

The experience of participants in therapeutic storytelling group /Te roopu
pakiwaitara who live with mental illness in the community:

A qualitative descriptive study

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Abstract

This qualitative descriptive study sought to answer the question “Does storytelling/pakiwaitara programme change participants’ life experiences in their journey of recovery?” This programme was initially established to engage and support clients’ recovery in the community mental health team where the researcher works. The aim of the programme in this research was to provide a safe environment to increase participants engagement with their teams and the community. It was hoped this study could produce evidence from practice that would unfold greater understandings about this kind of programme. A thorough literature review was performed revealing paucity in the literature about this topic. Qualitative descriptive methodology was selected for this study which sits under the umbrella of the post positivist paradigm, which seeks to understand what is like to be human, and the meaning of people’s live and experiences. Eight participants were recruited for this study, through an invitation given by a peer support worker. Participants lived and were selected from the Counties Manukau Mental Health services, New Zealand. Participants were of different ethnic origin but mainly Maaori. Semi-structured interviews were carried out and lasted approximate 45 minutes to an hour, interviews were recorded and transcribed verbatim. The transcribed data were analysed using thematic coding. Rich descriptions of participants’ experiences emerged.

Three main themes emerged from the analysis. The first theme was breaking barriers and was described, by participants as how they overcame barriers to attend to the programme. The second theme was creating positive memories, which uncovered the positive experiences that participants experienced during the programme. The final theme was becoming another person; this theme described transformative experiences that emerged from the data through language, feelings, hope, privilege, honour and inspirations that participants shared especially through participation in the programme. Strengths and limitations, of the study and suggestions for future research are identified.

Findings of this research demonstrated that participating in storytelling/pakiwaitara does help participants who live with mental illnesses in their journey of recovery by: breaking barriers, creating positive memories and experiencing another way of being.

Dedication

I would like to dedicate this work to my wife Jennifer who has given me a lot of encouragement and inspiration to complete this thesis. Also Jennifer and I have been facilitating storytelling/pakiwaitara for many years to the Tangata whenua of this country. It has been Jennifer's inspiration, creativity and willingness to support this kind of therapy in a mental health service that awakened my interest to use this in my own practice.

It is imperative to also dedicate this work to all the people of the world who are illiterate; that even though they cannot read or write, they still enjoy the power of listening and storytelling.

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Thank you to the AUTECH for the approval of this study Number 14/215 and I also extend many thanks to Counties Manukau Health for funding and approving this study. Thank you to the Counties Manukau Health Maaori Research Committee for allowing me to contact Maaori clients from the CMH area.

Attestation of Authorship

I hereby declare that this submission is my own work and to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for this qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements.

Signed.....

Dated.....

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Chapter 1 Introduction to the Study

1.1 Introduction

This study aims to increase understandings about the use of therapeutic storytelling/pakiwaitara for people who live with a mental illness. The research question is “Does participating in storytelling/pakiwaitara workshops change participants life experiences in their journey of recovery?”

This study emerged, as there was a paucity of literature about therapeutic storytelling, which is the method that is used in the storytelling/pakiwaitara workshops within Mental Health communities in New Zealand and around the world. It aims to produce evidence from practice and unfold greater understandings of this topic, which will contribute to current knowledge and literature about storytelling/pakiwaitara in a mental health context both in New Zealand and internationally.

A qualitative descriptive methodology was selected because its design provided ways of exploring human experiences. This methodology allowed participants in the therapeutic storytelling programme to focus on uncovering in-depth understandings of their experiences. It also allowed for the use of a combination of methods to be used for example: purpose sampling, data collection, analysis, and representational techniques to answer the questions of special relevance to the researcher (Sandelowski, 2000). The methodology and method used in this study is described in more depth in chapter three.

This chapter begins with the background that led to the current recovery model that is used in the New Zealand context. Recovery is then introduced and how this initiated the development of therapeutic storytelling programmes in Counties Manukau Health (CMH). An overview of the population of CMH is included. Next there is an overview of how group work such as the programme in this study benefits people who live with mental illness. This is followed by an outline of how and why therapeutic storytelling emerged and is used in CMH. An overview of the researchers’ journey as a psychiatric nurse that led to the implementation of storytelling/pakiwaitara as a tool to enhance recovery is then provided. The chapter concludes with an outline of the structure of the thesis.

1.2 Background of recovery in New Zealand

Historical changes in the mental health sector have occurred in New Zealand which led to the adoption of the recovery approach. These changes in mental health services in New Zealand were initiated in 1961 when the joint commission for mental illness and health published its recommendations for community alternatives instead of hospitals (Berks, 2003). Kingseat Psychiatric Hospital was one of the first hospitals to implement these de-institutionalisation¹ policies. Kingseat Psychiatric Hospital was built in Karaka in 1932. It was originally built to replace the overcrowded Avondale Hospital, which was one of New Zealand's first generation psychiatric hospitals. Avondale Hospital later became Carrington/Oakley Psychiatric Hospital (Berks, 2003).

In the 60's, as a result of the joint commission, recommendations for the establishment and maintenance of responsive residential environments for people living with mental illness took place. Recommendations also indicated the need for adequate support services and the introduction of Psychiatric Domiciliary Nurses(PDN) to follow up patients that were discharged from hospital into the community (Berks, 2003).

