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Eva Morunga
Debbie Bean (debbie.bean@aut.ac.nz)
Auckland University of Technology https://orcid.org/0000-0002-0606-8749
Korina Tuahine
Karlee Hohepa
Gwyn Lewis
Donald Ripia
Gareth Terry

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Original Article

Kaumātua (elders') insights into indigenous Māori approaches to understanding and managing pain: A qualitative Māori-centred study

Eva Morunga,[1,2] Debbie J. Bean,[3,4*] Korina Tuahine,[3] Karlee Hohepa,[3] Gwyn N. Lewis,[3] Donald Ripia,[5] Gareth Terry[6]

1. Department of Psychological Medicine, University of Auckland, Auckland
2. Cancer Support Service, Te Toka Tumai Auckland District Health, Auckland
3. Health & Rehabilitation Research Institute, Auckland University of Technology, Auckland
4. Department of Anaesthesiology & Perioperative Medicine, Te Whatu Ora Waitematā, Auckland
5. Te Ipukarea Research Institute, Auckland University of Technology, Auckland
6. Centre for Person Centred Research, Auckland University of Technology, Auckland

*Correspondence: Auckland University of Technology, Private Bag 92006, Auckland 1142. debbie.bean@aut.ac.nz, Phone: +649 9219999 ext7157.

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Abstract

Background:

Chronic pain/mamae is a major public health problem worldwide, and disproportionately affects indigenous populations impacted by colonisation. In Aotearoa New Zealand, indigenous Māori experience a greater burden of chronic pain than non-Maori. However, pain services based on Western models are unlikely to meet the needs of indigenous peoples well. Little is published about traditional Māori views of, or approaches to, managing mamae/pain, knowledge that is traditionally held by kaumātua/elders. This study therefore aimed to understand kaumātua (Māori elder) views on the effects of pain, traditional pain management practices, and mātauranga (Māori knowledge) relating to managing pain.

Methods:

14 kaumātua participated in interviews or a hui/focus group. Methods honoured tikanga (Māori protocol) and centralised whanaungatanga (relationships). Interviews and the hui/focus group were transcribed, and reflexive thematic analysis was conducted.

Results:

Three themes were developed: *1. The Multidimensional Aspects of Pain*: Pain stretched beyond the physical and encompassed emotional and mental trauma, wairua/spiritual pain, grief from the loss of loved ones, contamination of the environment or breaches of tikanga/protocol. Some mamae/pain was described as everlasting, passing between people or generations. *2.Whakawhanaungatanga/Relationships: Healing through Connection.* Healing of pain was seen to occur through strengthening connections with people, the spiritual realm, the natural world, and with papakāinga (one's ancestral homeland). *3.Tino Rangatiratanga/Self-determination: Strength to Self-Manage Pain.* Self-reliance to manage pain and self-determination to make health decisions were critical, and a stoical approach to pain was described. Stoicism was noted to avoid perceptions of weakness and burdening whānau/family, but may inhibit emotional expression, connection and healing.

Conclusions:

Mātauranga/Māori knowledge emphasises that pain and its healing should be considered multidimensional, incorporating physical, mental, and relational components, existing in the spiritual realm and incorporating links between people, places, the past and future. Individuals may approach pain with a stoical approach, which may have both positive and negative features. Pain services may wish to incorporate this knowledge of the spiritual, social and psychological aspects of pain and pain management to provide more meaningful care for people with pain.

Key words: Indigenous health, Māori, New Zealand, Pain, Thematic Analysis, Cultural knowledge

Chronic pain is a major public health concern, being the leading cause of disability in Aotearoa/New Zealand, Australia and worldwide (GBD Collaborators, 2016). There are cultural differences and inequities in the experiences and prevalence of pain (Fillingim, 2017). Previous work suggests that the experience of chronic pain may be affected by intergenerational trauma and colonisation (Baker, 2018), part of the wide-reaching health effects of loss of land, violence, and suppression of language and culture. Thus it should not be surprising that indigenous peoples experience a greater prevalence of chronic pain than others (Jimenez et al., 2011). Māori are the indigenous people of New Zealand and make up 17% of the population of Aotearoa. Māori experience a greater burden of chronic pain than other New Zealanders, with 23% of Māori adults reporting chronic pain (a relative risk of 1.41 compared to non-Māori New Zealanders) (Ministry of Health, 2021), and Māori also report greater pain intensity, pain-related disability and distress than non-Māori (Burri et al., 2018; Lewis & Upsdell, 2018). Chronic pain frequently leads to negative mental, physical, spiritual, and economic consequences and affects family relationships and systems (Dueñas et al., 2016). Given the unequal burden of chronic pain, pain management strategies that specifically assist Māori should be a priority in Aotearoa.

