 years in NZ)

I can't sleep and in the morning I don't want to get up. (Female 25-30 yrs, 25 years in NZ)

4.4.ii Sadness

In a depressive illness a key symptom is sadness or melancholy that is not resolving over a period of two weeks.

In the interviews, all participants confirmed sustained or unresolved sadness as a symptom of someone with such an illness. The representative quotes below are both from interviewees who had recognised sadness in other members of the community who had been ill and also quotes from participants who had subjectively experienced such an illness themselves.

Interviewees described a range of sadness that varied from slight unhappiness to a deep misery.

> *I know somebody's depression, is depressed when he is not talking, he is not happy, he is not normal like before, aye?* (Male 45-50 yrs, 8 years in NZ)
>
> *there is sadness there.* (Male 45-50 yrs, 8 years in NZ)
>
> *Very quiet, very quiet. Doesn't say much and sometimes is a bit teary.* (Male 55-60 yrs, 40 years in NZ)
>
> *very sad, that it is obviously not him any more.* (Male 55-60 yrs, 40 years in NZ)
>
> *I feel empty. I feel not worthy, - - - - -Very sad.* (Male 55-60 yrs, 36 years in NZ)
>
> *but I just cried, cried and cried like if I am angry with someone or a partner or family – I just don't want to see them anymore.* (Female 30-35 yrs, 1 month in NZ)

4.4.iii Summary

These findings suggest that depression in a Tokelauan person presented with many common symptoms including disturbed sleep pattern, loss of motivation, irritability and weight loss (loss of appetite). However the symptoms of sadness, isolation and withdrawal from family and community activities were much more frequent than other symptoms – perhaps because these were the most noticeable in a group characterised by a strong sense of community. Whilst sadness is an essential symptom in the diagnosis of depression, finding the predominance of isolation and withdrawal in the Tokelauan cultural group is significant.

4.5 Signs

One aim of the study was to try and identify what were the signs of a depressive illness specific to the Tokelauan culture. I investigated this by asking participants how they would know if someone had the illness.

In this section I present the main signs that interviewees associated with a person who was very sad.

The results confirmed objective signs of isolation and marked changes in behaviour. They also showed an association of sadness with increased alcohol use, particularly by men.

The quotes from the interviews demonstrate that sometimes the presence of the illness was so well hidden that there were not any signs at all. This is dealt with fully in Sections 4.8 and 4.9

of the results. The tendency of a sad person to isolate himself also made detection of signs difficult.

> *Unless we have a relationship with that person, no we would never know. We would honestly never know.* (Female 40-45 yrs, 43 years in NZ)

> *He hide himself from people but when I see him around he seems happy.* (Female 25-30 yrs, 4 years in NZ)

Some participants had observed behavioural changes in Tokelauans with extraordinary sadness. Occasionally I felt that their descriptions of this behaviour had features of psychosis such as talking to himself.

> *with our cultures there are signs, maybe talking to himself, or never going to work, this are the signs.* (Male 55-60 yrs, 46 years in NZ)

> *Oh that fellow maybe having a bit of problems eh" "Why? 'cause he talking to himself or singing. That sort of sign.* (Male 55-60 yrs, 46 years in NZ)

> *time she would be just sitting there and then all of a sudden mutter under her breath like she was talking to someone else.* (Female 40-45 yrs, 43 years in NZ)

> *They suddenly saw those signs, they never saw it coming. But they said "I wonder why his behaviour was starting to be like that? - - - - he behaved strangely you know, he was sort of – cut himself out of the circle of families.* (Male 55-60 yrs, 40 years in NZ)

> *you can tell by the way he is acting, you know. If you ask him a question he doesn't really talk to you he just distance himself or herself away from the family and that is how you know he has got that illness.* (Male 55-60 yrs, 36 years in NZ)

One interviewee described behaviour in a sad person that bordered on psychotic.

> *then all of a sudden mutter under her breath like she was talking to someone else.* (Male 55-60 yrs, 46 years in NZ)

4.5.i Increased Alcohol Use

This section presents the use of alcohol as a sign that someone is sad. It notes an association of alcohol with violence back in Tokelau. The section also reports association of recreational drug use with sadness.

Five participants in the study spoke of increased alcohol use in Tokelauans with sadness. Men seemed more likely to be seen using alcohol when in a state of melancholy but it was a sign also seen in women.

One interviewee described how people with sadness sought solace in their drinking while another spoke of how the sad person drank, thinking he was making it easier to hide his illness from others.

> *It is not many of us but we do have people you know when they sad they go to a bottle aye?* (Male 55-60 yrs, 40 years in NZ)
>
> *they keep on drinking as if the alcohol will bring a mask to you to hide.* (Male 45-50 yrs, 4 years in NZ)

Another participant in the study said that some men with sadness only talked about their feelings when they had been drinking.

> *I think that is the only time it comes out. When he is drunk and then, um, everything comes out*. (Male 20-25 yrs, 4 years in NZ)
>
> *You can never bring it out in a man when he is sober.* (Male 20-25 yrs, 4 years in NZ)

One interviewee made the association between alcohol and violence in a person with sadness.

> *When I went to the Island, yep. Because of alcohol – they drink all night and all day. Smack the kids, even the wife. And before I came they stop bringing alcohol back to the Island, especially where I come from, they stop now*. (Male 55-60 yrs, 36 years in NZ)
>
> *or having a beer or drinking and then he always causing a lot of trouble, damaging the hall or having a fight.* (Male 55-60 yrs, 46 years in NZ)

Recreational drugs were mentioned by three interviewees along with alcohol when talking about what they might see in people who were sad. However none of the participants suggested that recreational drugs were a major problem.

> *well here you are maybe having the chance to access to having a bit of a smoke I suppose or having a beer or drinking.* (Male 55-60 yrs, 46 years in NZ)
>
> *so it got to the point where either drugs or alcohol was frying his brain.* (Female 40-45 yrs, 43 years in NZ)
>
> *They find they drug up and I am pretty sure they boys in Auckland they into marijuana but not so much.* (Male 55-60 yrs, 40 years in NZ)
>
> *but I am haven't come across anybody that drugs is a problem. There are probably a few who do smoke the old dope.* (Male 55-60 yrs, 40 years in NZ)

4.5.ii Summary

This section looked at the objective signs that interviewees associated with a person who had an illness involving extraordinary sadness. It showed the difficulty of discerning signs, either because a person isolates him or herself or because he hides the sadness so well.

Participants commonly reported changes in behaviour. These included withdrawal and isolation, missing work and more psychotic type signs of the person talking to himself.

Four out of ten participants had also noticed that some sad people drink more alcohol. This occurred more often in men, who reportedly were more likely to share their feelings when drunk. Alcohol was seen being used for consolation and also to try and ‘hide’ sadness from other people. Some interviewees noted that violence could occur when people were drunk but one report of this referred to an incident back in Tokelau.

Occasionally drugs were observed being used by people with sadness but it was not regarded as a major problem.

SECTION THREE

CHALLENGE OF RECOGNISING A DEPRESSED TOKELAUAN

4.6 Introduction

When participants in the study were asked how they recognised someone who was sad, almost without exception they responded by saying that very often they were not able to. Two themes became apparent; firstly that sadness was often kept hidden and secondly, maintaining a smiling face – even if it was a mask- was culturally very important within the Tokelauan community. In addition to a lack of lexicon for depression, these two factors were a barrier to the recognition of depression.

I also present evidence from the interviews showing that sometimes an illness where someone is intensely sad is not recognised within the Tokelauan community.

4.7 Not Recognised As Illness In Community

The following quotations further illustrate that interviewees felt that the community did not know about 'depression' and did not recognise a 'sad' person as having an illness. One participant said that when the diagnosis of *depression* was made, it was unlikely to be given serious consideration by the community.

> *But if you say 'depression' to anyone in our culture, they won't take it seriously.* (Female 25-30 yrs, 25 years in NZ)

Another person described a sad person who had taken his own life. He felt something could have been done if the sadness had been recognised as an illness by the community.

> *people ask them "Why did he pass away" and the only answer they gave was he was so stressed out but I think they didn't know that depression is a sickness aye, so if only they knew about it they would have done something.* (Female 25-30 yrs, 25 years in NZ)

One participant said that when the diagnosis of *depression* was made, the patient was unlikely to take it seriously and seek help.

you never hear of a Tokelauan going to see a counsellor, for getting depressed. They never go and look for those help within the community. (Male 55-60 yrs, 40 years in NZ)

4.8 'Keep It Hidden'

In this section I present evidence showing that Tokelauans affected by extraordinary sadness tended to hide their feelings and emotions, trying not to worry family and friends. The quotes showed the difficulty family and community members had in recognising extraordinary sadness – even when it was so severe that the person was considering suicide.

The quotes in this section also show that participants considered pride and privacy to be important characteristics in the Tokelauan culture. As a result, feelings and emotions were internalised and hidden from other people so that no one else knew that a problem existed. The evidence will show how that this made recognition of 'depression' very difficult.

I just can't say to anybody oh I feel sad today, you know. And they don't even know that I am sad. In my own self I just keep it to myself, you know. (Male 55-60 yrs, 36 years in NZ)

That's why it is so hard for us to see the sign of somebody being depressed because they hide their feelings most of the time. (Male 55-60 yrs, 40 years in NZ)

Participants in the study spoke of the *'privacy'* that is very important to the Tokelauan. One interviewee said it is no one else's business to know about what is happening in his/her life unless he/she decides to let them know.

So if I kept something inside me, people don't know that I got problems and you know things going on in my life unless I let them know and if I don't want someone to know what is going on in my life, why should I? (Female 30-35 yrs, 1 month in NZ)

One interviewee explained that this characteristic of *privacy* meant that Tokelauans keep their thoughts very much to themselves. Even if someone says something that is quite hurtful, the recipient hides his or her responses and emotions.

people can say whatever they want to say without realising they are hurting other people and mostly we keep it in ourselves without telling them back. (Female 60-65 yrs, 61 years in NZ)

They also tried to stay polite at all times even if they were being hurt emotionally. Nothing would be said out loud. It was regarded as rude to speak feelings and show sadness no matter how bad the situation.

> *mostly we keep it in ourselves without telling them back, you know uttering back and say things that we want to say, because I think we are more, sort of, polite! I think when you answer back you are not polite – you know?* (Female 60-65 yrs, 61 years in NZ)

The privacy of the Tokelauan and the hiding of emotions made it very difficult for others to detect depression. Interviewees spoke of how difficult it was to detect sadness in a person who was hiding his feelings.

> *I never saw anything different.* (Female 40-45 yrs, 43 years in NZ)

This hiding of feelings meant that emotions were constantly bottled up and one interviewee recognised this. This quote from the interview showed how a member of the community could be almost at the end of his tether but still be very successfully hiding his feelings.

> *I mean you see people really ready to explode but they good at hiding those symptoms aye?* (Male 55-60 yrs, 40 years in NZ)

A person with depression does sometimes develop physical symptoms during the course of the illness. One interviewee commented that unless *he malohi* or such evidence of physical unwellness was noticed, no one would have any suspicions that the person was hiding feelings of sadness.

The Tokelauans have regular monthly community meetings but they are not often enough to be able to detect subtle changes in mood.

> *But it is very rare in our culture to be able to say "I am unwell" unless we actually physically see signs of unwellness in their moods or if we see them consistently, you know once a month is not consistent enough for us to be able to notice a change.* (Female 40-45 yrs, 43 years in NZ)

Friends and relatives also found it difficult to communicate with a person who was hiding his feelings. One participant compared the situation with the well-recognised symptoms of respiratory illnesses where everyone immediately understood the issue. However in the case of sadness it was almost impossible to get to the source of the problem. They might realise a person was feeling sad but find it almost impossible to get him to talk about it.

> *You know if somebody is sick with the flu, you know straight away the symptoms of coughing, tight throat and all that but, - - - - I mean you know someone is sad but try and get it out.* (Male 55-60 yrs, 40 years in NZ)

Even when a person committed suicide, his or her sadness often remained hidden until the end. A participant said that members of the community just did not realise someone was sad and never suspected suicide was a possibility. Afterwards there was the awful comprehension as to the true nature of the depressive illness that had evolved in their midst.

> *But they said "I wonder why his behaviour was starting to be like that? - - - -Oh that was why". ...He was probably trying to tell us something.... They never saw those signs.* (Male 55-60 yrs, 40 years in NZ)

One interviewee said the parents of young Tokelauans who killed themselves often had no idea their child was suffering from sadness. The suicide therefore came as a total shock and without any warning at all.

> *mum and dad never saw it coming.* (Male 55-60 yrs, 40 years in NZ)

The family is very important to all Tokelauans and even when depressed, the sick person does not want to worry his family. One interviewee said that a person who is feeling sad might hide his feelings from his family in order to prevent distress and concern being felt by his relatives.

> *if they see me in that way then they will think there is something really wrong so I don't want them to worry about it.* (Female 25-30 yrs, 25 years in NZ)

The characteristic of 'pride' is also important here. The ill person may also want to maintain the image the family has always had of him/her rather than admitting that he/she is feeling sad.

> *well for me I don't like showing it to my family and stuff because I kind of feel they don't see me in that way.* (Female 25-30 yrs, 25 years in NZ)

In a similar way the family might hide the fact that a member is sad from the rest of the community. This maintains pride and prevents loss of face.