People diagnosed with a mental illness at this time who were living in psychiatric hospitals were able to move and be treated in the community under a community treatment order which is currently Section 29 of the Mental Health Act (1992). As time progressed, amendments to the Mental Health Act (1992) gave patients more rights as people, initiating their recovery by having input into their treatment and integration into the community.

By the late 1990s New Zealand had fully implemented the de-institutionalisation process. De-institutionalisation was described as preventing admissions to institutions and by finding and developing alternative patterns of community care (Berks, 2003). Different services in the community were created to prevent admissions to institutions by finding and developing supports and training for

¹ Release of institutionalized individuals from a psychiatric hospital to care in the community (Becks, 2003)

clients, family/whanau, community and staff. It was at this time that mental health service delivery in New Zealand started to look at recovery.

1.3 Recovery in the New Zealand context

In New Zealand it is important to appreciate that the term recovery is known as the process of how people overcome the obstacles and challenges they face through living with a mental illness (Le Boutilier, Leamy, Bird, Davison, Williams & Slade, 2011). The recovery approach is seen to be a deeply personal unique process of changing ones attitude, values, feelings, goals, skills, and roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness (Murphy, 2012).

Recovery principles are defined by Curtis, Copeland, & Palmer (2002), as recovering rights, roles, responsibilities, decisions, potential and supports. Recovery is a process, not a place, and is used to facilitate and promote opportunities and safe environments where clients who live with a mental illness can be empowered to have positive experiences and develop understandings about their illnesses, strengths and their recovery.

It was amidst the emerging ideas around recovery in 1997 that the Intensive Community Team (ICT) was formed in Counties Manukau Health. This is where the researcher of this study worked as a Nurse Case Manager and the opportunity to train in therapeutic storytelling arose to use as an intervention. Therapeutic storytelling was an intervention that appeared to fit with recovery principles to enhance rapport, engagement, and socialisation, for clients who were not engaging in many interventions other than just taking medication. The programme was adapted to meet the needs of the CMH clients.

1.4 Demographics of Counties Manukau Health

All the participants interviewed for this study live in the Counties Manukau Health area. In 2011 Counties Manukau Health estimated that 35,180 people or nearly one in ten adults aged eighteen and over living in the Counties Manukau received care for a mental health disorder. These figures indicated a high prevalence of care for mental health disorders for Maaori compared to other ethnicities (Winnard, Lee & McLeod, 2015).

According to the demographic profile of the 2013 census population the estimated resident population of Counties Manukau in 2014 was 509,060 people, 11 % of the total New Zealand population (Winnard et al., 2015). The population of Counties Manukau is multi-ethnic with a high proportion of Maaori 16%, Pacific Islander 21%, Asian 23% with Europeans and others 40%. Counties Manukau has proportionally more people in the most deprived section of the population than the national average. It is estimated that the population in 2015 would equate to 187,250 people living in areas of high socioeconomic deprivation (Winnard et al., 2015).

1.5 Benefits of group work

The main intervention used with people who live with mental illness is medication, combined with psychosocial interventions. The World Health Organisation (WHO) reported confusing results regarding long term efficacy of medication as a sole intervention with clients who experience mental illness. Alternatively, evidence based research indicated the importance of the role of psychosocial intervention with individuals with schizophrenia (Andreasen & Black, 2011).

Psychosocial intervention plays an important role in the management of mental illnesses and must be adapted to fit individual's needs, the phase of the illness and the living situation. These interventions help to provide social skills training and a format to allow friendships to develop. Group therapy can provide a highly effective way for clinicians to follow and monitor relatively large numbers of people who experience mental illness (Cole, 2005).

Research highlighted the following benefits of group therapy: Instilling hope, developing skills, imitative behaviour, cathartic discharge of emotions, interpersonal learning, importing of information, behaving altruistically through attempting to help other members of the group and learning through feedback how ones behaviour affects others (Andreasen & Black, 2011; Cole, 2005).

Therapeutic storytelling as an intervention fitted well with these concepts of group work outlined. The idea of providing a psychosocial intervention that was friendly and non-invasive, that could offer people living with a mental illness the opportunity to have fun, and also be able to participate in something creative and new was inspiring. Landy (1994) argued that the use of creative forms of dancing,

art, music and drama, attempts to address mental health issues through non-threatening processes. This leads onto providing an overview of how and why therapeutic story telling emerged at CMH.

1.6 Introducing pakiwaitara

The therapeutic storytelling programme was initially established to support clients in the community mental health team where the researcher worked. The aim was to provide a safe environment to increase engagement, occupations, creativity, community involvement, self-awareness, self-expression, communication skills, socialization, strengths, and enhance recovery. The therapeutic storytelling programme is based on psychodynamic principles and involves the use of myths and legends which are re-enacted by the group, with discussion using a six stage story process (see Appendix A). This programme involves the use of mime, drama, music, movement and materials as props. Refer to (Appendix A) for a chronological account of how the individual session of each therapeutic storytelling programme is facilitated.