The design of health services likely also contributes to the unequitable burden of chronic pain, as has been demonstrated broadly in healthcare (Came et al., 2020). Gold standard care for chronic pain usually involves an interdisciplinary team, providing biopsychosocial rehabilitation based in Western models. These programmes may not be compatible with the views of, and responses to, pain of indigenous peoples. Aotearoa data indicate that Māori do not benefit to the same degree as others from pain management programmes (Lewis et al., 2021), which is consistent with international findings from other culturally diverse groups (Brady et al., 2016).

If pain services are to better serve Māori, they should be underpinned by a Māori worldview and emphasize cultural strengths that can assist people to manage pain. However, few studies have described Māori cultural views of pain or pain management practices. Those that have emphasise that pain is viewed through a holistic viewpoint (Magnusson & Fennell, 2011) and pain may affect mental, spiritual and whānau wellbeing (McGruer et al., 2019). Māori may approach pain with stoicism, which likely affects help-seeking (Baker, 2018), and Māori have negative experiences of pain treatment in Western healthcare settings, including

racism, difficulty accessing treatment, and treatment not meeting cultural needs (Devan et al., 2021; McGruer et al., 2019). Whilst these findings indicate the need for incorporating cultural aspects into service design, they do not necessarily provide information about *how* this might be done. Kaumātua/elders are the holders of traditional knowledge for Māori, and this knowledge may provide insights to inform the design of pain management services. The aims of the present study were to understand kaumātua views on the effects of pain, traditional pain management practices, and mātauranga Māori/traditional knowledge relating to managing pain.

Methods

The study was a Māori-centred project conducted in accordance with Te Ara Tika research guidelines (Hudson et al., 2010), with Māori (EM, DR, KT and KH) and non-Māori (DB, GL and GT) working collaboratively. This study was first proposed by a Māori team member. The research team was guided by one experienced Māori researcher (EM), two highly experienced cultural advisors (EM and DR), one fluent te Reo/Māori language speaker (DR), and supported capacity building for two Māori researchers (KH, a postgraduate psychology student who was supported to complete a summer studentship on the project), and KT (a skilled qualitative research transcriptionist who was supported to engage in qualitative analysis for the first time). Non-Māori team members brought expertise with pain management (DB and GL), and qualitative methodologies (GT). During research team decision-making, Māori voices and opinions were elevated, with non-Māori team members taking supportive roles. All interviews and analyses were conducted together with at least one Māori and one non-Māori team member. The project was reviewed by the AUT Mātauranga Māori Committee and ethical approval was received by the Auckland University of Technology Ethics Committee (20/254). Formal consultation with kaumātua groups was not conducted prior to commencement, noting that the project itself was consultative in nature.

Participants and sampling

Kaumātua/elders who were known to members of the research team were contacted either face to face or by phone, informed about the study verbally and in writing, and invited to take part in an interview or hui/meeting (the hui was

used for an established kaumātua group). Two members of the research team (EM & DB, and for one interview KH & DB) conducted all interviews and the group hui. Tikanga/protocol was central to all research processes (described below). Each interview or hui/focus group took 60-120 minutes. All participants provided written informed consent to participate in the study. An interview guide was used, however kaumātua were given the flexibility to discuss what they saw as important.