> *Oh the family, I think to save face, I think they would keep it in the family as a secret or something. I think my family hasn't told anyone.* (Female 25-30 yrs, 4 years in NZ)

4.8.i Summary

This section showed how ‘pride’ and ‘privacy’ are important Tokelauan characteristics. There is also a very high degree of shame associated with extra-ordinary sadness. The interview responses demonstrate how successfully the depressed Tokelauan hides his feelings and his emotions. Detection of sadness is extremely difficult even for close family and friends and suicidal thoughts might sometimes be unexpressed before they are actioned.

4.9 Mask of the Smiling Tokelauan

The results presented in the previous section demonstrated that it was considered normal for the Tokelauan to hide sadness and to keep feelings to him or herself. In this section I present results that show that sad feelings are hidden behind a smile that is learnt from childhood and is part of the Tokelauan culture.

Many participants said that a Tokelauan who was unhappy would almost always continue to smile. They acknowledged how this smiling was often false and a pretense – put on so that other people would think everything was fine and remain unaware of the problem.

> *she was never sad – she was always happy when we were talking. (Female 40-45 yrs, 43 years in NZ)*

> *Tokelau people always like smile and like I said they sometimes pretend like, they have to smile every time so people can see oh everything is alright.* (Female 30-35 yrs, 1 month in NZ)

One respondent spoke of a family member saying how difficult it was to tell what the true feelings were when the person was smiling all the time.

> *you can’t really tell someone who is sad because like I said they can still smile.* (Female 35-40 yrs, 4 years in NZ)

Interviewees described this smiling mask was one of the tools an ill person used to hide sad feelings from the family. Another participant commented however, that the happy mask sometimes did not stay on very long.

> *So, every time we used to see her when we went down to Wellington, she would have this mask of being happy.* (Female 40-45 yrs, 43 years in NZ)

> *a happy mask but it doesn’t stay long, you know.* (Male 55-60 yrs, 36 years in NZ)

Another interviewee acknowledged that the smiling was false and likened it to a form of dishonesty.

> *there is like the word 'pepelo' which means 'lying' as in not being your true self.* (Female 25-30 yrs, 25 years in NZ)

Some interviewees described how they continued to smile no matter how strongly they felt about a subject – even to the extent of bottling up quite violent feelings. It was always possible to bring a smile onto their face no matter how they felt inside.

> *the way your parents say stuff like, to be happy all the time, so sort of like, so it is sort of like a daily thing to a Tokelauan, even if you are mad you can still smile, so you can't really tell if that person is mad or that person is happy*. (Female 35-40 yrs, 4 years in NZ)

> *even if you are distressed with something but you still pull up your face, you know you can still smile. But I know it is right that you can't really tell someone who is sad because like I said they can still smile.* (Female 35-40 yrs, 4 years in NZ)

One participant described how happiness and smiling was important and expected as part of the Tokelauan culture.

> *like it is not in our culture to be depressed or, like, we always got to be happy and make others happy.* (Female 25-30 yrs, 25 years in NZ)

Another participant explained that happiness and smiling is a cultural characteristic that is taught early to all Tokelauan children.

> *it is just that being brought up as a Tokelauan, you know, the way your parents say stuff like, to be happy all the time, so sort of like.* (Female 35-40 yrs, 4 years in NZ)

I explored why this smiling was so important in the Tokelauan culture.

One participant explained that the principles of *"politeness and respect"* were the foundations on which the external happiness and smiling face was based. This respect for other people meant that sadness was kept inside and only happiness and a smile were portrayed.

> *Yeah, there is a something that the Tokelauan is trying to hide, aye? They respect, they try to show respect by trying to smile even though they are unhappy inside.* (Male 45-50 yrs, 8 years in NZ)

> *"You know the Tokelauan they are very polite, they try to show respect but when they are depressed I think - - - it cause of a lot pressure.* (Male 45-50 yrs, 8 years in NZ)

One interviewee told how the happy front could also prevent family and close friends from appreciating a person's true feelings and emotions.

> *you can't really tell someone who is sad because like I said they can still smile.* (Female 35-40 yrs, 4 years in NZ)

I asked participants whether the false smile was always successful in deceiving other people or whether sometimes other members of the Tokelauan community could tell that a person was just pretending to be happy.

At least two interviewees said that it was sometimes possible to tell that the smile was not genuine.

> *Some people they keep it to themself. They won't say, they can smile but you can tell that their smile is not the same.* (Female 60-65 yrs, 61 years in NZ)

> *In our culture we can know, they enjoy, we say things to make other people laugh. We talk and laugh and – but some people they laugh together with us but you can tell by the look on their face there is something wrong. They are not the same.* (Female 60-65 yrs, 61 years in NZ)

4.9.i Summary

This section presented findings that show that culturally the Tokelauan grows up encouraged to keep emotions such as sadness and anger to him or herself and to always portray a smiling happy face. When the Tokelauan develops a depressive illness, this front of happiness becomes a mask that can make detection of sadness very difficult, even for close friends and relatives.

SECTION FOUR
THE CAUSES OF DEPRESSION IN THE TOKELAUAN CULTURE

4.10 Cultural Clash

In the first section I identify the main causes of the illness that participants described as extraordinary sadness. Participants placed the causes of extraordinary sadness within the context of colonisation and its sequelae. An idealised image of a carefree life in a subsistence economy was juxtaposed with the pressures of making a living in a capitalist economy and the differing cultural expectations of Tokelauan and palagi societies.

Many participants described Tokelau as a country where life was free of worries. Food was free and people did not have financial concerns. It was a community where everybody knew and cared for one another.

> *In Tokelau you don't have to worry about anything. You survive on whatever you can get on the island. You don't need to worry about money. Everything is there for you. – you can get whatever you want without worrying about tomorrow – oh how can I feed my children? How can I pay the bill?* (Female 60-65 yrs, 61 years in NZ)

> *You don't have to worry about anything. And people, they know everybody. - - - - - There is no burden you know, everybody is happy.* (Female 60-65 yrs, 61 years in NZ)

One interviewee described Tokelau as it used to be when there was no monetary system as such and no official employment. Work was communal and performed for the village good. He contrasted that with the life that immigrants experienced today where employment was essential in order to put the family meal on the table. As a result people were often short of money and grumbled that they did not have sufficient food.

> *You know in the olden days, its a free life back in the Islands. You don't have to work, you don't have to earn money to catch your living. We are living off the land and the sea but nowadays they got work over there, you know. You have to go to work to look after your family.* (Male 55-60 yrs, 36 years in NZ)

The same person talked of food back in Tokelau saying it was obtained from local natural resources and was free. If a man wanted a fish he paddled out in his canoe and caught one. If he wanted a coconut, he paddled to an island and obtained one. The Tokelauan man

was seen as fit and strong. He again contrasted that with the modern-day fisherman who used motorised propulsion and did not maintain the same fitness.

> *If you don't go to work you don't get any money to buy some food you know. But the olden days you just go out to the outlets and bring some coconut or whatever to feed the family.* (Male 55-60 yrs, 36 years in NZ)

> *I remember when I grew up as a kid you know the people were strong as, they exercise, do lifting, lifting the bag of coconut from the island, that's exercise. But nowadays they just jump on outboard motor and the boat back to the island where they get the coconuts but the olden days they used to paddle, all the way to the island to get the coconuts. That's exercise. That's how I feel that's what the illness comes from, aye?* (Male 55-60 yrs, 36 years in NZ)

> *plus the olden days if you look at old picture of the old people they are strong, man, and if you look at the generation now back at the Island they are fat and lazy.* (Male 55-60 yrs, 36 years in NZ)

Another participant described the custom of looking after one another back home in Tokelau. Food used to be distributed and material goods shared amongst relatives within this subsistence economy. However that custom is threatened in New Zealand by the materialism where everybody is expected to pay for everything even if it is obtained from family. Responsibilities and obligations to relatives have changed.

> *Yeah it is mainly money because you don't have a good budget with money that's when problems started, because money is not a cultural thing to us. Back in the days you can give some food for free to your families to your relatives and stuff, but nowadays there is a lot of change. You have to pay and then you get some stuff, you know even if they your relative and stuff.* (Female 35-40 yrs, 4 years in NZ)

Two people being interviewed described the clash of generations occurring in Tokelau as a "sickness." The younger people are learning palagi values on a daily basis from television and eating western-style food. Their parents are continuing to try and preserve traditional ways in the bringing up of their children. He described how they try to teach respect towards the older people and towards the community in general as well as the cultural values that have existed for many generations.

> *the new generation had some new ideas. They try to think of the palagi ways or the new ways. They watch a lot of TV, they eat food from the outside world, not from Tokelau. They watch a lot of TV, I think there is a sickness in the Tokelau and when the cultures, the different cultures clash, there is confusion. You know that the parents try very hard to bring up their children to look up at the family, to also the community but it is very hard aye, it is very hard.* (Male 45-50 yrs, 8 years in NZ)

There is no respecting nowadays. That is the first thing our parents teach - us to respect – respect the old people, people older than you, but nowadays nothing respect in the islands anymore ...it changed, really changed. (Male 55-60 yrs, 36 years in NZ)

The same participant also described the influence people had on the Tokelauan culture when they returned to the islands, bringing western values, ideas and dietary ways with them. The children who returned with them were particularly keen to hold onto their western way of life and reluctant to adopt the traditional cultural thinking their parents attempted to teach them.

They are trying to learn how to live a normal life, aye and it is very hard. Especially the new way of life community, Tokelau, people from living outside coming to the island bringing the childrens, bringing new way of thinking to the island. The parents try to, you know, to live the old way of life and to teach their children. The childrens don't listen. Even though the parents start to listen to their children, instead of the children supposed to listen to the parents! (Male 45-50 yrs, 8 years in NZ)

The interviewee said that finally parents did not know which way was the right way and became confused as to how they should bring up their children. This resulted in an increase in family pressure and worry.

Confusion – the clash of the culture. Peer pressure. Not going in the right direction, aye. The parents, this is the way but then end up in a different way and this cause a lot of pressure. (Male 45-50 yrs, 8 years in NZ)

I think there is a lot of pressure in the family in Tokelau because they try to live their own life but there is also another different kind of life that come in and they trying to find out which one is the best one. (Male 45-50 yrs, 8 years in NZ)

4.10.i Summary

This section presented Tokelau as it used to be when food was free, everything was shared and worry and burden did not exist. There has since been a change to the lifestyle and culture to a system based on monetary values and working for pay. This section also records how traditional childrearing values have been challenged by palagi influences.

4.11 Changes and Stresses in New Zealand Causing Unhappiness

Tokelau islanders who made the move to New Zealand did so in the hope of a better life in the future.

For the Taupo Tokelauan community in 1966, the dream was for a new future after the devastation of a major cyclone. The new arrival in New Zealand looked to his or her new country for financial security and the promise of a good education and health for his or her family. The participants in the study told how the reality was often vastly different.

In this section the results show that Tokelauans who migrated to New Zealand arrived to a country that was very lonely and strange to them. The quotations from the interviews show that the culture and customs caused stresses which participants felt contributed to the development of illnesses involving extraordinary sadness.

Respondents noted the stresses caused by the different and much colder weather in New Zealand. Tokelauans often came to New Zealand without adequate clothing for the cold weather and obtaining warm clothes was very expensive and beyond the financial means of the recent arrival.

> *Because being in a new place, you know, a time like this of the year, you know the weather doesn't help! Feeling cold and you freeze your brain.* (Male 55-60 yrs, 40 years in NZ)

For many the language is completely different and New Zealanders are not good at making allowances for those who speak poor English. This language barrier was identified by at least two interviewees as causing unhappiness.

> *language barrier could be another (cause for unhappiness).* (Female 40-45 yrs, 43 years in NZ)

> *With me, like it (the sadness) started off when I was a kid and I couldn't speak English properly.* (Female 25-30 yrs, 25 years in NZ)

The same interviewee described the daunting task faced by Tokelauans who had to deal with the Inland Revenue Department and Work and Income – both bureaucratic government departments on a scale that is unknown in Tokelau.

> *Maybe people get this illness because, I mean, if they have had enough or perhaps someone just comes from the islands and they can't deal with having to deal with agencies like Work and Income or IRD, language barrier could be another.* (Female 40-45 yrs, 43 years in NZ)

One participant said that homesickness becomes a major problem for some Tokelauans settling in New Zealand. They miss their friends and relatives back in the islands and they

miss the island community in which they have lived for many years. Loneliness becomes a problem.

Faced with all this culture shock and loneliness, some Tokelauans even start to regret having decided to leave the islands at all but lack the finances to return home.

> *but getting into New Zealand can be a lonely place if you here by yourself and your wife.* (Male 55-60 yrs, 40 years in NZ)
>
> *But life over here can be hard sometimes and some families can be struggling and then suddenly hit bottom, hit the bottom and suddenly realise 'what am I doing in New Zealand?* (Male 55-60 yrs, 40 years in NZ)
>
> *can't go back home.* (Female 40-45 yrs, 43 years in NZ)

One person being interviewed explained how the New Zealand lifestyle is based on working for money and the constant need for employment caused ongoing stresses for many immigrant Tokelauans.

> *You know in the olden days, its a free life back in the Islands. You don't have to work, you don't have to earn money to catch your living. We are living off the land and the sea but nowadays they got work over there, you know. You have to go to work to look after your family. I am pretty sure that is why.* (Male 55-60 yrs, 36 years in NZ)

However far from being a land of plentiful jobs where the new arrival can easily earn money and have extra to send home to relatives, New Zealand has a high rate of unemployment. Jobs are hard to get and often the Tokelauan worker has to travel to find work.

The interviewees described the effect that western society and materialism had on the new arrival in New Zealand. They explained how families started to develop materialistic desires and started to want appliances, electronic items and all the goods for "modern living" that they had neither needed nor desired in the past.