The therapeutic storytelling programme started in the Intensive Community Team in 2002 and has been facilitated successfully for the past fourteen years at Counties Manukau Health by a range of different services in a variety of settings. These include: Pacific Care Trust which is a non-government organization that caters for Pacific Island clients who live with a mental illness, Tiaho Mai which is the local acute mental health unit based at Middlemore Hospital and Te Puna Waioara, a Maaori clinical mental health community team. Some of the tangata whaiora² /clients have attended only once and others for up to two years, once a month or have been part of a 6 week programme running four times a year for up to two years. Approximately 2000 clients/tangata whaiora have attended these groups between 2002 and 2016. Many of these tangata whaiora do not engage with other community agencies and have not had the opportunity to be involved in any expressive therapies such as therapeutic storytelling. The theoretical underpinnings of the storytelling/pakiwaitara programme are outlined in the next section.

² Person seeking wellness: mental health service user

1.6.1 Theoretical approaches

A number of therapeutic approaches are the basis for guiding the understandings and practices implemented in this programme. I begin with drama therapy because it is the core practice that was implemented.

1.6.2 Drama therapy

Drama therapy is an expressive therapy developed out of the work of remedial drama, by people such as Peter Slade between 1940 and 1950, and Sue Jennings between 1960 and 1970. Drama therapy had its roots and influences embedded from Greek theatre with ideas of ritual and catharsis Ruddy and Dent-Brown (2008).

Drama therapy is described by Ruddy and Dent-Brown (2008) as action orientated, using client's issues in dramatic metaphor, and by the application of a number of techniques, modalities and dramatic processes. Some of these included the use of role play, storytelling, myths and legends, fairy tales, folk tales, performance making, dance, music, mime, working in small groups, improvisation, the creation of therapeutic rituals, use of masks, puppets, and symbolic objects such as archetypes which will be described shortly.

Role

Landy (1990) talked about story and role as theoretical concepts that constitute drama therapy. Story is described as the utterance, the gesture and sound that inform the nature of the client's role (p.223). Role is described as what is inside the individual that contains the qualities needed to be enacted in the drama therapy Landy (1990). Identification, projection and transference are aspects that happen while taking a role (Landy, 1994, p.110). Acting is a form of projection where the actor projects the thought, feelings, spirit and behaviour of another, then enacts them in the guise of the other as if he or she were the other (p.108). Projection also has a positive function by projecting qualities of one's self, outward in order to play and test reality from a safe distance (p.108). Distancing is where the actor experiences a separation of thoughts from feelings (Landy, 1994, p.111). Identification occurs when the actor identifies with the other, imitating their

actions, qualities of thoughts, feelings, and behaviours, and allows this to drive the role-play (Landy, 1994, p.110).

Transference is how we see others for example a friend as a mother, and therapist as father representation (Landy, 1994, p. 108). Transference is an imaginative act and can include transferring archetypes onto individuals, which is described in the next section. Landy (1994) informed us that it is normal for the creative individual to transfer archetypal images into neutral objects.

1.6.3 Archetypes of the collective unconscious

Images of the universal experiences contained in the collective unconscious are called archetypes by Jungian psychologists (Corey, 2013). Hyde and McGuiness (1992) described Jung's theory of collective unconscious as being formed by two components: the instinct and the archetypes. The instinct controls our impulses to act and the archetypes determine the mode of apprehension of our actions.

Archetypes reveal themselves as inherited images and according to Van Eenwyk (1997), these images are common to humankind e.g. Mother and Father.

Archetypes contain aspects of balance, excess, intensity and shadow (Butler, 2014).

Butler (2014) identified the most important aspects of archetypes:

- the shadow
- the anima and the animus which take a major role in the process of identification
- the persona

I will discuss these in turn below.

The shadow

The shadow as described by Christopher and Solomon (2000) is the part of our self that we do not like and project onto others, such as, weakness, vulnerability, sexuality, brutality and violence. Jacobi (1973) identified that by bringing the shadow into a conscious state it allows a chance for correction of one's self and to find wholeness. This process according Van Eenwyk (1997) involves recognising the dark side of the personality.

The anima and the animus

Jung named in males the anima and in females the animus and that these images represent the male and female part that we each carry e.g. every man has his own Eve 'female' and that every woman has her own Adam 'male' as part of being human (Jacobi, 1973). Butler (2014) talked about Jung's work of the anima and animus as being a pre-stage of discovering the self. That one needed to get to grips with this stage in order to open the way for higher achievements such as self-actualization.

The persona

Jung talked about the persona as the individual that we present towards the outside world (Jacobi, 1973). The persona according to Landy (1994) "is the mask or role that one's wear in relation of the social world" (p.21).

The collective unconscious

The collective unconscious is referred to as the deepest level of the psyche or mind containing the accumulation of inherited experiences of our personalities that connect with our past and history (Corey, 2013). Acknowledging the work of Jung, Corey (2013) recognised that the unconscious expressed itself in symbols and metaphors. These expressions are common in myths and legends and they provide a medium to work with group members in a non-invasive and non-intrusive way.

Storytelling/pakiwaitara deals with a range of different personalities. In addition, some people's personalities have been impacted by abuse. It is very important to recognise different personalities to be able to provide appropriate interventions to use. Jung developed a personality typology that begins with the distinction between introversion and extroversion.