Tikanga Māori

Whakawhanaungatanga was used to establish relationships. Researchers and participants described their own whakapapa/genealogy and formed connections. We also described the purpose of the research project and our commitment to using the information for advancement of Māori health. We opened and closed each interview with karakia/prayer. We sought to meet kaumātua face to face at a location of their choosing, although offered a phone and Zoom interviews when this was not practicable. Kaumātua were invited to include whānau/family in their interview/hui. *Manaakitanga*/hospitality was another key tikanga/protocol that aided the research approach. Kai/food was provided and shared with participants following the kōrero/discussion, and a koha/gift ($40 voucher) was given to each participant. By using open and reflective listening kaumātua knew their views were being heard and respected. Following the initial data analysis, kaumātua were invited to a hui/meeting to provide feedback on our data interpretation. Due to a COVID-19 lockdown, we had to do this using Zoom. Noting that the mātauranga/knowledge shared may be considered a taonga/treasure, a written summary of each interview was provided to each kaumātua for their retention along with a summary of the overall research findings with invitation for clarification, correction or additions.

Data analysis

All interviews/hui were transcribed in full (by KH & KT) and reflexive thematic analysis (TA) (Terry & Hayfield, 2021) was used to support analysis of the data through the six phases of analysis, with whole team discussion during each phase. KT and DB familiarised themselves with the data through multiple readings and casual note taking. They then independently engaged in systemic coding of the data at semantic and latent levels, and transferred codes to online Miro boards. The boards were used to cluster the codes and visually map potential themes. Taking on board team feedback and assessing them in relation

to the whole dataset, potential themes were developed into final themes. Themes were then named and defined and presented to the kaumātua at the zoom hui/meeting for further feedback, which was incorporated. Finally, the report was developed in line with Braun and Clark's (2021) guidelines for quality TA. Data storage: In keeping with the principles of Māori data sovereignty, data are in the possession of EM, a senior Māori member of the research team, and interview/hui summaries have been provided to participants. Reflexivity: The research team are a collaborative group with a shared vision of seeing Te Ao (Māori world) values brought into the mainstream of healthcare in Aotearoa.

Contextualised Results and Discussion

Fourteen kaumātua participated in the research project; their demographic details and pseudonyms are displayed in Table 1. The TA generated three themes that captured the shared meanings of mamae/pain. These themes all worked to tell a story of mamae/pain that countered reductionist, biomedical understandings of pain, and offering solutions that often extended beyond individual bodies that made sense within Te Ao Māori (Māori world). These themes were 1) the Multidimensional Aspects of Pain, 2) Whakawhanaungatanga: Healing through Connection, and 3) Tino Rangatiratanga: Strength to Self-Manage Pain.

Theme One: The Multidimensional Aspects of Pain

Very quickly, kaumātua led us to understand that mamae/pain is not limited to negative sensation in the body. They gave examples of pain stretching beyond the physical and into a person’s hinengaro/mind and wairua/spirit. Kaumātua gave examples of experiencing mamae tinana/physical pain on a daily basis. They spoke of aching limbs and joint pain, arthritis and old sports injuries. Christine spoke of living with a “frozen” shoulder, *“I’d had this major pain and, you know, you lift your arm a certain way and it just pain, you couldn’t get it any further, so getting dressed was difficult.”* Peter added, *“I’ve had both my knees replaced, elbows operated on, my back’s all worn.”* Hone added, *“Try having psoriasis and having a backache and having a headache.”*

However, there was little distinction between physical and other kinds of pain. Mamae tinana/physical pain was sometimes seen as a manifestation of

emotional or mental trauma. Whina discussed pain as a tohu/sign of something deeper when she shared a story of a young woman who sought rongoā Māori/traditional treatment when her broken foot was not healing:

> *This young woman is going to come and stay with us because she needs awhi [support] for her, not just this foot, but her depression, her mental well-being, the grief of her mother dying and not being able to go home - All in this foot.*

This resonates with the findings of Baker (2018), that Māori with chronic pain acknowledged that emotions 'held' in the body contribute to their pain. For some kaumātua, mamae tinana/physical pain was overshadowed by mamae hinengaro/psychological pain. Hone expressed, *"Physical pain is nothing to think about, really that isn't my worry."* Recounting a loved one's psychological distress after an amputation, Hone added, *"He just didn't want to live life with half a leg."* Hone's emphasis on the wider implications of the injury rather than the physical symptoms is evident in other research (Lambert et al., 2021). The mamae hinengaro/psychological pain, caused by fractures in whakawhanaungatanga/whānau-kinship relationships, was particularly relevant for Wendy, who shared her experience of growing up whangai/informally adopted:

> *'Your parents didn't want you that's why you're with us, but we love you,' and I knew that love was unconditional, but when you found out that your parents did want you that's when the pain hit. I had these mixed emotions, I was angry, but I didn't hate my parents I just felt as though they shouldn't've bullshitted about my parent, my biological parents, that hurt.*

This contribution of whānau/family or social disconnection to pain is consistent with prior work on Māori health, which shows near universal agreement that healthy whānau/family relationships are a key determinant of Māori health (D. Wilson et al., 2021).