> *I am pretty sure that is why and plus the modern days living, you know. Like those palagi food they bring to the Islands. There was nothing like that before.* (Male 55-60 yrs, 36 years in NZ)

Respondents told how families start to compare themselves with others and see what other people own and what other people are wearing. Jealousy and desire soon developed and produced more financial tension and stress.

for example you just came here and me and my husband lived here for how many years, we got a house but we not that rich aye, and here you are just came from Tokelau and got a nice job, your wife you live happy and get everything, so we start get jealous of yous aye? "Look they just came and they got that and everything, but look at us, we are not like that family". (Female 25-30 yrs, 4 years in NZ)

One interviewee said children can continue to put pressure on parents to buy them food and clothing. Also some people can become dissatisfied with their own situations and compare themselves with others who are more successful. Occasionally this can result in crime when there is no money to purchase goods.

It is not the kids it is the parents. The time they come home "Oh we want something to eat, there's nothing". So the next thing they do they have to go break the shop down town because they want something to buy. Especially the Islanders and Maori. I think that what causing that missing out. "Why he doing all right and we're not doing. Why is he doing alright but what about me?" (Male 55-60 yrs, 46 years in NZ)

One participant described the development of consumerism as the Tokelauans became established in New Zealand.

it is like people try to be competitive and that – they saw somebody having that thing, like new boat – "Oh I can get a new boat." (Male 45-50 yrs, 8 years in NZ)

Sort of trying to be better than the others but sometimes very hard. And this cause a lot of pressure and depression. (Male 45-50 yrs, 8 years in NZ)

Two participants described how children very quickly develop material desires as a result of peer pressures and pass this pressure onto their parents.

Cause the kids from the Islands they say, "can I get this" "can I get that?" (Male 20-25 yrs, 4 years in NZ)

One of these interviewees said that at school they see what other children have and demand to have it as well. Unfortunately, they do not have the financial maturity to think of the consequences of overspending.

growing up as a young boy I never eat chips or things to go to school but now the school as I heard, young girl and young boy going to school they say, "mum and dad give us some packet of chips" – that is part of their culture now going to school. (Male 55-60 yrs, 40 years in NZ)

and if they don't have that they cry. (Male 55-60 yrs, 40 years in NZ)

4.11.i Summary

This section describes the severe and often unexpected stresses faced by Tokelauans arriving in New Zealand. These ranged from climatic to dealing with significant cultural changes that affected the whole family. The development of materialistic attitudes by children added a new pressure.

Interviewees regarded the resultant anxieties and stresses as a major cause of illness involving extraordinary sadness in the immigrant Tokelauan.

4.12 Poverty and the Difference in Financial Pressures between Tokelau and New Zealand

This section presents results showing that many participants regarded the effects of poverty as a major cause of depression. The quotes from the interviews outline the relationships between unemployment, high rent, food prices and poverty. The link from poverty to crime is noted, as is the pressure created by needing to give to the community and send monies back home to Tokelau.

Three participants in the study directly identified a shortage of money and poverty as a major cause of sadness and depression in the Tokelauan population.

A fourth participant related the lack of money to unemployment.

> *I believe that is the main reason why people get depressed. Lack of money.* (Female 25-30 yrs, 4 years in NZ)
>
> *why maybe someone gets depression over here may be money?* (Male 20-25 yrs, 4 years in NZ)
>
> *In English, - - - - is something to do with unhappy - - - - -But it is to do with no job, no money, so it create - - -another world for- -people and sometime probably affecting- the mind.* (Male 55-60 yrs, 46 years in NZ)
>
> *If you don't go to work you don't get any money to buy some food you know.* (Male 55-60 yrs, 36 years in NZ)

Respondents noted the importance of monetary stress in their new lives in New Zealand. It appeared that this sort of stress has not been a feature of life in Tokelau and that adjusting to

this aspect of New Zealand life may be a significant factor in the incidence of sadness and depression. Study participants contrasted this situation in New Zealand to Tokelau where hitherto there have not been the same financial stresses.

> *Difference is – there is a bit difference. In Tokelau you don't have to worry about anything. You survive on whatever you can get on the island. you don't need to worry about money.* (Female 60-65 yrs, 61 years in NZ)

> *you can get whatever you want without worrying about tomorrow – oh how can I feed my children? How can I pay the bill? You know? You can survive in whatever is there.* (Female 60-65 yrs, 61 years in NZ)

Another participant talked about the younger Tokelauan who often faced unemployment in New Zealand and became short of money. He or she would often seek help from parents who had no extra finances themselves and were unable to provide assistance.

> *Causing that, no money, no job, maybe not help from the parents, from home.* (Male 55-60 yrs, 46 years in NZ)

One subject talked about the financial stresses caused by Tokelauans living in houses where the rent was too high and spending money on meals was beyond their means.

> *where they were living they couldn't afford it.* (Female 40-45 yrs, 43 years in NZ)

Two subjects interviewed described how a recent Tokelauan immigrant might find it difficult to feed his or her family and in time could end up in a poverty trap.

A temporary solution might be found by obtaining a benefit but that was not sufficient to relieve the poverty, which creates the unhappiness and depression.

> *those people on a benefit must be really struggling, financially they must be finding it really struggling and they will get depressed and struggling through life.* (Male 55-60 yrs, 40 years in NZ)

> *a lot of people in Taupo, who were living on the benefit, would remain unwell.* (Female 40-45 yrs, 43 years in NZ)

Two interviewees created imagery of unhappiness and depression when they spoke of the poverty using the words "I get worried," and "it can be a heavy load."

> *if we don't have any food at home, I get worried because I am supposed to provide for the family. That is another way of feeling sad.* (Male 55-60 yrs, 36 years in NZ)

> *and struggling through life and it can be a heavy load sometimes.* (Male 55-60 yrs, 40 years in NZ)

One interviewee explained that poverty can lead to such stress and desperation that criminal activity can result in an attempt to get money.

> *"So the next thing they do they have to go break the shop down town because they want something to buy. Especially the Islanders and Maori.* (Male 55-60 yrs, 46 years in NZ)

One interviewee described how some Tokelauans have actually been sent to New Zealand from the islands by their family in order to find a job and send money home. If they find themselves unemployed or on a benefit and failing in their task, this stress can lead to illness.

> *maybe they were sent from the islands to come here and work and they can't find a job that will pay them enough to be able to send some money.* (Female 40-45 yrs, 43 years in NZ)

Another interviewee described the loyalty Tokelauans display towards their community. This often includes supporting it financially to the extent that the family misses out.

> *that is the other thing with the culture they put their community first, then their family.* (Female 35-40 yrs, 4 years in NZ)

> *so if there is any fund-raising, you don't have enough money and stuff like that, you put the community first and then the family so the problem arises in the family, like, to get the money to look after the kids and stuff, you know, but you have to give the money to the community. That is another problem with the Tokelauan culture.* (Female 35-40 yrs, 4 years in NZ)

4.12.i Summary

This section presented quotations, which supported the direct relationship of the stress of poverty with illness involving unhappiness. It was shown that the poverty could be a result of unemployment as well as the high cost of rent and food. Benefits did not relieve the financial stress, which was exacerbated by commitments to family overseas and to the local Tokelauan community.

4.13 Relationship Issues as a Cause of Unhappiness

In this section, I present quotations from the interviewees that provide objective evidence of stresses within relationships in the Tokelauan community. The relationships involved were

both parent-child and husband-wife. The difficulties described lead to unhappiness, illness and occasionally to violence.

The older members of the Tokelauan community were more likely to be affected by the influence of the change in environment and the effects of change of culture. They were also the group who were more likely to be affected by employment issues. In contrast the younger and in particular the adolescent members of the community were less likely to be influenced by problems such as unemployment. Two participants described how sadness in their case was often viewed as the result of problems in the relationships with their parents and in particular problems in communication.

> *Feelings. No communication.* (When asked what can cause the illness) (Male 20-25 yrs, 4 years in NZ)

> *The childrens don't listen. Even though the parents start to listen to their children, instead of the children supposed to listen to the parents!* (Male 45-50 yrs, 8 years in NZ)

One interviewee explained that young Tokelauans often struggled to enjoy the benefits of a modern palagi culture whilst living in a strict traditional Tokelauan family.

> *The parents try to, you know, to live the old way of life and to teach their children.* (Male 45-50 yrs, 8 years in NZ)

There was obvious concern amongst participants about the incidence of suicide in young Tokelauans. Some interviewees felt that this was also related to problems within families where communication broke down

> *there is a lot of problems and stuff in the family because you don't have a say in the family. Some of the problem arises in the family – that is the reason why kids do suicide and stuff like that because I know they got no support at all in the family.* (Female 35-40 yrs, 4 years in NZ)

Another participant suggested that children would bottle up all the tension until they finally cracked.

> *they sort of don't want to get involved but deep down they are working very hard they trying to think, to find a way. They take a lot of pressure and it seem it's alright but they don't say much, they just keep it to themself and it spill out of themself and cause a lot of sadness.* (Male 45-50 yrs, 8 years in NZ)

Many interviewees identified relationship issues in adults as a cause of sadness. This included conflict between the husband and wife, which were often identified as a problem.

> *we all just assumed it was just relationship issues.* (Female 40-45 yrs, 43 years in NZ)
>
> *Probably from the marriage problem.* (Female 25-30 yrs, 4 years in NZ)
>
> *the last time I wanted to kill myself was when my partner left me.* (Female 30-35 yrs, 1 month in NZ)
>
> *What happened was, my wife had an affair with another fella, and that has really hit me, you know.* (Male 55-60 yrs, 36 years in NZ)

Finally, two participants specifically identified domestic violence in the family as contributing to relationship tensions and to sadness.

> *Family violence just about every day.* (Male 55-60 yrs, 36 years in NZ)
>
> *Fighting.* (In answer to "What other things can cause this illness?") (Male 20-25 yrs, 4 years in NZ)

4.13.i Summary

This section has presented the evidence for stresses both in inter-generational relationships and in marriages in the New Zealand Tokelauan community. The quotations show that the tension associated with these problems can lead to extreme unhappiness with suicidal ideation and even violence.

SECTION FIVE

HOW IS EXTRAORDINARY SADNESS MANAGED WITHIN THE TOKELAUAN COMMUNITY

In the initial chapters I presented evidence that an illness that involves extraordinary sadness exists in the Tokelauan culture. There is no specific word for it in their language and a person with the illness often successfully hides sadness such that a diagnosis is probably missed.

However I presented evidence that the illness does has specific signs that are often recognised by community members. These signs included isolation by the ill person from family and the community, absence from work, changes in behaviour, increased alcohol intake, irritability and loss of temper with possible violence.

In this chapter I present evidence showing how the family and the community manage sadness in a Tokelauan once they have correctly detected the signs of illness in a person.

When a palagi patient presents to their general practitioner with symptoms that fulfill the diagnostic criteria of the western disease called *'depression,'* he or she is often given the option of being treated with medication such as an antidepressant or alternatively with counselling by a psychologist or therapy with a psychiatrist.

The 2003 New Zealand Mental Health Survey (2) showed that only 25% of Pacific people with severe mental illness use mental health services compared with 58% of the rest of the population. It was therefore important to me to ascertain how the Tokelauan community responds to a person who had an illness with symptoms of extraordinary sadness. Furthermore I wanted to discover whether any therapeutic assistance is given to an individual who is unwell.

Analysis of themes from the interviews showed three distinct sources of support for a Tokelauan displaying extraordinary sadness. These were:

- The family
- The community
- Faith and the church.

4.14 The Family

In this section I will present evidence from participants showing the important role that the family, and in particular, the parents had in caring for members with an illness hallmarked by extraordinary sadness. The quotes demonstrate that interventions used included treating the person with love, respect and softness. Listening to him or her is emphasised, as is the use of 'family talk.' Participants also discuss the severe stress endured by parents who have a family member in the house with this illness.

Many interviewees highlighted the role of the family in caring for a person with extraordinary sadness. One interviewee regarded it as the particular responsibility of the parents to adopt the caring role.

> *but how to deal with it? The family need to deal with it - the parent need to but sometime no parent but sometimes the family is important.* (Male 55-60 yrs, 46 years in NZ)
>
> *you can't go beyond the family or the parents. If the parents still alive they are the ones supposed to help.* (Male 55-60 yrs, 46 years in NZ)

One subject stated in his interview that the father of the house was regarded as the one who might have the 'strength' to make things better.

> *Yeah, I think that the family can really help their own family. Maybe understand what is going on but it is very hard if not only the member of the family feeling depression but if there is someone really strong in the family like maybe the Dad make you better because they understand more what is going on so sometime they bring the whole family together.* (Male 45-50 yrs, 8 years in NZ)

One interviewee described how scared parents became because they did not know what was going to happen. They were particularly afraid that the family member would deteriorate or commit suicide. He talked about how they felt trapped and unable to leave the ill person alone.

> *But the most sad ones is the parents if they do have a son or daughter involved, and they are the ones always sad because they don't know what they are going to face during the day, during the year wherever they go. They are like a prisoner of this person, you know, have to be with them all the time if they think it is really bad.* (Male 55-60 yrs, 46 years in NZ)

The same subject went on to describe the insomnia experienced by parents with family members who were ill with extraordinary sadness.

But I don't think they have a good sleep at night time too when they go to bed.
(Male 55-60 yrs, 46 years in NZ)

He also described how the parents felt they did not understand the illness. They did not understand how it suddenly appeared, why it came and what would happen next. They knew that the situation could quickly become worse but did not understand the triggers that caused these deteriorations.