1.6.4 Jung's personality theory

Jung described introverted people as preferring their inner internal world of thoughts, feelings, fantasies and dreams to the external world; and, they tended to be shy. However, extroverted people prefer the external world of things, people, and activities thus tending to be more sociable (Boeree, 2007). Jung suggested

four basic ways in which humans create a connection between the inner and outer world. These are the following:

- Sensing: getting information by means of the senses e.g. seeing, touching, hearing etc.
- Thinking: evaluating information.
- Intuiting: kind of perception outside the rational thinking.
- Feeling: evaluating information by being aware of one's emotional response.

Jung informed us that all humans have these functions (Boeree, 2007). He recognised that whether we are introverted or extroverted we need to deal with the inner and outer world (Boeree, 2007). Jung's psychodynamic theories have opened new avenues for different approaches to support humans to deal with their inner and outer worlds. Presented next is the sesame approach which uses the psychodynamic theories discussed by Jung that are used in the storytelling/pakiwaitara programme.

1.6.5 The sesame approach

The sesame approach originated in England in the 1960's when understandings into the world of mental illness were limited. At this time, there were few opportunities for people who lived with mental illnesses to alleviate their difficulties other than drug treatments (Lindkvist, 2007). The sesame approach uses stories, movement, and drama, and is based on a psychodynamic approach. The word 'Sesame' gained its meaning from the magic call 'Open Sesame' as described in the story of Ali Baba when he yelled these words to the magic cave which opened its door revealing all of its treasures inside. In this context it is significant as being used to open the closed doors of group members' unconscious which has a rich wealth of material stored (Lindkvist, 2007).

Drama and movement became part of the sesame approach in 1964 and were based on the work of Rudolph Laban's Art Movement, Peter Slade's drama therapy with children and the work of Marian Lindkvist who specialised in movement and touch.

The sesame approach is based on creativity, providing a safe space to facilitate this process. Storytelling/pakiwaitara draws on creativity as an important aspect of

providing healing and opportunities to access the unconscious and use self-expression in a creative and non-intrusive way. It uses the story as a medium to access the collective unconscious. The following model of creativity is presented next as it was useful in understanding how participants in the programme and this study experienced being creative.

1.6.6 Creativity

Jung argued that creativity is a psychic function that has its roots in the conscious and unconscious mind. He felt humans have lost access to creativity, which springs from the collective unconscious (Jacobi, 1973). Later research conducted by Christopher and Solomon (2000) defined four stages of the creative process.

The first stage: Preparation; which is the time period when information is taken in. In the context of this study was when participants received their invitation (refer to Appendix L) to take part in the programme. Participants immersed themselves in the title of the story, the picture, date, and venue by depicting the story and preparing mentally to meet with other group members. This stage is recognised by Meekums (2002) as the warm up stage or early stage of the therapy.

The second stage: Incubation; is where the unconscious has its say, where work gets put aside and not thought of consciously, a time sorting and evaluating information. For example participants will ask themselves will I go or will I not go to the group and are unconsciously waiting for things to happen. Meekums (2002) mentioned that this stage is letting the control go characterised by more risk taking on behalf of the client; secrets may emerge including events that the client may find painful or embarrassing.

The third stage: Illumination; inspiration, flashes of insights and new ideas occur. Plsek (1996) suggested that if this stage is successful the individual will experience sudden illumination and a surge of energy to resume to work. In other words it is like going through a tunnel and seeing the light at the other end. This aligns in the storytelling programme with when participants initiate participation and connections over a range of different experiences at the programme.

The fourth stage: Verification; is where participants fully participate in activities facilitated at the programme until the end of the therapy and there is a sense of

achievement (Creek, 2008). Meekums (2002) also described this stage as gaining insight into the world.

The psychodynamic understandings in this section have described how myths and legends, and drama therapy modalities can be used to explore the collective unconscious in a non-invasive way.

At the time of this study therapeutic storytelling programmes were being facilitated by staff from Te Puna Waiora at the Papatuanuku Marae³ in Mangere South Auckland.

And so the researchers' journey as a nurse seeking alternative creative interventions progressed.

1.7 Overview of my nursing journey

Having worked in psychiatry for the last thirty years, I have had many different roles in my profession. These started from institutional days when I worked initially as a kitchen hand at Kingseat Psychiatric Hospital. I then completed a three year nursing diploma and my role changed to a registered nurse and the focus became clinical and holistic. Watson (1985) suggested that a holistic focus of care is necessary for providing good quality health.

However, working in an institution often made it hard for me to carry out a holistic approach. As a registered nurse, the therapeutic relationship was often based on power and control due to the institutional structure. This included oversight of how residents slept, played and worked in the same environment where all activities were tightly scheduled and possessions of personal clothing were denied. For some patients this meant that they had very little choice and input into their own journey of recovery.