Kaumātua also gave a broader picture of mamae/pain stretching into a person's wairua/spirit. Whina explained how spiritual contamination occurs in everyday life:

> *Something has contaminated their spiritual wairua, and that could've been abuse, sexual abuse, all kind of abuses, but in the time when it happened to them they might've been too young to understand.*

Kaumātua spoke of people suffering from terminal illness, mental health issues from violence and childhood trauma, and whānau disaffected by betrayals and rivalries as examples of mamae wairua/spiritual pain. When it came to mourning a lost loved one, kaumātua talked of remembering the pain that person was suffering and within Te Ao Māori (the Māori world), a whānau/family may envelop that spiritual pain, carry it with them and pass it from generation to generation. Hone clarified:

> *When that body becomes non-existent it doesn't feel pain anymore, your wairua [spirit] does because that never dies that will go on living and living, and I'll tell you how it lives, through you guys remembering the person that I was.*

These findings are consistent with broader views of wairua, that it extends beyond spirituality, but also has connections to past, present and future, to whenua/land and tipuna/ancestors, and is fundamental to Māori (Valentine et al., 2017).

Kaumātua are the conduits of knowledge given to them by tipuna/ancestors to pass on to their tamariki/children. However, these holders-of-knowledge experienced mamae/pain from having their voices drowned out by commercialism of the taiao/environment, pollution of modern-day living practices, and breaches of tikanga/protocols. Whina gave an example when describing spiritual contamination of the environment:

> *For Māori that's a mamae [pain], a deep deep mamae [pain] because we have a whakapapa [genealogy] that connects us to the earth and to the spirit and to the universe, and we have all our atua [gods] and kaitiaki [guardianship] in there that we're related to that we're meant to karakia [pray] to, we don't cut trees until we have a karakia [prayer], <u>but</u> some of those practices are all lost, so that honouring of all of those levels have diminished.*

Despite this mamae/pain of being ignored, kaumātua recognised their duty of care as kaitiaki/guardians. Whina explained:

> *You've got this little treasure box outside of the system and that's really painful, also, to not have that accepted by the rest of the world, when for Māori this is a beautiful rongoā [medicine] for everyone really, you know, but we had systems that protected it against abuse.*

Kaumātua also discussed end of life and the importance for Māori to return home and be buried on their papakāinga/ancestral homeland. DR (a senior Māori member of the research team) explained at the hui to discuss findings, *"Being back in the cemetery with all the people they grew up with, they know, that's what puts them at rest."* However, Wendy explained the mamae for kaumātua, *"Our kaumātua tell us to take them home. The children say, 'No. Why? Too far away. We can't afford.'"* DR added, *"And sometimes it can impact the parents if they know that the tamariki [children] isn't going to take them home."* The thought that they might not be laid to rest in their papakāinga/ancrestral home with ancestors was a deep source of pain for kaumātua.

Overall, theme one demonstrates that kaumātua viewed pain as multidimensional, physical symptoms were mentioned but not emphasised. More importantly, pain was also seen as a product of negative emotional or social experiences, trauma from life events, breaches of tikanga/protocol and spiritual and environmental contamination.

Theme Two: Whakawhanaungatanga: Healing through Connection

Kaumātua articulated an equally multidimensional process for healing pain. Many kaumātua viewed pain medication as a 'short cut', and explained that in order to heal mamae/pain, a deeper level of wānanga/learning was required. This healing involved forming or strengthening connections with people, the spiritual realm, the natural environment, and their papakāinga/ancestral home.