But it is also hard if they discover that it is a sickness now and then is going to pop up and go, disappear and they don't know when its going to happen and what trigger the whole thing. There are certain things that sometime, people with this sickness, there are certain thing that trip the whole thing and Hullo it pop up and it is very dangerous. (Male 55-60 yrs, 46 years in NZ)

All participants were keen to share the different ways in which the family took care of members who had an illness involving sadness. Three subjects emphasised the need to ensure that the ill person become the focus of love and support in the household.

That's where you be soft and kind because you know he is sick. You have to give the full love and everybody in the family have to know and treat this like, just like a baby. (Male 55-60 yrs, 46 years in NZ)

*They (*family*) were very supportive. They were very supporting of me. And even my wife.* (Male 55-60 yrs, 36 years in NZ)

Maybe being there for them? Making sure they are loved. Praying... (Male 20-25 yrs, 4 years in NZ)

all they can do it to please that person,- - - - sharing love and stuff like that.
(Female 35-40 yrs, 4 years in NZ)

One of the interviewees described how 'respect' is particularly important and the person with sadness is made the priority in the home, treated with respect and given encouragement.

You have to treat him like a baby and to make him happy and make him priority out of your home. (Male 55-60 yrs, 46 years in NZ)

I think respect is very important to what you want. He might turn around and say I want to - whatever, and so.... I think that's the only word, you've got - to respect - that cover the whole thing. It's a two-way thing. (Male 55-60 yrs, 46 years in NZ)

I would show them that I am there for them to listen, if they need someone to listen to, or and try and help them, encourage them. (Female 25-30 yrs, 25 years in NZ)

A number of the participants spoke of the importance of sitting down and listening to the person with sadness and encouraging him or her to talk about problems. They also emphasised that the first step was to put the family member at ease and this sometimes might mean going with them to another place where they felt more comfortable.

> *Well, I mean wherever you go you also listen to what he want. You got to listen.* (Male 55-60 yrs, 46 years in NZ)

> *if they take too long, you know being in their room I would show them that I am there for them to listen, if they need someone to listen to or and try and help them, encourage them, like, I don't know, like getting out more and you know to avoid them from going to their room and to talk about what is making them hide, you know, and why they are like that.* (Female 25-30 yrs, 25 years in NZ)

> *They don't want other people to know when you are having a problem. But I think the main thing is to talk. Take them to a place that you know he feels comfortable and be open. I think that is the thing that people need to know.* (Female 60-65 yrs, 61 years in NZ)

> *Keeping to themselves is no good but if they can talk and let people know.* (Female 60-65 yrs, 61 years in NZ)

Interviewees also described involving the sad person in what they called *'family talk'* where everyone in the family sits down in a large circle and all points of view are exchanged.

In some families this 'family talk" took place on a regular weekly basis and its format of trying to resolve problems seemed to be very therapeutic.

> *Maybe a family talk – plenty of family talk.* (Male 20-25 yrs, 4 years in NZ)

> *then we have a meeting you know, they need to know what is going on - -they need to understand.* (Female 30-35 yrs, 1 month in NZ)

> *because it's a big family there is so many of us so that's what we usually do every week especially Sundays.* (Female 30-35 yrs, 1 month in NZ)

> *whatever happen to any of the kids, we always have to have a meeting. We have to sort out the problems because she need to see everyone happy because everyone like the same, so that is our family, that's where we coming from.* (Female 30-35 yrs, 1 month in NZ)

> *Whatever happen to me or whoever, aunty just call a meeting and fix up everything and each and every one of us need to have a say.* (Female 30-35 yrs, 1 month in NZ)

> *Talking with the family, doing a job together with the family. 'Cause they are very comfortable with their own family here.* (Male 45-50 yrs, 8 years in NZ)

Participants also gave examples of family members involving the ill person in activities such as sports and dancing. They also described practical ways in which they supported the sad person such as providing child support.

> *Sport. Because Tokelau has a lot of old games to play. It is another way of getting out of depression, playing sport, dancing, singing a song, yeah or being with the family.* (Male 45-50 yrs, 8 years in NZ)
>
> *Some days they take the kids away from me, you know to look after them for an hour or two hours.* (Male 55-60 yrs, 36 years in NZ)

4.14.i Summary

This section showed evidence of active involvement of family members and especially the parents in the management and care of the Tokelauan with extraordinary sadness. The quotes showed the parents are poorly informed about the illness and live in fear of a negative outcome.

Significant therapeutic care is given with the provision of loving care and support with the emphasis on respect for the person and listening to him or her in a safe environment. Problems were also resolved in '*family talk,'* which may be an excellent Tokelauan version of group therapy.

4.15 The Community

This section outlines the different ways in which the Tokelauan community involves itself in caring for people with sadness. The quotes presented show the need for the community to acknowledge and respect members with extraordinary sadness. The quotes also showed that members are trusted to listen and to give encouragement or advice. The Tokelauan community is also in a position to involve the ill person in a range of social activities including sport, singing and dancing.

There is however, a tendency for the community not to acknowledge the presence of unhappiness as an illness. One interviewee felt that it would be extremely helpful for the ill person if members worked on changing this attitude.

> *I think just – they need to acknowledge or you know that the people that are feeling sad need to be respected.* (Female 25-30 yrs, 4 years in NZ)

Many of the people interviewed indicated that once the community became involved with a person with sadness, one of its main roles was to listen and to provide advice. This listening function for the community seemed to be less of a passive role than the listening described for the family in the previous section. Respondents described a more active role for community members in giving advice to the ill person.

> *I think talking is a very effective way, you know. Talk to them, and let them talk to you and tell you what they want. Because you can't help them unless they talk to you.* (Female 60-65 yrs, 61 years in NZ)

> *They just give out advice, you know encourage.* (Female 30-35 yrs, 1 month in NZ)

One interviewee told how community members would seek a comfortable place where they could listen to and talk with the person, trying hard to understand everything from his or her point of view.

> *you can talk to somebody that you know who is very close to her or to that person and have a little talk or take them out for a cup of tea, you know. And share – sharing so that you will understand what is going around.* (Female 60-65 yrs, 61 years in NZ)

The same person explained how important it was for the Tokelauan with sadness to find someone in the community they could trust.

> *Keeping to themselves is no good but if they can talk and let people know. But talk to a person that you trust!* (Female 60-65 yrs, 61 years in NZ)

Another participant described the importance of looking for a person in the community with excellent listening skills as well as the time and ability to give good useful advice.

> *so the only thing is I have to go find the one that I know that really care and really got time to listen, you know and to give me good advice.* (Female 30-35 yrs, 1 month in NZ)

One interviewee discussed the problems of talking to family members who were often too close. It was sometimes easier to get a dispassionate view on a topic by talking to a stranger.

> *You can go and pour your heart out to people and you don't know them.* (Male 45-50 yrs, 4 years in NZ)

Another participant talked about elders. If they identified sadness in a person, they would sit down and give one-to-one advice.

> *I don't know what's going to happen but if the old people know that I am sad, they probably sit me down and talk to me. Right?* (Male 55-60 yrs, 36 years in NZ)

Interviewees also described how community members actively involved a person with sadness in activities and kept him occupied and busy – sometimes to an extent that he did not have the opportunity to think of his problems.

> *you have got so many things to do every day, you are pretty much not given time to wallow.* (Female 25-30 yrs, 25 years in NZ)

> *They make you do things so that you don't have time to feel sad or unhappy, like running errands for them and stuff.* (Female 25-30 yrs, 25 years in NZ)

> *Oh, they try to say "Oh we going to the dance" or maybe go fishing, yeah. Just another way I think of getting out from depression is to make the person do something when he is depressed.* (Male 45-50 yrs, 8 years in NZ)

Other participants talked of the Tokelauan community socials, which are held on a monthly basis. These are fun events with laughing joking, dancing and singing. They talked of trying to keep an ill person occupied by involving him or her in these or similar social activities.

> *the whole culture is a very helpful one because we normally have once or twice a month we gather together, have fun with our singing and our dancing and our feast.* (Female 60-65 yrs, 61 years in NZ)

> *Don't let them drift away on their own. You have to have a constant – and if it helps take him or her wherever you go, either to a social or to picnic or shopping. Why not? Would be another way of sharing.* (Male 45-50 yrs, 4 years in NZ)

> *Yeah even the woman going there is very useful because sometime they laugh, they joke and yeah.* (Male 45-50 yrs, 8 years in NZ)

Interviewees also described how they involved sad members of the community in recreational activities

> *with my mates. My good friends. They take me out, you know. Take me fishing.* (Male 55-60 yrs, 36 years in NZ)

> *playing sport.* (Male 45-50 yrs, 8 years in NZ)

> *maybe go fishing.* (Male 45-50 yrs, 8 years in NZ)

in Tokelau there is always community gathering, like the men, they have special job they do for the whole people of the island. (Male 45-50 yrs, 8 years in NZ)

4.15.i Summary

This section described the ways in which the wider Tokelauan community gets involved in caring for a person ill with extraordinary sadness.

Quotes showed that the community, and in particular the elders, have an important role in listening and giving advice. The ill person looks for someone he or she can trust, and the advantages of a stranger over family members who might be too close were noted. The community can also involve an ill person in social and sporting activities.

4.16 Faith and the Church

This section presents the evidence of the pre-eminent part faith plays in the life of the Tokelauan community. The quotes from interviewees show that God is never forgotten and is always there as the final word.

The community minister is treated with respect and paid in kind with the best the family has. Quotes show obedience to biblical commandments and fear of the consequences of failing. Participants also described using faith healing and prayer to help sad people as well as the role of counselling of ill people by the minister.

Eight out of ten of the people interviewed talked of the importance of faith and spirituality in the Tokelauan community. One interviewee described their belief saying:

> *That is my only word – keep to the simple life that over there is always pray 'cause God is everywhere, whether you go to church or not, he is here with us. That is my advice, anyone who want to be perfect, he have to keep saying "Our Father" the Lord's Prayer.... That's what I say to the community.* (Male 55-60 yrs, 46 years in NZ)

> *But that only my best advice. Don't go too far away from the Fellow up there.* (Male 55-60 yrs, 46 years in NZ)

Another interviewee described God as having the final authority.

> *as we have emphased in our faith, God is in control.* (Male 45-50 yrs, 4 years in NZ)

Another participant explained the high stature the minister had within the community. He enjoyed special treatment because of this and received gifts from families in the community.

> *In our culture every good things you have in your family like big fish, you take it for the church minister.* (Female 25-30 yrs, 4 years in NZ)

Three participants made direct reference to the importance of obeying the biblical laws and commandments.

Although the previous section presented good evidence of positive caring by the community, it was clear from one quote that a fundamental Christian approach was also present.

> *Oh, they just kind of tell you off – to stop feeling sorry for yourself. They just tell you that um, to go to church and that God put you on earth not to feel sorry for yourself.* (Female 25-30 yrs, 25 years in NZ)

Quotes from another two interviewees showed that obedience to the biblical laws could well have been a factor in preventing suicide.

> *God is in control. No one has the right to take away one's life aye, because I cannot kill myself, I cannot kill someone else.* (Male 45-50 yrs, 4 years in NZ)

> *Especially if you are Christian, you know that you can't just go kill yourself because I don't want to go to hell! I want to go to heaven.* (Female 30-35 yrs, 1 month in NZ)

This deep involvement with religion by the Tokelauan community laid the foundation for involvement of spirituality and the church in the therapy of a person with symptoms of extraordinary sadness.

One participant described the church as the ultimate in assistance for a person with sadness.

> *I think that (the church) is the biggest help for someone who is really sad.* (Female 30-35 yrs, 1 month in NZ)

Another person emphasised that when it came to caring for an ill person, faith in a loving God who cared for his own creation became very important.

> *doesn't matter whether they young or old as long as you know they were created in name of our God they will be fine, you know.* (Male 55-60 yrs, 40 years in NZ)

One interviewee described how a sad person would bring his or her problem before God at church in order to obtain healing.

> *But in regard to others that are sad, they do believe they go to church for God to be able to heal them.* (Female 40-45 yrs, 43 years in NZ)

One participant also identified the importance of prayer. It was identified as a way of asking God for healing.

> *I can pray and ask God to help me.* (Female 55-60 yrs, 20 years in NZ)

Whilst another said prayer was a means of telling God about the problem with the faith that if he understands, he will provide the answer.

> *but if God knows, He can heal me.* (Female 40-45 yrs, 43 years in NZ)

Some interviewees also described the therapeutic effects of the community at church. One person stressed the positive effects of just meeting and being with people.

> *whatever you were worrying about, you go to church, meet with these people.* (Female 60-65 yrs, 61 years in NZ)

The same person also described the healing effects of the physical contact of hugging one another at church.

> *I think person hugging somebody is a very good thing. You know, you feel comfortable, you feel good, you know.* (Female 60-65 yrs, 61 years in NZ)

Another interviewee talked of the positive effect of members of the church community performing Tokelauan Massage and offering prayers for the ill person."

> *they will massage you or do prayers on you.* (Female 25-30 yrs, 25 years in NZ)

Interviewees also identified the church minister or pastor as someone to go to for help. One participant explained how the minister stopped all bible preaching and became a confidential counsellor for community members.

> *The church minister is more like a counsellor, is more like Mr. Fixer and they have their respect for the ministers, aye?* (Female 60-65 yrs, 61 years in NZ)
>
> *we have the hospital and the doctor there but there was also the church minister there, so usually the church minister can become a problem solver in some cases*

> *like a counsellor, a private counsellor to confide in, no preaching of the gospels around and confidentiality aye.* (Female 60-65 yrs, 61 years in NZ)

One participant described how useful he had found talking with the minister.