Moving into the community from the institution system in 1996 as a community registered nurse for me was a very exciting, due to the new challenges waiting in the community environment. The nursing interventions had to be adapted to the

³Marae "is an institution that is vital part of Maaori culture and is a significant place to carry out ceremonies" (Meads, 2003 p, 96.)

new challenges as nurses no longer carried the 'keys'. Clients were no longer living in an institution they were living in the community in halfway houses, boarding houses, flatting situations, caravan parks or went to live with their families. Nurses working in a Community Mental Health Centre in 1996 for Counties Manukau District Health Board area as a Psychiatric District Nurse had big caseloads, up to seventy clients, with many clients having high risk profiles. Some of these clients were assigned to my case load and at that time I had about seventy clients under my care. It was impossible to be creative due to work being chaotic and a great deal of time was spent with clients in crisis. In 1997 the Intensive Community Team (ICT) was established and I went to work there and I am still currently working there. The criteria to gain entry to the ICT was: non-adherence to treatment, lost to follow up, no fixed abode, poor engagement with services, revolving door syndrome (which means that clients were in and out of hospitals), violent behaviours, drug and alcohol misuse and/or a forensic background (which means that they have been under the justice system). The ICT works under an Assertive Community Treatment Model that was developed in the 1970's in the context of deinstitutionalisation and provides continuity of community care for people with serious mental illness, who might otherwise have a high risk of hospitalization or service disengagement (Vanderpyl, Humberstone, Law, LeProu, Abas & Kydd, 2003).

Five nurses had twelve clients per case load but after a year this changed to twenty clients per case load which currently still stands. By working in the institutions I had developed a trusting therapeutic relationship with many of these clients who are now living in the community and this has helped me to walk alongside them in their journey of recovery.

1.8 Presuppositions/my practice journey

Over time my approach has become recovery focused by providing opportunities for clients to participate in their own growth and development. I have been running the storytelling groups for over fourteen years and looking at therapeutic storytelling was a focus in enrolling in my Postgraduate Diploma in expressive therapies. I took the opportunity to use myths and legends as part of supporting tangata whaiora with their recovery. Initially storytelling developed as a tool to

work alongside tangata whaiora to enable self-expression, identity, development of creativity and engagement with the community in a safe environment while developing wellbeing as a natural part of this group process. Watson (1985) talked about the nurse who recognises and uses his or her sensitivity and feelings to promote self-development and self-actualisation. These storytelling workshops have developed so much and my understanding of both practical and theoretical aspects has developed through working with this marginalized population and my academic studies.

As a child I was very interested in ancient stories and remember from an early age at school when our teacher used to read the myth 'Arabian nights' and the effect this story had on me, it took me to another world full of fantasies, and happy times. These experiences lead me to participate in theatre where as a child I participated at school in different plays and dancing groups. Today when remembering these times, it brings back happy memories that have inspired and influenced me to focus on expressive therapies and particularly to use myths and legends as an intervention to enhance recovery. Doing this study is part of my journey in being able to reflect on how storytelling could be of value in the recovery journey of this vulnerable population.

From the fourteen years of implementing these workshops personal assumptions had arisen so before this study began I took part in a presuppositions interview with an AUT staff member who was not part of the study. These presuppositions were part of what I had observed through clinical observations of running the workshops and my diploma that looked in depth at therapeutic storytelling theories. They included ideas that this therapy does help clients in their recovery that the myths and legends brought group members closer to their ancestry, and were able to connect with strong archetypes. Also many clients were on antipsychotic medication with side effects of weight gain and my observation was that the workshops provided an opportunity to exercise through dance and become grounded through movement and that communication, confidence, assertiveness, and negotiation skills increased. Group members were stimulated, provided with a safe play space where positive memories were created. In order to counteract any possible bias these presuppositions might bring to the study

they have been discussed and analysed in supervision. They provide understandings that contribute to the trustworthiness of the study.

1.9 Overview of thesis

Chapter one presents an overview of this study, gives a background to the purpose of the study, reviews theoretical underpinnings and introduces myself as the researcher. Chapter Two presents an in-depth literature review of psychodynamic approaches and studies in New Zealand and internationally that pertain to this study. Chapter Three provides a thorough outline of the post positivist paradigm, ontology, epistemology and methodology, ethical procedures, recruitment, data collection and analysis. Chapters Four presents the analysis and interpretation of the findings. Chapter 5 concludes with a discussion and recommendations for practice and future research.

Chapter 2 Literature Review

This literature review focused on the research question “Does participating in storytelling/pakiwaitara change participants life experiences in their journey of recovery?” In order to gain understandings that were applicable to this research, literature sourced looked at a range of modalities and theoretical approaches used in the therapeutic storytelling programme of this study. This chapter begins with an outline of search strategies used. It then discusses the therapeutic approaches used in the storytelling programme that included drama therapy, the sesame approach, a creative model and Jung’s psychodynamics approaches using archetypes, the collective unconscious and personality theories. This is followed by a study on recovery which is the context of this study and a review of underpinning literature from a Maaori worldview. Literature is then presented in chronological order of studies that describe the use of storytelling and drama therapy. This chapter concludes with a summary of the literature that identifies a gap in this area of research that this study sets out to uncover.

2.1 Search strategy

A search of the literature was carried out by accessing the following data bases: Ovid, Psychinfo, CINAHL, and a search of the grey literature were also under taken. Search terms included: storytelling, pakiwaitara, mental health, myths and legends, school counselling, drama therapy and recovery. No constraints were put on the year search.