First, kaumātua described how connections between people were a source of healing, both within whānau, and within healthcare relationships. Whina described the importance of whānau relationships:

> *It's really important to have whānau [family]. With each other some, ahh, get hōhā [frustrated], but the strongest bond that keeps Māori going through that pain is the aroha [love] that they feel… That comes through and permeates this pain, this hōhā [frustration].*

Whina's comments resonate with Rameka's (2018) argument that deeply interwoven links between people form the basis for health. For some, the connections are to wider whānau/family, for others, it was specific individuals. Wendy described how after growing up in a world of dishonesty, her respectful relationship with her husband healed her mamae/pain:

Holding that mamae [pain], um, it sometimes used to make me vomit. But when I got married to Tom, um, I sorta left that, that didn't occur around me for quite some time. So I think I healed, if that's a word I can use, Tom, Tom healed me.

Within therapeutic relationships, aroha/compassion, listening, and connecting were key to healing. Participants emphasised the importance of aroha/compassion when using rongoā/traditional medicine. Whina explained when providing rongoā to a woman who stayed in her home:

The people around her at the time have to be in the spirit of aroha [compassion]. Ya know, there were times there where I could have lost it (laughing). But I had to be really true to what I've learnt about the power of aroha [compassion] and so I was able to hang on.

Kaumātua noted that human connection was often lacking in medical environments, but was highly valued when present. Previous pain research has identified racism and lack of cultural safety for Māori in pain management settings (Baker, 2018; McGavock, 2011), but has not necessarily focused on the subtle interactions that support better care. Mere, when asked about interactions with health professionals, explained:

I asked the next doctor that looked at me when my older one retired [about my pain]. *He was like, I don't think he wanted me. So, um, there are different doctors with different attitudes…* [My new doctor] *listens to me and it's, so I'm grateful that I've found other people that can hear what you're saying and not just writing it down on a piece of paper and giving you a pill every time, you know what I mean?*

The importance of meaningful healthcare relationships has also been emphasised in previous Māori health research (B. J. Wilson et al., 2021). These insights resonate with broader research on person centred care, which highlights the need for a reorientation to *cultures* of care; moving beyond the efforts of individual healthcare practitioners (Terry & Kayes, 2020).

In addition to being connected to people, kaumātua emphasised how being connected to the spiritual realm was a source of healing. Most participants spoke about using karakia/prayer to effectively manage pain. Ngaire commented:

if I'm in, um, really acute severe pain I'll just have to yell out to the Lord above and karakia [pray] to him and just ask for that relief and nine times out of ten he's listening.

Participants articulated how karakia/prayer strengthened their wairua/spirit, allowing them to cope with pain. Whina explained how her parents' faith influenced their pain:

> *Some moan some don't, so I'm talking about my father and my mother, ya know. My mother had, she had long ailments, but she put up with it through pregnancies through whatever because she had a faith. And so it was in that faith that kept her spirit strong. My dad was the opposite, he moaned every day, "I gotta sore back, I gotta sore head", but his faith, he had a faith but it wasn't quite as strong as mum's*.

Overall, this connection to the spiritual realm provided healing and pain relief. This is consistent with previous studies reporting that karakia/prayer is key to maintaining safety and centredness for Māori experiencing chronic pain (Baker, 2018), and that karakia/prayer is the most common and fundamental form of Māori healing (Reinfeld & Pihama, 2007).

Kaumātua also explained how connections to the natural environment heal mamae. Collecting and using native plants such as harakeke, kawakawa and tūpākihi were described as effective for relieving pain. Mere commented "a*s I became an adult and I found out what I felt was good for me and it* [rongoā] *works, it really works for me".* When asked if it reduces her pain or takes it away, she did not hesitate in explaining *"definitely take the pain away, that's for sure."* Kaumātua emphasized the benefits of heat and wai/water, particularly puna/spring water or bathing in waiariki/thermal water. Drinking pure water was valued for cleansing and healing. Kaumātua also described the therapeutic process of growing or collecting plants for rongoā/medicine, or going into nature to access thermal pools, which connected them to the whenua/land and provided exercise. Christine described:

> *I mean the puna [springs], you know especially at the Ngawha* [thermal springs], *those are the best of course, because it's got all those other things that are good for skin and everything else, so it was about heat and sometimes cold… but it was also the act of going there so it was the exercise, um, it was the fresh air and it was all those things.*

Katarina told a powerful story of allowing nature's elements to cure her cancer and pain:

> *I went to stay with my daughter… and she said to me, "Mum what are you doing outside?" I said "I'm letting the elements heal me". I put a mat,*

something on the ground. I sat there, and you know, I was cleaning up her garden with my hands, sun shining, wind blowing, and I was out there. Well thank you Lord, after a while I went back to the doctor (pause) it's gone.