> *In my case Father helps me a lot.* (Male 55-60 yrs, 36 years in NZ)

The same participant explained how the minister had a detailed knowledge of the community and the makeup of all the member families. He felt that because he understood the community so well, the pastor was particularly useful when there were marriage and relationship problems causing the illness.

> *he talk to me about the church, about marriage life and the family life. It helps me.* (Male 55-60 yrs, 36 years in NZ)

Another interviewee also felt that the minister was particularly useful in helping with marital problems.

> *If there is a marriage problem, go and see the minister and he will give some advice about this and that. You have to help each other in your marriage, love each other.* (Female 60-65 yrs, 61 years in NZ)

4.16.i Summary

This section produced evidence of the importance of faith in the Tokelauan culture. God is present in all that they do and is regarded as the final authority. Biblical rules are strictly followed and there is a strong belief that faith and prayer will heal. The minister is held in high regard and his counselling abilities are widely recognised, particularly where there are marital problems.

SECTION SIX
RECOGNITION OF RECOVERY, PREVENTION OF SADNESS AND GENDER DIFFERENCES

4.17 How Do Community Members Identify Recovery?

Having investigated what symptoms of an illness equivalent to depression are recognised in the Tokelauan community, I also wanted to study how recovery from sadness was detected. In the palagi culture, resolution from depression is characterised by disappearance of presenting symptoms such as sadness, sleep disturbance and lack of motivation.

In this section I present the evidence that in the Tokelauan community, confirming that someone is recovering depends on seeing them return to normal function. The quotes below show that a person who is recovering is seen to have increased involvement in community activities. His or her self-care increases and the troublemaking diminishes. Isolation comes to an end and new activities are attempted. The person peaks more and is seen to start a new life.

Interviewees remarked that they detected someone was recovering as they once again spontaneously joined in community activities and started to contribute to dialogue once again.

> *they would be more involved in activities and conversations and discussions.* (Female 25-30 yrs, 25 years in NZ)

One participant also noted that people, who had previously caused trouble at community events because of their illness, were now behaving normally as they recovered.

> *not causing any trouble again when he go out into the community.* (Male 55-60 yrs, 46 years in NZ)

The same participant described how a person who was recovering would take better care of himself.

> *you are looking tidy, the clothing, shaving.* (Male 55-60 yrs, 46 years in NZ)

Another interviewee commented that as a person improved, they would often start to make better life choices and their whole routine would become more positive.

they would show like a change in their lifestyle like - - - doing something different, like in a good way different in their – yeah like in their weekly routine or their daily routine. (Female 25-30 yrs, 25 years in NZ)

As an example, the interviewee said the person was also more likely to partake in club activities and sports as he or she recovered.

maybe they would join another type of sport. (Female 25-30 yrs, 25 years in NZ)

more involved in club events. (Female 25-30 yrs, 25 years in NZ)

One participant described how the feature of isolation disappeared as a person improved.

he is *outstanding, different from staying in the bedroom all the time.* (Male 55-60 yrs, 46 years in NZ)

The same person noted that as recovery occurred, family members were finally able to relax, with the knowledge that suicide was now highly unlikely.

trusting him to stay home by himself, that is, you know, giving the trust from the family. (Male 55-60 yrs, 46 years in NZ)

Some interviewees noted that a person who was getting well started to speak normally again and talk appropriately in a conversation.

There are some signs when you are speaking properly. (Male 55-60 yrs, 46 years in NZ)

we tend to just ask questions and they answer as normal, so that's how I knew she was alright. (Female 40-45 yrs, 43 years in NZ)

However just as some participants said they had difficulty identifying when someone was becoming sad, at least one person who was interviewed said that it was also difficult to identify recovery.

Again, we wouldn't have a clue! Unless we have a relationship with that person, we wouldn't know the changes in their mannerisms, and how they are thinking. (Female 40-45 yrs, 43 years in NZ)

4.17.i Summary

This section showed evidence that the Tokelauan community see improved function as signs of recovery from sadness. Signs of improvement include positive life changes, increased sport

and community activity involvement, improved behaviour, an end to self-imposed isolation and improved socialisation and conversation.

4.18 How Should A New Arrival Avoid This Illness?

In this section I present the advice participants would give to new arrivals who wanted to avoid getting extraordinary sadness. Quotes show that their guidance fell into three distinct categories. Firstly many participants suggested maintaining a close contact with families and culture. Secondly some interviewees advised talking to other people early when they were worried or troubled about things. Family talk and getting informed about depression were also recommended. Thirdly, interviewees suggested maintaining a close spiritual contact with their church.

4.18.i Immersion in the Local Tokelauan Community

One interviewee said that that new arrivals should develop a close relationship with local Tokelauan communities and try to stay closely linked to their cultural values.

> *My advice to those people is to get connected to the community. You know be part of the community and that way they continue on their culture back home.* (Male 55-60 yrs, 40 years in NZ)

> *but get connected to the community, that would be my advice. And from there, you know because we are still trying to do things Tokelauan way when we get together.* (Male 55-60 yrs, 40 years in NZ)

Another participant said that the influence of Tokelauan community members in New Zealand would help them settle and adjust in their new country without becoming sad.

> *I* know *a lot of them come over and whoever they hang out with it kind of rubs off on them.* (Female 25-30 yrs, 25 years in NZ)

Other interviewees also spoke of the importance of maintaining close contacts with other family members who were living in New Zealand.

> *So* it *is hooking up with families and hooking up with somebody you know.* (Male 55-60 yrs, 40 years in NZ)

> *But if they coming here through relationship with family, with family over here, I think they be enjoy themselves because they all related.* (Male 55-60 yrs, 46 years in NZ)

4.18.ii The Importance Of Talking About Problems

Many participants emphasised the importance of attempting to resolve issues expeditiously before they became a major worry.

> *Don't let anything here worry them because otherwise they will get unwell to the point that they can't deal with it.* (Female 40-45 yrs, 43 years in NZ)

Two participants in particular felt that new arrivals should talk about their problems and difficulties with others.

> *I would say to them if they ever get stuck on anything, if something has troubled them and they worry about it too much then talk to someone about it.* (Male 40-45 yrs, 43 years in NZ)

> So *going through all of these, you know you have to let others know how you feel at the time.* (Female 55-60 yrs, 20 years in NZ)

One of these people emphasised how talking was an outlet that improved the ability to cope. The same interviewee also felt that new arrivals had no concept of what the illness of depression was. Talking also provided an opportunity to discuss the topic.

> *If they had knowledge of being able to talk to someone about it then they would probably be able to cope. Otherwise if they don't know what sadness is or they don't know what depression is, then they would probably just go deeper and deeper because there is no knowledge of why they are like that.* (Female 40-45 yrs, 43 years in NZ)

Participants also suggested that new arrivals should discuss problems in a group discussion with members of their family who already lived in New Zealand.

> *Maybe a family talk – plenty of family talk.* (Male 20-25 yrs, 4 years in NZ)

4.18.iii Involvement In The Church

Two participants specifically suggested that new arrivals should use prayer and their relationship with the church to avoid getting ill.

> *My advice for them, you know, because people will leave the islands, the most important advice the parents and family and village can give, please make sure keep praying.* (Male 55-60 yrs, 46 years in NZ)

> *Don't go too far away from the Fellow up there.* (Male 55-60 yrs, 46 years in NZ)

> *the people who come over from Tokelau just to have a solid faith community like the Taupo Catholic, just for the Catholic people to accommodate their fellow*

Catholics when they come over, the Tokelauan people. (Male 45-50 yrs, 4 years in NZ)

4.18.iv Summary

This section showed that participants would advise new arrivals to maintain a close contact with local Tokelauan culture and communities, attempt to solve problems promptly through discussion and use prayer and their relationship with the church to stay well.

4.19 Do Women Cope with the Illness Differently from Men?

I studied differences in the ways in which Tokelauan men and women coped with extraordinary sadness.

The evidence in this section introduces men as the dominant sex in the Tokelauan culture. Although not unanimous, the interviewees felt men tend to hide their feelings and do not show or talk about what is on their mind. They reportedly get frustrated easily and some participants said they sometimes drink more alcohol when sad. Violent outbursts also sometimes occur during times of sadness.

Some interviewees however, also felt women kept feelings hidden.

In this section however, I will present evidence suggesting that Tokelauan women tend to share their feelings more and talk to other people when they are sad. One participant also described drinking and acting out amongst Tokelauan women who with sadness.

4.19.i Men

Participants described men as the dominant gender

> *the Island way is the man is I am the Master and he think he dominate the woman.* (Male 55-60 yrs, 46 years in NZ)

> *Mind you the woman is always expected in the home doing all the cooking, looking after the kids and anyone coming in, the man going to work and coming in and expecting everything to be 100% with food on the table.* (Male 55-60 yrs, 46 years in NZ)

Mostly interviewees said that a man was much more likely to keep to himself and was less likely to talk about his problems with other people. They did not feel that he was very good at sharing feelings or discussing emotions.

> *I think when the man when they are depressed they try to get away. They try not to be involved.* (Male 45-50 yrs, 8 years in NZ)

> *you know the man doesn't really show whatever is going on in his mind and stuff but then even like if he has got problems but he has his own way of solving his own problems.* (Female 55-60 yrs, 20 years in NZ)

> *They (men) hold it in. They don't share it but you can sometimes tell they do have it.* (Male 20-25 yrs, 4 years in NZ)

> *But men, I hardly see men sharing.* (Female 60-65 yrs, 61 years in NZ)

Some interviewees also described men as temperamental.

> *But Man not always the same, some day bad some day good.* (Male 55-60 yrs, 46 years in NZ)

They identified them as more likely to become frustrated, angry and to resort to violence when coping with sadness.

> *They show their frustration.* (Male 55-60 yrs, 40 years in NZ)

> *they get easily frustrated.* (Male 45-50 yrs, 8 years in NZ)

> *men physically show the sign of frustration, the old fist will come out.* (Male 55-60 yrs, 40 years in NZ)

> *The male show his maleness aye by physically throwing things around.* (Male 55-60 yrs, 40 years in NZ)

Some participants mentioned that men resort to alcohol as a coping mechanism. One reported that the alcohol was used as a 'mask' where the ill person mistakenly felt that by drinking he was hiding his problem. Another said that men were more likely to discuss feelings when they were drunk.

> *most of them go drinking.* (Male 55-60 yrs, 46 years in NZ)

> *I guess they go beyond some limits as well, aye, like you know they keep on drinking as if the alcohol will bring a mask to you to hide.* (Male 45-50 yrs, 4 years in NZ)

When it gets to the point they can't control it, they turn to alcohol and other stuff. (Male 45-50 yrs, 4 years in NZ)

Well, he only shows it when he is drunk! (Male 20-25 yrs, 4 years in NZ)

You can never bring it out in a man when he is sober. (Male 20-25 yrs, 4 years in NZ)

4.19.ii Women

A minority of interviewees felt that when women were sad they too could become quiet and not talk.

I mean women, they do sometimes keep things within themselves. (Male 55-60 yrs, 40 years in NZ)

I don't think so doctor. No, just the same. (as men) They just shut themself. (Male 55-60 yrs, 36 years in NZ)

Most participants said that women were much better at sharing their feelings than men when they were sad and generally talked to others more easily when they had a problem.

Women can share ...some women can share and tell other people how they feel. If they are not happy. (Female 60-65 yrs, 61 years in NZ)

To me, women, they can talk. (Female 60-65 yrs, 61 years in NZ)

Yes there is a difference. Women are more involved within the community and they talk a lot. (Male 45-50 yrs, 8 years in NZ)

Two interviewees said that women particularly talked to family members when they had problems and one participant said she shared particularly easily with her husband.

they talk a lot to their children. (Male 45-50 yrs, 8 years in NZ)

I know I only complain to my husband. (Female 40-45 yrs, 43 years in NZ)

so it is good to be able to have a good husband who is supportive that way, otherwise I wouldn't be where I am now. (Female 40-45 yrs, 43 years in NZ)

There was only one interviewee who mentioned women acting out and increased alcohol use during times of sadness.

That is the other action they do, when female gets stressed out in Tokelau, they go drinking. (Female 25-30 yrs, 4 years in NZ)

4.19.iii Summary

These sections provided some suggestive evidence that Tokelauan men tend to hide their feelings and are less likely to discuss their problems when they are sad. They sometimes become frustrated and angry and are more likely to resort to alcohol and violence than Tokelauan women. The presented evidence also suggested that Tokelauan women are more likely to share their feelings and discuss problems. Alcohol and acting out does not seem to be a major problem in Tokelauan women suffering from sadness. Interviewees did not have unanimous opinions on these subjects.

CHAPTER FIVE
DISCUSSION

5.1 Introduction

In this chapter I first provide a brief factual summary of the research results. I then review the prevalence of depression in the pre-western Pacific Islands and in New Zealand in 2012. Using the anthropological theories of Durkheim and Gosling, I then consider possible reasons for the differences in prevalence.

I discuss the symptoms and causes reported in the study after consideration of work on depression in different cultures by Kleinman and Scheper-Hughes. I next consider the challenges facing the general practitioner who is treating a Tokelau Islander with depression and consider how he can successfully recognise and treat extraordinary sadness. Finally I consider the limitations and possible transferability of the study.

5.2 Summary of Results

5.2.i The dual problems of nomenclature and the 'mask of smiling'

A significant finding of this research is that an illness the equivalent of the palagi condition known as depression does exist in the Tokelauan culture although there is no specific word for depression in the Tokelauan language. However the interview data suggests that Tokelauans do recognise that there is a difference between sadness, which is often treated as part of life in the same way as is happiness, and extraordinary sadness with recognisable associated behavioural change.