Because of the paucity of literature on storytelling for adults, populations included adults, children and elderly, who had used drama therapy and other similar modalities. Literature was also sourced that used other models and approaches as a therapy, such as narratives, myths and legends, fairy tales, and storytelling that excluded drama therapy and role-play. It is important to note that only one of the studies sourced on storytelling identified a particular ethnic group. An outline of the theoretical approaches that underpin the storytelling group programme that participants in this study engaged in is outlined below.

2.2 Literature review of relevant research studies.

This literature review begins by presenting a study of recovery, which is an underlying model used as a context of this study. This is followed by a review of the underpinning literature from a Maaori world view. Literature on drama and storytelling is then presented in chronological order as a way of providing a sense of understandings of how therapies that use drama and or myths and stories have progressed through time.

2.2.1 What does recovery mean in practice?

This qualitative study was carried out by Le Boutillier et al. (2011). The aim was to identify key concepts of recovery-orientated practices, based on current international views, and to develop a framework that would assist and translate recovery guidance into practice.

A qualitative analysis of 30 international documents offering guidance for recovery orientated practices was done. The method was inductive, semantic-level, and thematic analysis used to identify dominant themes. An interpretive analysis was then undertaken to group the themes into practice domains.

Six countries were involved in the review: The United States, England, Scotland, Republic of Ireland, Denmark, and New Zealand. Sixteen themes emerged from this study: seeing beyond 'service user', service user rights, social inclusion, meaningful occupation, workplace support structures, quality improvement, care pathway, workforce planning, individuality, informed choice, peer support, strengths focus, holistic approach, partnerships, and inspiring hope. These sixteen themes were then grouped into four practice domains: Promoting citizenship, organizational commitment, supporting personally defined recovery, and working relationships.

Results concluded that there is a lack of clarity and a challenge for mental health about what constitutes recovery orientated practices. However, sixteen themes that described recovery were able to be identified, and there was discussion of what this looked like in practice. The authors of this study acknowledged that this conceptual framework contributed to the knowledge gap and provided guidance for recovery orientated practices.

2.2.2 The use of Maaori mythology in clinical settings

Cherrington (2002) presented the importance of training psychologists to use purakau⁴ in clinical settings. Acknowledging that psychology is a western model that contains western ideas, beliefs, and values. Cherrington (2002) offered another perspective of Maaori psychology, demonstrated in the work of Durie (2001) who outlined the power of the use of the Marae, identifying concepts and processes that added new understandings of Maaori thinking and behaviours.

Cherrington (2002) described the rational and relevance of purakau as a Maaori focused intervention when working with tangata whaiora and their whanau.

Purakau contains stories about the creation of the world, the creation of human beings, the deeds of the gods, and illustrious ancestors (Royal, 2002). Purakau is concerned with how the world came to be and how we can live in it and contains models, perspectives, ideas and consequences of the people who recite them.

Royal (2000) defined pakiwaitara as “stories of a higher nature; they may involve ancestors, telling of deeds of one fellow man” (p. 3). They are less formal and can be humorous. Cherrington (2002) reaffirmed that the same can be said about purakau. The author also reaffirmed that the art of purakau is passed down and through generations serves as a vehicle that provides and maintains information about understandings, feelings, thoughts, and actions of Maaori ancestors. The Maaori Women’s Welfare League (2002) indicated that purakau provides a way of reviewing and reconnecting actions of today, with actions of the past.

The author offered how purakau could work in a clinical setting. Retelling the story of various gods/Atua⁵ to tangata whaiora and their family/whanau and aligning these stories with the realities facing clients in the present. Within this approach used by Maaori is the acknowledgement and belief that Maaori are descendants from their gods. In using stories of the various gods/Atua it is suggesting that there is a move from working with the unconscious directly (Van Eenwyk, 1997). This more non-invasive way suggested by Cherrington (2002)

⁴ Use of stories that explained the nature of reality and human conditions (Royal, 2002)

⁵ Maaori god (Ryan, 2008)

that aligns with western approaches that use symbols and metaphors (Corey, 2013).

Cherrington (2002) presented in her study with children and adolescents using folktales in therapy in Puerto Rico using a technique of 'peer modelling' which involved children and adolescents identifying with the beliefs and values of characters in the story. During the intervention the story was read by the child, parent and the psychologist. Feelings, behaviours and the moral of the story was discussed as a group.

The results of their research indicated that families were able to resolve their conflicts modelled from the story using drama therapy and that this cultural intervention produced positive outcomes for people. It was recognised in the therapy that the story used needed to be relevant to the culture people could identify with. Cherrington (2002) acknowledged that little has been written about the use of purakau as a therapeutic technique.

In the next section literature relevant to the context is presented and drama and story based programmes are reviewed. This includes programmes with children, adults and the elderly with a focus on defining gaps in the literature that support this study. Review of studies begins next with the work of Johnson (1984) who was a catalyst of using drama in a new way as another intervention with people experiencing psychosis. Studies are summarised and critiqued.

2.2.3 Representation of the internal world in catatonic schizophrenia

Johnson (1984) presented eight case studies of male adults that had been hospitalised and diagnosed with catatonic schizophrenia with the aim to improve their treatment through therapy. The methods implemented were drama therapy, non-lexical movement, symbolic gesture and improvisational role play, to provide venues for expressions of unconscious conflicts, transferential relationships of self and other representations. Johnson (1984) acknowledged that these methods implemented in one to one therapy were successful in evoking representations of the patient's inner life. This therapy was facilitated at a weekly hospital based programme. There was an imaginary focus on the patients' problems e.g. anger,

which then was role-played in a situation. As part of Johnson's interventions patients were allowed to push and touch each other.