Overall, connecting to the natural environment formed a powerful point of healing for kaumātua. Similarly, Durie (2000) argued that people have a spiritual connection to the environment, the nature and quality of people's interaction with the natural world influences their health.

Finally, kaumātua agreed on the importance of being connected to their papakāinga/ancestral home. Particularly when unwell or at the end of life, returning to papakāinga, and being buried with whānau/family and tipuna/ancestors was seen as essential. Knowing that one would be buried in one's ancestral home was described as giving peace. This finding echoes the work of Jahnke (2002), who found that connections to one's home place links a person to the whenua/land, their whakapapa/geneaology, whānau/family, marae, te reo/language, and ultimately helps to maintain their cultural identity.

Overall, the importance of being connected to people, place, the spiritual realm and the natural world is consistent with prior research on Māori health in general. Little previous research has identified the centrality of whanaungatanga/connections for pain specifically, but it was clear from kaumātua that these connections were key to managing or (more importantly) healing mamae. This challenges public healthcare provision for chronic pain, which usually has a biomedical or individual biopsychosocial focus but leaves out the natural and spiritual components of care. The Kapakapa Manawa Framework (Robinson et al., 2020) describes applying aroha/compassion, nurturing connections, knowing the patient, and using manaakitanga/hospitality within healthcare settings. This framework and others used for mental health (Niania et al., 2016) appear relevant to pain services. In inpatient settings, a limited number of kaumātua and chaplains usually attend to patients' spiritual needs, but it is currently unlikely that this is incorporated into (generally outpatient) chronic pain management. Providing spiritual care remains a challenge for Western healthcare.

Theme Three: Tino Rangatiratanga: Strength to Self-Manage Pain

Kaumātua spoke of people facing pain with personal strength and individual resourcefulness. In contrast to Theme 2 which describes healing through connection, this theme focuses on what people must do as individuals – especially when ongoing disconnection still exists. Three aspects of using strength to cope with pain were discussed: self-reliance, self-determination and stoicism.

Kaumātua described using positive strategies and activities to maintain self-reliance and live a meaningful life despite mamae/pain. For example, using exercise, maintaining a positive attitude, accepting pain, and enjoying dance, music, and laughter were all mentioned as antidotes to pain. Several participants discussed the importance of exercise, for example *"I have to walk for exercise. I used to walk up and down the deck, up and down, just for exercise… Because being idle is not good for no tinana [body]"* (Katarina). Accepting pain as a part of life, especially with ageing, was viewed as positive. Mere explained *"as I've gotten older it's like a gradual declining in health… And with it comes this slow peaceful acceptance. That's the only way I can explain it, you are accepting what's coming along really gradually"*. This acceptance was accompanied by an acknowledgement of the benefits of maintaining enjoyment in life. This was clear from the group discussion at the hui; Margaret: *"when you wake up have a big fat feed (laughing) you know, and then";* Katarina: *"a cuppa tea";* Margaret: *"a good laugh yeah"*; Harriet: *"a good laugh keeps you young"*; Margaret: *"and I love dancing so I put the music on and just dance (laughing), I just dance even though sometimes I can't move my bones"*; Ngaire: *"and you get up and kanikani [dance]"*; Margaret: *"my bones clicking and I'm going "ohh this is hard""*; Harriet: *"I just sit there I dance on my chair sitting"*… Margaret: *"I know we need medication but dancing, being happy"*; Harriet: *"singing"*; Margaret: *"it cleanses your soul you know, your soul feels free"*; Marama: *"what lovely medicine".* This positive self-reliance and active coping is consistent with the skills taught in Western pain services, however kaumātua had developed their own personal strategies based on their lived experience.