Participants offered diverse opinions on whether or not extraordinary sadness could be classified as illness, with suggestions for a word indicative of depression including *'he malohi'* which means unwellness and *'fita'* which means a burden or exhausting.

The research indicates that the most common symptoms of an illness involving extraordinary sadness in the Tokelauan culture are isolation and withdrawal from family and community activities. These were the most noticeable symptoms as far as respondents were concerned. The presence of common depression symptoms of sleep disturbance, loss of motivation,

irritability and weight loss (loss of appetite) was also reported. However behavioral changes including missing work and occasionally signs of psychosis were also seen. Some respondents also commented that men drank more alcohol when sad and sometimes resorted to violence.

Detecting sadness in a Tokelauan can be difficult. They often successfully hide feelings and emotions because of a strong sense of pride and privacy. Respondents indicated that there was a marked sense of shame associated with having sadness so severe that it disrupts daily life and the cultural norms of behaviours. Respondents reported that smiling is important culturally and this is taught to children from an early age. Tokelauans hide emotions such as anger and sadness and show a 'mask' of happiness on the outside. This makes detection of extraordinary or abnormal sadness difficult, even for family and friends.

5.2.ii Causes and Contributors to Depression in the Tokelauan Community

Respondents identified several causes of extraordinary sadness. Older participants described stressful changes that have occurred in Tokelau as it altered from a subsistence community where food, work and possessions were shared to a western-influenced society where food and materials have monetary values. Palagi influences affected childrearing customs as well as traditional intergenerational relationships. This was identified as a source of further anxiety and sadness.

The stresses associated with the cultural change of arriving in New Zealand were said to cause anxiety, stress and eventually sadness. The effect of peer pressure on children who develop materialistic desires creates further stresses and illness. Poverty, which was often a result of unemployment and the high cost of housing and food, was identified as a significant stressor and contributor to extraordinary sadness. This highlighted how the impact of circumstances of living can affect this group of patients. The impact of poverty was exacerbated by the expectations for financial contributions to the local Tokelauan community and the remitting of monies back home to Tokelau.

All of the above were recognised by respondents as contributing to relationship problems, both between husbands and wives as well as between parents and children. These also caused tensions and eventually extraordinary sadness.

While the contribution of poverty to stress and illness is well-recognised in New Zealand across all cultural groups, this study highlighted the added impact of poverty on a mixed community of newly arrived Tokelauans and those born in this country.

5.2.iii Dealing with Extraordinary Sadness: Existing Strategies

This research identified a number of existing strategies within Tokelauan communities that assist people struggling with extraordinary sadness. The importance of these findings lies in being able to utilise culturally acceptable family and community resources when appropriate, and to recognise when those resources may not be sufficient and other interventions may be needed.

Respondents reported that the Tokelauan family often assumes the main responsibility for the care of the ill person. This research indicates that parents are poorly informed about extraordinary sadness and are fearful of it. However they do have mechanisms to help those who are struggling. The family manages the ill person by providing love and respect as well as listening attentively to his or her story in an appropriate environment. *'Family talk'* is also used in a group situation to discuss problems.

Respondents indicated the importance of trusted community members who listen to the ill person and give advice. Elders in particular were seen as useful in advisory roles. The wider community is important in that it involves the ill person in social and sporting activities that are valued by the Tokelauans and counter the tendency of the depressed patient to further withdraw from society.

The research indicated that religion is integral to the Tokelauan community life and faith is used to help with healing. The minister is held in high esteem and the findings indicate that the ministers are valued for providing counselling.

Respondents also reported that in general, members of the community detected recovery from sadness by observing return to normal function. Examples included lifestyle changes with increased sport, socialisation and community involvement as well as an end to isolation.

In response to questions about prophylactic advice to those new to New Zealand, community members said that they would advise new arrivals to avoid sadness by discussing problems early, avoiding stress and maintaining a close contact with their faith.

The results indicated that men tend to hide feelings and avoid talking about problems whereas women are much more likely to discuss concerns with other people including family members. Four respondents said that men with the illness are also more likely to develop anger, frustration and resort to alcohol and have violent episodes. I am reluctant to make generalisations based on only four of ten interviews, but this appears consistent with other reports on symptoms of depression in Polynesian populations.(118)

5.2.iv Low incidence of depression in pre-western Tokelau

The results give a clear if perhaps idealistic picture of the Tokelauan community before the palagi cultural influences started to change both economic and social values. Interviewees felt that previously, there was little or no illness involving extraordinary sadness in Tokelau. They spoke of a place, which was happy and without burden. Sadness was just part of life – no different from happiness, or else treated simply as *'he malohi'* or *'unwellness.'* Generally, depressive illness was not a recognised entity. These findings suggesting that in the past, Tokelau had a low prevalence of depression are supported by previous research. In 1977, Murphy (57) noted that Pacific Island communities had a significantly lower prevalence of major mental disorder than that seen in the rest of the world. He recorded a low rate of admissions of Samoans to Apia Hospital compared with Americans and a significantly lower prevalence of mental illness in Tonga compared with other ethnic groups. Dale (59) also recorded a low prevalence of mental illness in Pacific communities. He studied schizophrenia and found that the prevalence decreased as isolation increased, reaching zero in the most distant islands.

5.2.v Higher incidence of depression in New Zealand

Whereas respondents had described Tokelau as being free of depression in the past, they were just as adamant that extreme or abnormal sadness was more prevalent or visible among Tokelauans living in New Zealand. The results of this study support the findings of the New Zealand Mental Health Survey (NZMHS) (2) which confirmed a high prevalence of mental illness, and of major depressive disorder among Pacific people in New Zealand. It showed that Pacific people have a lifetime prevalence of mental illness and a twelve-month prevalence of major depressive disorder that is higher than the rest of the New Zealand population.

The NZMHS also showed that the older a person was when they immigrated to New Zealand, the less likely he or she was to suffer from mental disorder. Remaining in the islands as a

child and growing up within the local culture seems to provide some protection from the future development of mental illness.(2)

5.3 Reasons for difference in prevalence

In this section I will discuss how the traditional Tokelauan community structure provided protection against stress and unhappiness. I also discuss the consequences of the breakdown of that structure as a result of western influences.

5.3.i Traditional Tokelauan Community

Tokelauans living in the islands were part of a close, tight-knit community. It was a hierarchical structure with elders who were respected as wise and responsible. The elders, along with the community council and church, made the decisions and strict rules that guided community members in their daily life.(4)

Tokelauan society fits the profile of traditional cultures with a stable governed community which Emile Durkheim used to illustrate how a strict base of regulations produces “social solidarity.”(119) He stated that in many such cultures, there was homogeneity, both in moral and social values. This was often because of the rules, which were based on religious beliefs. In these groups, there developed a very strong ‘collective conscience.’ Durkheim felt that the constant communication that occurred in a cultural community that integrated political and family groups, provided protection against stress and suicide. The closeness and cohesiveness of the community ensures that feelings and thoughts are shared and advice is readily given. What develops is in fact a large “mutual moral support group.”(120)

The traditional Tokelauan community with its solid social structure and strong spiritual faith would have produced this “social solidarity” and individual support as described by Durkheim. Furthermore the community ran a subsistence economy where people worked for the common good and worry about unemployment and poverty did not exist. Food and material supplies were freely shared with friends and relatives without the need for monetary exchange. Desire for bigger and better consumer items did not exist.

In summary, the structured community of the traditional Tokelauan culture provided social harmony with individual support. The subsistence economy avoided many of the causes of depression such as unemployment, poverty and consumerism.

5.3.ii Increased Prevalence In New Zealand

With migration to New Zealand, new local Tokelauan communities developed. However the recent immigrants had to live in a new system. Instead of working for the common good of the local community, they now had to work first and foremost for themselves and for their family.

The stress of not having enough money for food or for basics such as health and clothes caused worry while further severe anxiety resulted from periods of unemployment. The presence of consumerism resulted in the development of individual desire, jealousy and greed, which was well described by the interviewees in my study.

This movement away from the community and towards *'self,'* resulted in a breakdown in the rigid community control and cultural rules that had been so important in the past. The 2013 census data also shows that affiliation to church has decreased amongst Tokelauans since 2006 and this observation is most marked amongst those born in New Zealand. This decreased church attachment would be associated with diminished congregational and spiritual control.

This lessening of the cultural control, religiosity, and support along with the increased stress and anxiety of coping with adversity in a hostile economic system, provided fertile ground for the development of illness with sadness as a major component. It is clear that according to participants in this study, that with the altered cultural and socioeconomic circumstances, the prevalence of depression was much higher in the Tokelauan population after immigration to New Zealand.

Because the community treated sadness as "part of life" or just as "unwellness", the depressed Tokelauan therefore found him or herself trying to cope with extraordinary sadness that was largely undefined in the Tokelauan language. In fact my results show that some members of the community did not even recognise extraordinary sadness as an illness. This then became a non-supportive environment, in which the ill person was reluctant to display sadness, for fear of attracting attention.

5.3.iii Community Response to Sadness and Symptom of Withdrawal

Goffman (121) discussed the effect of humiliation on a person. He stated that if a person is shamed in front of a group he or she becomes "discredited." The person thereafter is reluctant to bare him or herself before others who are not similarly stigmatised.

'*Privacy'* becomes very important and he or she seeks to avoid invasion of personal space. The person feels that people are staring and consequently avoids meeting others, choosing to hide away instead. I suggest that this becomes the situation with the depressed Tokelauan. He or she is reluctant to show their sadness in front of a community that might well be largely unsympathetic.

Furthermore, my results suggest that the Tokelauans are a very proud and private people and the perceived dishonour caused by the sadness of depression would encourage the ill person to withdraw and avoid other people. Isolation therefore becomes an important symptom of depression in the Tokelauan culture. My results supported this contention by showing withdrawal from family and from the community as being the primary symptom of extraordinary sadness readily identified by interviewees.

5.4 Presentation of Depression and The Metaphor Of Illness

As discussed in chapter two, Arthur Kleinman (81) makes a distinction between *'illness'* which is the patient's subjective experience of sickness and *'disease'* which is the biomedical condition which doctors try to cure. Some patients can suffer from an illness without having a disease whilst other patients need treatment for disease yet have no individual experience of illness. He suggested that patients often attend physicians with symptoms of human suffering seeking healing. They may be faced instead with diagnostic tests and attempts to cure a medical disease.

The exact nature or manifestation of 'illness' is moulded by the effect of culture. It influences the outlook a person has of the symptoms as well as the label that is given to them. It also has an effect on the reasons that are accepted for the experience of sickness. Culture is the determinant of the way in which a sick person talks about the illness and to whom. It teaches a person the "approved" manner of being ill within a particular community or social setting.

Depression is a *'disease'* rather than an *'illness.'* It is a diagnosis that exists in the culture of palagi doctors. The condition can be explained in chemical terms looking at decreased levels of serotonin, which affect enzymes in the brain. Treatment aims to correct the imbalance and the prognosis depends on whether the correct drug is given at a therapeutic dose. At times little attention is given to community upheaval, relationship and other social issues that might be expressing themselves in a person's life.

The Tokelau Islanders noted changes in their emotional responses and the way in which they functioned in their family and in the community. They had an *'illness'* and were feeling the human experience of extraordinary sadness. However their culture did not have a place for the disease 'depression.' In fact they did not recognise it and did not have a word for it in their language. The Tokelauan culture determined the expression of the illness and the 'approved' way to deal with sadness was to treat it as 'part of life' and to hide it. The cultural norm ensured that men, in particular, hid their feelings.

Also as described in chapter two, Arthur Kleinman (86) showed that the presentation of depression could vary considerably between cultures. He argued that the symptoms were *'culturally coded.'* The patient could present with physical symptoms rather than sadness and this could cause diagnostic challenges for doctors. He gave the example of the Chinese culture in which depressive illnesses are stigmatised, whereas having a physical illness is socially acceptable. Patients therefore often present with physical symptoms such as inner pressure, pain, fatigue or dizziness. Patel (35) described how the phrase '*neurasthenia'* rather than depression is used to describe the illness in China.

Scheper-Hughes and Lock (122) contend that many illnesses are metaphors for "social discomfort" and reflect the turmoil and distress in which a patient finds him or herself at the time of affliction. They say that through illness, a person can 'cry out' and give expression to feelings of grief, anguish, frustration and worry. The symptoms speak about the parts of a person's life, thoughts and innermost feelings that are otherwise never expressed. Their body takes in the entire social disharmony and distress that exists in the social environ. It becomes the vessel containing all the negativity of the external world.

As detailed in chapter two, Scheper-Hughes (85) describes the metaphor of the symptoms of the labourers of Alto de Cruzeiro. They worked long hard hours for minimal pay and had no way of objecting to the condition of their employment. They collapsed, with symptoms such

as "angry nervousness," weakness, paralysis, and inability to continue working. The condition was called *'nervos'* rather than depression and Scheper-Hughes considered it to be a metaphor of protest against the conditions under which these labourers were made to work.

Scheper-Hughes and Lock (122) also refer to observations showing that sadness, worry, bitterness and anger can lead to increased rates of morbidity. They note that the breakdown of community and family along with disharmony in work and family relationships are precursors for bitterness, anger and eventually sickness. These negative emotions and feelings can be expressed as physical symptoms in 'somatisation.' They discuss how bereavement, anger and frightening situations can all increase the pulse rate, respirations and alter electrolyte concentrations. Endorphin levels also decrease. These changes can contribute to hyper–'tension' and heart dis–'ease' but often biomedicine ignores the social disharmony message that the individual needs to bring to the healing.