He reported three cases with outcomes when the patients recovered, and experienced a decrease in symptoms of violent disorganised hallucinations. Johnson (1984) suggested that drama therapy was useful with the severely disturbed and ego impaired patients, for example those who lived with schizophrenia.

The work of Johnson's (1984) was based on observations and was an anecdotal report. There is no known literature that evaluated or developed Johnsons work. There was no use of myths and legends, and no specific theory was discussed. However, Johnsons work was clearly based on psychodynamic approaches as drama therapy was used and he referred to working with unconscious conflict.

Drama therapy emerged not long after Johnson's work as a related strategy in mental health working with children.

2.2.4 Drama therapy in a child and family psychiatric unit

Drama therapy was used by Trafford and Perks (1987) in a child and family psychiatric unit, as an integral part of various treatments in their department. This therapy implemented drama therapy, which increased trust and decreased anxiety with children that were hospitalised in a psychiatric hospital. Drama therapy techniques included: role play, movement, mime, music, improvisation, sculpting and free expression. The aims and goals were to develop trust, encourage interactions and self-awareness. By providing a safe environment, it encouraged trust to be developed. Sessions provided an outlet for anxiety, aggression and opportunity to work through real life issues, which allowed the therapist to enter into the child's inner world.

These were open groups for children who were hospitalised and ran over a number of weeks at a time, for one hour. The sessions had a structured routine. This programme encouraged the children to reach their full capabilities where they could be spontaneous and creative. Sessions opened in a circle with a warm up that was appropriate to the children who were attending that week. Mimes were used for relaxation and group socialization.

The authors suggested that this workshop created warm feelings, togetherness and a sense of belonging in the group. They also identified that drama therapy enabled the children to become more assertive and creative without imposing great demands upon them. This approach also enabled the therapist to understand the children's feelings towards their families through the role play.

Trafford and Perks (1987) work, although anecdotal and self-reporting provides positive outcomes that support the work of drama therapy with children in hospital.

Building on the work of Trafford and Perks (1987) below is another drama therapy intervention used with young adults and children.

2.2.5 Drama therapy in one-to-one treatment with disturbed children

Dunne (1988) used a drama therapy technique with children that live with autism, conduct disorder and childhood schizophrenia in one to one therapy sessions. The aim of this therapy was to accept each individual's reality. It was proposed that by instilling respect and gaining skills to deal with the here and now it would de-emphasize the past. This would enable clients to commit to actions of their true values, and take responsibility for their own life. Through clients experiencing unconditional positive regard it would free the client to develop a constructive image of self- worth.

Methods implemented by Dunne (1988) were based on Rogers and Maslow's humanistic approach and incorporated the three stages of drama therapy (see Appendix A) used by Landy (1986). Dunne (1988) used modalities such as pictorial dramatization, creative movement that included follow the leader, narrative pantomimes, dramatic enactment and problem solving. Clients moved on to act out short pantomimes or scenes based on issues that facilitated them to reflect on what they had done (Dunne, 1988). The author stated that this technique of ongoing drama and problem solving encounters, pictorial dramatization, movement and drama exploration provided opportunities for the clients to experience relief, emotional, physical integration and personal growth, where the client experiences reach new horizons in their struggles to become more whole individuals.

The outcomes of the work of Dunne (1988) are presented through case studies and are the therapists own observations. This type of drama therapy is very different to storytelling/pakiwaitara as it is done individually and personal stories are used through role play. However this programme uses the three stages of drama therapy which were considered in the structure of pakiwaitara.

2.2.6 Drama therapy and the theory of psychosocial reversals

Fontana and Valente (1993) used drama therapy to work with clients of all ages who were experiencing psychological stress or abnormal behaviours. They initially assessed the meaning of client's behaviour and then the most appropriate therapeutic drama techniques were selected and applied. Drama therapy modalities such as myths and legends, fairy-tales, symbols, imagery, mirroring, masks and role play were used. This approach used psychodynamic theories from the work of Jung and Freud who provided guidance for the therapist to work with the unconscious mind, neurosis and related psychological problems (Fontana & Valente, 1993). They worked with the unconscious in a direct and intrusive way. Their work using drama therapy in conjunction with reversal therapy allowed clients to recognise the barriers they had erected in their lives and those areas where they had behaved inappropriately to be corrected. Reversal therapy involved selecting stories to match individual's personalities and then choosing reverse roles for them to act out, write their own myth, or make their own mask. Fontana and Valente (1993) concluded that by bringing drama theory and reversal theory together it brought great benefits for clients and therapist.

The approach used by Fontana and Valente (1993) used myths, legends and the role play of drama, which were used in this study. However a point of difference is that Fontana and Valente used techniques that facilitated the client to experience reversal psychological behaviour, working directly with the clients unconscious. This work is not specifically done with clients who have a diagnosed mental illness. It is questionable whether this type of approach would be suitable for the client group in this study as it is intrusive and more appropriately done in one to one therapy.