Kaumātua also articulated the importance of exercising tino rangatiratanga/self-determination to take control over their health. They did this by developing physical awareness, making their own health decisions, and even identifying their own health problems. Mere gave an example:

> *I had a blood clot on that same leg and it was like all the doctors and nurses running around, and I went straight to the doctors and I said "I*

> *think I have a blood clot" and, oh, they started panicking. And that's what I mean, I was able to do that because I knew my body, but other people don't have a clue*.

Similarly, Katarina argued for the superiority of her own knowledge of her body over that of health professionals:

> *I think I wanna be my own doctor. I don't mean to be rude to the doctors here, but, you don't know my body, only me, and I'll tell anyone that, you don't know my body*.

A number of kaumātua described rejecting Western medicines due to side-effects and ineffectiveness, and utilising rongoā/traditional medicine or other strategies. Many participants described being judicious in their healthcare decisions, and emphasised the importance of making health decisions themselves.

The value of tino rangatiratanga/self determination for coping with pain is not surprising given the socio-political context and importance of self-determination for Māori across life domains. Colonisation, racism and marginalisation are all powerful determinants of Māori health (D. Wilson et al., 2021), and ongoing racism and inequities exist. Therefore, being able to make one's own health decisions or find personalised strategies may be empowering and contribute to wellbeing.

Finally, valuing a stoical, uncomplaining approach to pain meant participants often did not discuss pain with others, which had both positive and negative aspects. Positively, kaumātua described feeling strong and not needing help with pain. Accordingly, they did not want to burden whānau/family. When asked why she does not tell family about her pain, Mere explained:

> *Because I'm handling it. Uh, they'll all come running if I talk like that eh, and that is not helping me to see them running like that. My son lives* [nearby]*, he'll prop me up if he needs to, I know that. But, I have this thing about trying to be strong within myself as I'm getting older, because to me that it's so important that I stay as strong as I can be right now*.

This sentiment echoes McGavock's (2011) study of Māori with chronic pain, who preferred to keep pain to themselves rather than burden whānau/family. Kaumātua in the present study explained that disclosing pain outside of the whānau/family may be associated with feelings of whakamā/shyness. Rawiri described his work supporting families in a healthcare setting:

One of the biggest pains for them… is talking about it… their pain… I just listen and let the nurses talk and you can see some of the body language and they don't want to talk or they dunno what to talk about or they too shy or… they'd rather not, they'd rather suffer in silence.

This resonates with Magnusson & Fennell's (2011) finding that Māori view pain as a private experience and prefer not to discuss It. Kaumātua indicated that another reason to keep pain to themselves was a general negativity towards pain in society; those who complained of pain may be seen as weak. Some described examples of being 'hardened up' to pain in a time when physical punishment was the norm in both Māori and Pākehā cultures. Peter described this, saying:

Oh, I can only remember, you know, Māori Pākehā rānei [either/or] about "if you don't shut up I'll give you something to cry about". So, you know, we're taught at an early age, hey, to toughen up… so you build up that you know, you gotta, I've gotta high pain threshold.

Hone described violence from teachers, caregivers and siblings, and explained the macho rugby culture he had experienced:

My knees were like this since I was 35… playing rugby in those days they didn't have those people running onto the field and [saying] *"are you alright?" – and they'd bring out the ambulance with a stretcher and all that. I hurt myself up at Riverhead. Bloody hell – all the players finished and I was "hey where's my ride?" "oh bugger you, we're going to the pub". I mean, what I'm saying, the difference between generations of looking after one another's pain is far, far away.*

This kind of story fits with the kinds of masculinities expected in Aotearoa, especially in the days before rugby's professionalisation. Similar accounts have been found in previous studies involving Māori men and pain (Baker, 2018; Dixon et al., 2021).