A person attempting to cope with negative emotions and feelings of stress and anger can deal with it by lashing out with physical violence or verbal abuse. Scheper-Hughes and Lock note however, that such responses are socially unacceptable in most cultures and individuals often turn their emotions inwards against themselves, developing self-destructive habits such as alcoholism. They can also develop self-harming tendencies or commit suicide.

The Tokelau Islanders moved from a place of relative (albeit perhaps idealised) social harmony to New Zealand where they often experienced cultural upheaval, lack of money and resources as well as social conflict yet lacked the skills to manage these problems. They did not have the same extended community structure as existed back in the islands and disharmony was caused within families and the community by the effect of western influences. These factors fulfill the conditions described by Scheper-Hughes and Lock (122) for the incubation of feelings of anxiety, resentment, anger and eventually sadness. The occasional violent outbursts by Tokelauan men with extraordinary sadness are also consistent with the external expression of angry emotions associated with sadness described by Scheper-Hughes and Lock.(122) Significantly, Tokelauan men may also express these angry feelings with self-destructive habits such as high alcohol use.

Scheper-Hughes stated that illnesses represented a "hidden language of pain and suffering" (123) and it is possible that the condition the Tokelauans describe as extreme or extraordinary sadness is a metaphor for their social, economic and cultural distress. It speaks of

unemployment and poverty as well as for their shame and loss of status in the community. Scheper-Hughes notes that doctors can either respond to this "hidden language of pain" or just ignore it and condemn it "to the domains of medicine."

5.4.i The Mask Of Smiling

The results also showed that the importance of maintaining a smiling face is emphasised in the Tokelauan culture from an early age. This learnt skill of maintaining a happy expression at all times can become a habitual mask when a Tokelauan is extremely sad. Interviewees indicated that a sickness involving extraordinary sadness caused a loss of respect and status. It therefore becomes an easy step to hide the sadness behind the smile, which they have been taught to display since childhood. This constant happy face makes sadness difficult to detect, whether by other members of the Tokelauan community or by the palagi general practitioner trying to diagnose depression.

5.5 Challenges for General Practitioners Treating Sad Tokelauans

The typical New Zealand general practice is modeled on the British system and with its emphasis on timed appointments, it is organised to suit the doctor rather than the patient. Barriers identified for Tokelauans attending the general practitioner in Taupo (124) included a failure by the doctors to understand the Tokelauan language or the importance of family or *'kaiga'* values. Complicated medical terminology was a further barrier as was personal pride, cost and transport problems. Patients often worked all day and were unable to get to an appointment without taking a full day off which caused income loss. When one member of the household took the car to work, remaining family members were unable to get to their appointments during the normal surgery opening hours. Taxi fares along with doctor's fees were prohibitively expensive.

It is extremely easy to have a consultation with a Tokelau Islander and be totally unaware that the patient is depressed. The typical New Zealand general practitioner is aware of time constraints and might already be running behind. He or she is aware of depression as a 'disease entity' that can present in a patient with certain symptoms. These include sadness or loss of interest in pleasurable activities as well as lesser symptoms from a list that includes sleep disturbance, loss of motivation and self esteem, irritability, anxiety, morbid thoughts and suicidal ideation.(30)

The Tokelau Islander who is experiencing extraordinary sadness is unlikely to present to the general practitioner overtly displaying any of these classical symptoms of depression. It is a cultural imperative that sadness is kept hidden and the Tokelauan can present apparently happy and with a completely different problem.

I now discuss the challenges facing the general practitioner who suspects a happy-appearing Tokelauan might be depressed. I will describe two relevant Pacific Island models of health that could assist diagnosis and identify the pertinent signs suggesting extraordinary sadness might be an issue. I will then propose an approach to the treatment and management of Tokelauan patients with extraordinary sadness within the general practice consultation.

5.6 Pacific Models of Health Care and Treatment

There are two existing models for Pacific health care that are particularly relevant to the clinical management of Tokelauan people in general practice. One of these is the Samoan Fonofale model, which is transferable to the Tokelauan context, and the other is a Tokelauan model that is similar in many respects.

5.6.i Fonofale Model

This is a Samoan model of health (125) but it appears relevant to the beliefs and values of the Tokelauan people as well as other Pacific Island nations. The model is one of a house or *'fale'* with a roof, a foundation and four pillars or *pou.* The roof is representative of the cultural ideals and beliefs of the people. Inclusive in this are the traditional healing methods. Many patients wish to incorporate these into their treatment and amongst the Taupo Tokelauan community, Tokelauan massage is commonly used for healing.(124)

The foundation represents the family, both extended and immediate. They are the important base from which the patient gets their values and culture. It is imperative for the general practitioner to offer to involve the family in the management of the Tokelauan patient. For reasons of confidentiality, this might not be always be appropriate, but involvement of family often makes 'detection of the metaphor' much easier. Three of the pillars or *'pou'* are representative of a person's *spiritual, mental* and *physical* health. Spiritual health is particularly important in the Tokelauan culture and mental health care must include it. This is predominantly represented by Christian values and in the Taupo region, includes participation in the local Catholic and Methodist communities. The fourth pou represents other variables in

life that affect health. These include, education, employment, poverty, age and status. The complete fale is enclosed in an *'envelope'* that is representative of environment, time and context. All these have can have an effect on the health of the Tokelauan presenting to the general practitioner.

5.6.ii Te Vaka Atafaga Model

As detailed in chapter two, Kupa (73) described a holistic model for the treatment of mental health conditions in Tokelauan people based on the Te Vaka Atafaga or outrigger canoe. This model varies from the Samoan Fonofale model by including important Tokelauan cultural values such as *'inati'* and *'fatupaepae.' 'Inati'* which was well described by interviewees in the study, refers to the Tokelauan custom of sharing both material possessions and food with the extended family and other members of the community. *'Fatupaepae'* refers to the privileged title given to older women who have a matriarchal role within the *'kaiga'* or extended family. He saw the canoe or 'paopao' as consisting of six parts each of which represented one component of mental wellbeing. These structural elements of the paopao were:

Te Tino o Te Tagata or the Tokelauan physical body is represented by the physical structure of the canoe. Kupa considered that "mind, body and spirit" were inseparable in the treatment of a Tokelauan patient.

Mafaufau or the Mind is the "navigator" or head fisherman who guides the canoe. He needs a healthy state of mind and excellence in his mental wellbeing to give him the wisdom and clarity of thought to sail a true course. Similarly mental wellness allows the Tokelauan to journey safely through life.

Kaiga or the Family are the "intertwined threads" of the rope. All parts join together to create strength and support for the paopao. They also bring with them the "beliefs, values, traditions and history of ancestors."

Tapuakinga / Talitonunga is the person's Spirituality and Beliefs and is represented by the sail. Health may be influenced by spirituality and the ancient belief that some mental illnesses are caused by evil spirits still exists. Similarly some Tokelauan patients may wish to see a traditional healer.

Puipuiga o Te Tino Te Tagata is the environment around the paopao including "the weather, the land, the sea, the sky and the wind." It represents everything in nature and the atmosphere that determines how smoothly the canoe sails on its journey.

The same environment provides food, clothing and affects the health of a person with different weather, winds and polluted air.

'Environment' also includes the conditions and cultural pressures that produce social inequality, unemployment and poverty. These are particularly prevalent in New Zealand society and cause stress, disharmony and ill health.

Fakalapotopotoga /Tautua are the social support systems and are represented by the *'ama'* or outrigger, which supports the canoe and keeps it upright. Similarly the Tokelauan social systems such as *'inati'* ensure that a person is well supported.

5.7 Successful General Practice Management of Sad Tokelauans

5.7.i Detecting The Metaphor

The Tokelauan patient with sadness may easily present wearing a 'smiling mask' and sadness might not be an obvious feature. However by using the metaphor of the Te Vaka Atafaga and assessing the Tokelauan using the variables in the structure of the canoe, the general practitioner can quickly detect the presence of disharmony in family, spiritual and other social factors. If the 'journey of the paopao' has been compromised by unemployment or poverty, the person may well be speaking of his distress through extraordinary sadness as described by Scheper-Hughes and Lock.(85, 122) The general practitioner can ensure family involvement – if appropriate – and individually assess each of spiritual, physical, mental and environmental factors. If social conflict or disarray is discovered during the environmental assessment, the general practitioner is then able to look for supporting evidence of an illness with extraordinary sadness.

The very sad Tokelauan is likely to be withdrawing from social contact both with family and with the rest of the community. He or she may have curtailed involvement in sporting and social events and may be avoiding regular Tokelauan community meetings. Faith is extremely important in the Tokelauan culture and the depressed Tokelauan might be remaining at home rather than attending church. Missed workdays are also possible and the patient might simply come to the doctor wanting a medical certificate to cover such unexplained absences. The sad Tokelauan male might also present after an episode of family violence and/or showing signs

of increased alcohol use. These might be the only signs of sadness in an otherwise happy-looking patient.

5.7.ii Danger Signs In A Depressed Tokelauan

This study did not attempt to conduct a detailed examination of suicide in Tokelau Islanders. However, the prevalence of suicide in the Tokelau Islands and amongst Pacific Islanders in New Zealand has increased over recent years.(2, 69) Although only a few participants in the study had personal experience of a friend or relative committing suicide, they commented that they did not see it coming. The ill person had possibly become quieter and more withdrawn prior to the ultimate event and these may well be warning signs. He or she might also have suffered a recent breakdown in social functioning or a loss of status in the community. There might have been a marriage breakup or a loss of employment causing financial catastrophe. In younger Tokelauans it might be the result of intergenerational tensions and upheaval.

5.7.iii Explanations Of Illness In Pacific People

Illness in Pacific Islanders is believed to occur when there is a breakdown in the structures comprising the fale of the Samoan model and in particular when there is antagonism between kin or disharmony in relationships.(126) For example, in Cook Islanders and Samoans, illness is believed to be due to disarray in social harmony, particularly amongst family whilst the explanation of mental illness may be given as a violation of *'tabu'* or sacred relationships. In Hawaii ill health is often blamed on previous "antisocial" behaviour.(126)

5.7.iv Treatment Of Sadness In Pacific People

Whereas the Pacific beliefs are that illness results from family disharmony as a result of disarray in other relationships, treatment can use both the Palagi medical model as well as traditional methods that deal with the upheaval and disarray. Traditional methods used in Hawaii include "family therapy" to resolve differences resulting in "apology and forgiveness."(126) Tokelauan families in this study used similar methods.

Suaalii-Sauni, Wheeler et al. (72) looked at the views of Pacific people regarding mental health treatment in New Zealand when Pacific models of care, including the Fonofale model, were used. Some important principles for successful treatment were emphasised. First, they stressed the importance of building "trust and rapport" between the provider, the consumer and the families. Second, respondents felt a holistic approach to treatment was vital. In stressing that a holistic approach to mental health was essential for success, the authors stated

that there needed to be “balance in mind, body and soul if there is to be health and wellbeing.” Thirdly respondents felt health workers needed to ensure that treatment involved the family. Interviewees felt that involvement of the family in treatment was a significant factor in their recovery and the cultural worth of *‘group therapy’* in a Pacific model of care was also stressed. Finally, interviewees said that a person’s cultural values including spirituality must be taken into consideration. Spirituality was part of mental health and this included both Christianity and “indigenous” spirits.

Kupa (73) emphasised the importance of respect when interviewing the Tokelauan, especially when referring to family members. He also stressed that many Tokelauans may wish to start and finish a consultation with a prayer. Kupa also uses a clinical case to show how using the Te Vaka Atafaga model enables full family involvement and holistic assessment of physical, spiritual, mental and social factors.

5.7.v Patient Centred Approach

Prior to the late 1980s and early 1990s, clinical consultations were predominantly ‘doctor centred’. The aim was to elicit all the symptoms of the biological disease process from the patient and then after doing appropriate tests arrive at a logical diagnosis.(127) Understanding the patient’s human experience of illness or its social context was considered unnecessary. This model was heavily critiqued by Levenstein, McWhinney et al. (127) and alternative models for the clinical consultation proposed. In their recent book, Wilson and Cunningham (128) describe the Patient Centred Clinical Method. This varies from the doctor centred consultation in that the patient’s illness experience is explored along with the details of the biomedical disease. The doctor enters the patient’s world and ascertains his or her “ideas, expectations, fears and feelings.”(128) These are then reconciled with the information the doctor has obtained on the organic disease. Although the essentials of the biomedical disease process are still elucidated, the consultation is patient-centred with the doctor responding to cues in the patient’s answers (127) and signs such as the body language. A “biopsychosocial” approach to the problem is now possible in which the psychological and social as well as the biological aspects of the illness can be considered.(129)

In the traditional ‘doctor-centred’ consultation, the interview characteristically opens with questions about the disease but Levenstein, McWhinney et al. (127) maintain that in the patient-centred approach, the doctor should start by listening carefully to the patient and elucidate exactly what his or her agenda is. This may modify the doctor’s own aims for the

consultation and will certainly clarify the future direction of questioning. With this approach, the doctor and patient can reach agreement on the causes of the illness. These causes will include all the environmental and social contributing factors as well as the physiological and anatomical influences that contribute to a disease process. In patient-centred medicine the doctor and patient negotiate and agree on a treatment plan that considers any fears and preferences that the patient might have as well as being able to take into account cultural and spiritual considerations.

The Te Vaka Atafaga model of health is a patient-centred clinical method. It allows the general practitioner to look at issues affecting the patient's health from the perspective of the sick person. The general practitioner becomes aware of social, family, spiritual and cultural aspects of the illness as well as considering the biomedical aspects of the disease process. The doctor is able to assess whether counselling or prayer is already occurring within the church or whether some therapy is occurring in the family. If these seem useful they can be affirmed and continued family and church involvement ensured. In this way, the general practitioner can use the Te Vaka Atafaga model to facilitate a patient-centred approach for treatment of the extremely sad Tokelauan. The doctor is able to have an approach to therapy that accounts for issues of social disharmony while supporting spirituality and continued family involvement.

This holistic patient-centred approach provides a toolbox for the general practitioner treating the Tokelauan with extraordinary sadness. The general practitioner needs to establish rapport and ensure that he has some understanding of Tokelauan culture before attempting treatment. This should include the importance of family involvement and spirituality as well as the nature of the Te Vaka Atafaga model.

After the diagnosis of depression is made the general practitioner should assess whether it is appropriate for family to be involved. Immediate or extended family members can come into the consultation and a further meeting can involve the minister if the patient desires. It is important that the causes of any social or community disarray are addressed and the doctor can now arrange family group therapy or counselling by the minister. Some locations have Pacific Islander social workers or mental health nurses and they can also assist in resolving underlying problems. The general practitioner also has to assess whether antidepressants are necessary and start them after full negotiation and acceptance by the Tokelauan patient.

Once a holistic treatment plan is in place, the general practitioner needs to follow the Tokelauan up to ensure that the underlying social, relationship and contextual issues are being successfully resolved. The doctor will also need to look for signs of return to health, remembering that in the Tokelauan culture these are very different from the biomedical signs of health. The general practitioner must again involve the family and ascertain whether withdrawal and isolation has lessened and whether the patient has started to become involved in community and church activities once again. The definition of *'health'* in the Tokelauan is the *'ability to perform normal function.'*(124) The doctor must ascertain when this occurs as part of the assessment of when the illness has resolved.

5.8 Limitations

The main limitation of this research was the small numbers of interviewees involved. However the factor was overcome as much as possible by continuing the interviews until the point of saturation when no new information was being obtained. I had originally intended to interview equal numbers of new arrivals to New Zealand as well as Tokelauans who had lived most of their life in the country. However with the diminishing size of the Taupo community there were not any recent immigrants and I had to seek participants in Auckland but was still unable to find recent immigrants in the time I had available.

Although I worked through a Tokelauan advisory committee, my position as a local general practitioner was sometimes a weakness. Circumstances necessitated the switching of roles between that of researcher and doctor. This position however was also a strength as the Tokelauans I interviewed trusted me and were happy to tell me about their culture. The language barrier was also a weakness as demonstrated by one interview, which was done in its entirety through an interpreter.

The main strength of the study was the consultation with the Tokelauan community in Taupo and the guidance of the steering group. A steering group member chose all the Taupo interviewees. I also had excellent support from members of the Tokelauan community in Auckland who were very cooperative in providing respondents for the study. The steering group members were also a vital sounding board. I was able to consult them individually for help or advice or to discuss depression and sadness in Tokelau Islanders.

5.9 Transferability

This study only involved the identification and treatment of depression in the Tokelau Island culture. However there may well be similar unmet health needs in other cultures where the symptoms and signs of sadness are different from those expected by western biomedicine. Transcultural and language barriers might mean that the patient has difficulty articulating these symptoms, especially when they are socially based. The general practitioner, on the other hand, might not recognise signs of depression that are ‘culturally coded.’ Use of a holistic, patient-centred approach involving the Fonofale model for diagnosis and treatment is likely to be successful for other Pacific people. A similar holistic approach but with a different culturally-based model might also be the foundation for the diagnosis and treatment of extraordinary sadness in many other cultures. This needs to be investigated by further research in the future.

CHAPTER SIX
CONCLUSION

This project originated during my consultations with Tokelauans in general practice.

Patients told me that there was no word for *depression* per se in the Tokelauan language. Although the incidence of depression amongst patients attending New Zealand general practices is 18.1%, the Tokelauans rarely discussed mental health. When I asked them what they understood by the meaning of health no one mentioned emotional health. I could find no evidence that the experience of depression had been studied in the Tokelauan culture and it seemed that the western model of depression was being applied to a culture where the illness did not even exist.

There is no specific word for depression as a disease entity in the Tokelauan language. However an illness involving extraordinary sadness, equivalent to depression as western medicine understands it, does exist in the culture. Tokelauans describe this condition using the words for unwellness and for burden or exhausting.

As well as extraordinary sadness, there are other symptoms of the condition that are recognised by Tokelauans. These include isolation from family and the community as well as absence from work and church. Tokelauan men with extraordinary sadness may display behavioural changes such as increased alcohol use and excessive violence in the home although the sample was too small to allow generalisations to be made.

There are three important barriers, which make detection of depression in the Tokelauan difficult for a general practitioner. First, pride is important in the Tokelauan culture and because of this, there is an element of shame and loss of status associated with showing extraordinary sadness. Second, Tokelauans also value their privacy and keep feelings of sadness to themselves. Third, the Tokelauans have a propensity to appear happy under all circumstances and to hide inner feelings behind a mask.

According to participants in my study, the main causes of extraordinary sadness amongst Tokelauans in New Zealand are social factors. The effects of socioeconomic changes result in unemployment and poverty whilst cultural changes produce tensions in the family and the

community. These influences cause anxiety, stress and eventually an illness characterised by extraordinary sadness.

Te Vaka Atafaga is a metaphor for Tokelauan wellbeing.(73) It is symbolised by a canoe formed from the structural components of health in a Tokelauan. It gives the general practitioner a logical patient-centred method for assessing the Tokelau Islander with possible extraordinary sadness. The doctor can use the components of the model to separately evaluate physical, spiritual, family and wider environmental contributors to the person's mental health. The Te Vaka Atafaga model also allows a holistic approach to therapy that includes traditional treatment and involves the family and church as well as palagi medicine.

The results from this research may be transferable to other Pacific people. It is likely that they have similar issues with diagnosis and treatment of extraordinary sadness. The Te Vaka Atafaga approach is a Tokelauan model but representatives of other Pacific people have accepted the Samoan Fonofale model, which is very similar. Using it as a holistic treatment approach involving family and spirituality will possibly be successful for the general practitioner treating Pacific islanders with extraordinary sadness.

It is also possible that the results of this study can be applied to other cultures where communication of culturally coded signs of sadness causes diagnostic and therapeutic challenges. Further research needs to be conducted to confirm this.

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APPENDIX

STUDY OF DEPRESSION IN THE TAUPO TOKELAUAN COMMUNITY

INFORMATION SHEET FOR PARTICIPANTS

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate thank you very much. If you decide not to take part there will be no disadvantage to you.

Aim Of Project

The Tokelauan language does not have any word for depression but in general practice Tokelauan patients are frequently seen with the symptoms of depression.

The project seeks to better understand the *palagi* illness of depression as it is experienced and treated within the Tokelauan community.

It is hoped that this knowledge will lead to better models of mental health care for Pacific people in the future.

I am doing the project as part of my Masters of General Practice Degree at the University Of Otago.

Ethical approval for the project has been given by the Northern Y Regional Ethics Committee.

What Type of Participants is being sought?

You are invited to participate because you are a member of the Tokelauan community.

A steering committee comprising Viane Perez, Isitolo Pakome and Maria Simeona has been set up and is approaching you on my behalf.

What will Participants be asked to do?

Should you agree to take part in this project, you will be asked to have a talk or an interview with me. The interview can be held at any time and place that is convenient to you and you are welcome to bring a support person with you if you wish.

A $30.00 petrol voucher will be available to pay for the travel costs of coming to the interview.

A translator will also be available if you require one.

The length of the interview can vary but may be as long as ¾-1 hour.

What data or information will be collected and what use will be made of it?

The interview will be recorded.

During the interview I will ask whether there is an illness in the Tokelauan community involving sadness and if so how it is treated. I will ask questions about what *palagi* call depression, and how you understand that idea.

You can decide not to answer a question if you feel uncomfortable and you can change your mind and withdraw from the project at any time if you want to.

I will then have the interview typed out and the copy will be returned to you for checking and correcting. I would like to have the opportunity to meet with you again at this stage so you can provide me with feedback about the interview.

You will not be personally identified on the typed sheets and no one except the typist, my supervisor at the University of Otago and I will see the typed copy of the interviews.

My study will not identify you personally but for statistical purposes I will anonymously record the ages of all participants as well as the number of males and females. I will also need to specifically know how long you have been in New Zealand.

Later in the study I would again like to meet with you and present my preliminary results and obtain your feedback.

All the information collected will be kept securely locked away at all times during the study in such a way that only those mentioned above will have access to it.

Once the study has finished personal identifying information, including the recording of the interview will be destroyed. However the data necessary for the results will be kept in secure storage for at least 10 years and then destroyed when no longer needed.

Results

I will be presenting the full results to a meeting of the Taupo Tokelauan community.

The results of the research may be published but they will not identify any of the participants.

Further Questions

If you have any questions about the project, either now or in the future, please feel free to contact me: -

Dr. Iain Loan
Ph: 0274 961 361 (mobile)

STUDY OF DEPRESSION IN THE TAUPO TOKELAUAN COMMUNITY

CONSENT FORM
FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that: -

1. My participation in the project is entirely voluntary.

2. I am free to withdraw from the project at any time.

3. Personal identifying information including the recording of the interview will be destroyed at the conclusion of the project but any data on which the results of the project depend will be retained in secure storage for at least ten years.

4. The questions during the interview will ask whether there is an illness in the Tokelauan community involving sadness and if so how it is treated.

   The project involves an open-questioning technique. The general line of questioning includes questions as to whether there is an illness in the Tokelauan community involving sadness and if so how it is treated. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decide not to answer a question and I can change my mind and withdraw from the project at any time if I want to.

5. It is possible that discussion of the subject of sadness may leave participants feeling uncomfortable. If this is a problem arrangements will be made for me to see a trained health nurse.

6. $5.00 petrol vouchers will be available to cover the cost of travel to the interviews.

7. The results of the project may be published but every attempt will be made to preserve my anonymity.

I agree to take part in this project

....

(Signature of participant)

....

(Date)

Health and Disability Ethics Committees

Northern Y Regional Ethics Committee
c/- Ministry of Health
Level 3, Bridgewater Building
130 Grantham St
Hamilton 3204
Phone: (07) 9293612
Email: northerny_ethicscommittee@moh.govt.nz

30 November 2011

Dr Iain Loan
65 Henry Hill Road
Taupo 3330

Dear Dr Loan -

Ethics ref: **NTY/11/06/066** **(please quote in all correspondence)**
Study title: **The experience of depression in the Tokelauan culture**
Investigators: **Dr Iain Loan**

This study was given ethical approval by the Northern Y Regional Ethics Committee on 30 November 2011.

Approved Documents

- Information sheet and Consent form version 2 dated 25/09/2011
- Questionnaire version 3 dated 25/09/2011

This approval is valid until 30 August 2013, provided that Annual Progress Reports are submitted (see below).

Amendments and Protocol Deviations

All significant amendments to this proposal must receive prior approval from the Committee. Significant amendments include (but are not limited to) changes to:

- the researcher responsible for the conduct of the study at a study site
- the addition of an extra study site
- the design or duration of the study
- the method of recruitment
- information sheets and informed consent procedures.

Significant deviations from the approved protocol must be reported to the Committee as soon as possible.

Annual Progress Reports and Final Reports

The first Annual Progress Report for this study is due to the Committee by 30 November 2012. The Annual Report Form that should be used is available at www.ethicscommittees.health.govt.nz. Please note that if you do not provide a progress report by this date, ethical approval may be withdrawn.

A Final Report is also required at the conclusion of the study. The Final Report Form is also available at www.ethicscommittees.health.govt.nz.

Statement of compliance

The committee is constituted in accordance with its Terms of Reference. It complies with the *Operational Standard for Ethics Committees* and the principles of international good clinical practice.

The committee is approved by the Health Research Council's Ethics Committee for the purposes of section 25(1)(c) of the Health Research Council Act 1990.

We wish you all the best with your study.

Yours sincerely

Amrita Kuruvilla
Northern Y Ethics Committee Administrator

Email: amrita_kuruvilla@moh.govt.nz

23 Motutahae Street
Taupo
09/06/2011

Ms Raewyn Sporle
Chairperson
Northern Y Regional Ethics committee
130 Grantham Street
PO Box 1031
Hamilton 3204

Re: Ethics Application- Dr. Iain S. Loan

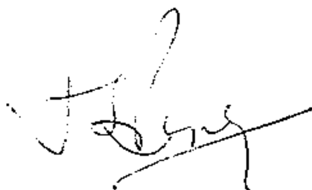
Dear Ms Sporle,

As a member of the Tokelauan community steering committee here in Taupo, I, on their behalf offer full support to Dr. Iain S Loan's ethic's application for approval for a research project studying the **"The Experience Of Depression In The Tokelauan Culture,"**

We as a steering committee will try our best to help and support Dr. Iain S Loan and his medical colleagues in trying to achieve the goals and objectives for this research project, because we know it will be good for our people in terms of better treatment not only now but for future generations.

I am happy to be a contact person for the Tokelauan community steering committee, if you need one.

Yours sincerely



Rev. Viane Perez
(Catholic Deacon)
Catholic prison chaplain-Tongariro/Rangipo prison.
Catholic Tokelauan chaplain- Diocese of Hamilton.