Several kaumātua described how this stoicism could have negative effects as it left them unable to express emotions and receive support. This was particularly relevant when pain was too challenging to manage independently. Wendy described growing up in a time where it was unacceptable to talk about mamae/pain, explaining *"the people that I spoke to never never talked about it"*. Instead, despite painful life events she would present a view of having a happy life. However, Wendy acknowledged that this meant she and others were

“bottling up” their mamae/pain, leading to an emotional burden and lack of support. There was also no professional support available;

> *But the thing with Māori and I think some of the kaumātua… even Pākehā [NZ European], a lot of them never got counselling. So they just carried that mamae [pain] inside… When you’ve got no counselling you don’t get any help so you’re, you’re carrying that day in and day out*

The concept of carrying the ongoing burden of unexpressed pain is consistent with the concept of whatumanawa, the need for healthy open expression of emotions like grief, anger, joy or jealousy (Pere, 1997). Such emotions may be expressed through means other than talking, such as haka, waiata/song, or tears (Love, 2004). Overall, kaumātua therefore described enduring pain with considerable strength, but recognised the risks of people not sharing their pain.

Strengths of the Research

The main strength of this study was the Māori-centred approach based on Kaupapa Māori principles, with tikanga honoured throughout the research process. Four members of the research team are Māori and two senior Māori members of the research team are experienced cultural advisors with deep expertise in tikanga/protocol, Te Reo Māori (language), and knowledge of Te Ao Māori (the Māori world). A further strength is the depth and quality of the reflexive thematic analysis, conducted in parallel by two members of the team with oversight from an expert methodologist. The sample was made up of a majority of women, predominantly those living in the city, and with whakapapa/ancestry to Northern and Central New Zealand iwi/tribes. Given the limited research in this field, future studies may wish to explore the topic in a wider group of kaumātua.

Clinical Implications

Based within the mana of the kaumātua who participated, this study provides firm guidance that for Māori, optimal pain management should be based on a broad holistic understanding of wellbeing. Although current multidisciplinary pain management typically includes biomedical and psychological treatments, spiritual, social and natural components are rarely incorporated and this needs to be prioritised. This study highlights that Māori have successful ways of managing pain, and indicates that promoting rongoā/traditional medicine, spiritual support

and self-management within community or Māori healthcare settings is important. Māori-led services for pain management need to be developed, and mainstream services may need to embrace a significant cultural shift and incorporate mātauranga/Māori knowledge and values from Te Ao Māori/ the Māori world into their practice. The He Awa Whiria (Braided Rivers) approach provides a framework for integrating Māori and Western knowledge in research and practice and this could guide such a process.

Conclusions

Kaumātua insights into the nature of pain and traditional approaches to pain management indicate that first, pain should be considered a multidimensional phenomenon with possible origins in the spiritual realm, broader natural environment, as well as an individual's social relationships, history of trauma or psychological distress, and the physical body. Second, the healing of pain involves forming or developing connections between people, with the spiritual realm, the natural world, and one's ancestral home. Third, pain may be approached by individuals with significant strength, whereby people utilise positive self-management strategies, exert self-determination over their bodies to make their own health decisions relating to pain, and approach pain with significant stoicism, keeping pain to themselves rather than risking loss of mana or burdening whānau/family. These findings highlight discrepancies between broad holistic indigenous approaches to pain and the individually focussed biological and psychological approach in Western healthcare, and provides impetus for developing better services for pain management in Aotearoa.

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Table One. Participant Characteristics

Pseudonym	Age and gender	Iwi	Participation
Ana	69, female	Ngāti Maru	Hui
Christine	62, female	Te Aupouri, Te Rarawa, Ngāpuhi	Hui
Harriet	80, female	Ngāpuhi, Ngā Tiwai	Hui
Hone	74, male	Ngāti Hine Ngāpuhi	Individual interview
Katarina	73, female	Tainui	Individual interview & Hui
Marama	64, female	Ngāti kahu, Te Rarawa	Hui
Margaret	60, female	Tuhoe, Ngāpuhi	Hui
Mere	72, female	Ngāpuhi	Individual interview (phone)
Ngaire	63, female	Ngā Ruahinerangi	Hui
Peter	71, male	Te Roroa	Hui
Rawiri	71, male	Te Rarawa	Couple interview
Sue	83, female	Pakeha*	Hui
Wendy	76, female	Ngāpuhi, Te Rarawa	Individual interview (video call)
Whina	72, female	Ngāpuhi	Couple interview

* Sue is a Pakeha, she was included as she is recognised by the kaumātua group as a kaumātua and group member.