2.2.7 Rehabilitation for people with schizophrenia

Around this same time period Bielanska, Cechnicki, Budzyna-Dawidowski, (1991) created a programme using drama therapy as a means of rehabilitation for adult patients living with schizophrenia. The aim of this programme was to allow patients to gain understandings of their emotional health in relation to others. They used a range of modalities from drama therapy such as role play, filmmaking, and theatrical performance. This programme used the psychotherapy model of Moreno. According to Yotis (2004), Moreno worked with individuals diagnosed with schizophrenia on a reality-based enactment to decrease psychotic symptoms by including other group members 'auxiliary egos' who acted out different roles of the individual's inner or social self.

Patients involved in this programme moved from being inpatient to a day treatment clinic where the emphasis was on the psychosocial therapeutic relationship with their therapist. Part of this treatment involved patients' families being involved by being given information about the illness, treatment and ways to support their loved ones mental health conditions. In the day clinic, drama therapy involved simple motor exercises, voice training, and mimes to express emotions. These activities acted as a warm-up that lead to a group mime of a situation, where difficult tasks that they might face in daily life were practiced. At the day clinic, drama therapy was conducted for two years with two groups of twelve people, where a play was produced (Hamlet and Othello) and presented at a public performance. The play produced was carefully selected, as in Shakespearean dramas lie timeless issues on human existence and a richness of characters which allowed for discussion on the text to be discussed (Bielanska et al., 1991).

Outcomes noted that of the 51 patients who took part in the drama therapy groups, 8 were re hospitalized and 5 failed to keep in contact with their psychotherapists. However 38 patients were observed as having an improvement in social competence, specifically with interpersonal communication. Patients achieved a better self-image. Two case studies were presented that demonstrated these observations (Bielanska et al., 1991).

Next is another study done with elderly clients that lived with dementia using drama therapy and other psychodynamic approaches.

2.2.8 Drama and movement therapy in dementia: a pilot study

This prospective study by Wilkinson, Srikumar, Shaw and Orwell (1998) investigated the effects of drama therapy and movement in a group of people with dementia. Sixteen participants were included in the study, nine were in the drama groups and seven were in a control group who attended the day hospital but did not take part in the drama groups. The participants involved in the drama therapy were divided into two separate groups which ran one afternoon a week, for twelve weeks. The first group focused on character work and role play while the second group was nonverbal due to the patients' lower ability to communicate verbally. All the patients that attended the programme met the DSM IV criteria for dementia. Details of their age, sex, number of years of education, current social situation, major medical diagnosis and drug treatment were obtained. Qualitative data about the experience in the group and any potential improvements in everyday life were collected. A selection of rating scales covering cognition, and mood was completed by participants prior to beginning the therapy and repeated at the end of the twelve weeks.

This programme implemented the sesame approach and described this method as a symbolic approach based on the creative and expressive use of the imagination being non-confrontational and non-invasive. The authors felt that the sesame approach was a safe tool to use because it didn't work directly with personal material.

Quantitative results from the sixteen participants indicated that the drama therapy group had better cognition, function and daily living skills and lower dependency than the control group. Qualitative findings of Wilkinson et al. (1998) study indicated that individuals discovered they had something positive to enjoy and look forward to while the group was running and were also able to recall details of previous sessions they had attended.

The approach showed many similarities to storytelling/pakiwaitara. It used the sesame approach and placed emphasis on the creative and expressive base of the imagination. It identified a mixed method using both a quantitative and qualitative methodology to gather data which was useful for this population who have more difficulty with recall. However this programme did not use myths and legends

instead used symbolic images such as the circus to facilitate the drama therapy. There was no mention of participants' ethnicity or any documented process re ethical considerations.

The authors acknowledged that participants' gender was a major obstacle in the study, as there were all females in one group and all males in the other group. They also advised that future studies need to consider age, sex, cognitive impairment and functional dependency (Wilkinson et al., 1998).

2.2.9 Creative art groups in psychiatric care

A report by Korlin, Nyback, and Goldberg (2000) presented outcome data collected from 58 psychiatric inpatients and outpatients who were invited to a creative art group programme. The inclusion criterion was that the patients had to be stabilised on their medication before starting the programme. Each group was followed by a psychiatric nurse who acted as a co-therapist to the specialised group leader who was trained and certified in creative modalities e.g. body awareness, receptive music therapy, art therapy. Occupational therapy and several creative and cognitive elements were added to the programme. The authors also acknowledged the therapeutic and caring environment that was provided in the ward, promoted security for this fragile population. Outcomes measures included self-rating scales and evaluations were administered before and after the four week treatment and then again at six month post discharge from the unit.

The authors of this research indicated that from this programme that outcomes were significantly better for trauma patients and suggested that art therapy may be used as an alternative treatment where pharmacology and conventional verbal therapy had failed. Similarities with the storytelling/pakiwaitara were that Korlin et al. (2000) used drama therapy modalities such as movement and music. They also had a core focus on creativity work with a mental health population. This study adds to the literature that supports creative therapies that includes drama therapy modalities as successful interventions to use when other pharmacology and conventional verbal therapies have failed.

The next study has been included because it incorporated modalities of drama therapy, such as stories, music and dramatic movement and was embedded in the creative process.

2.2.10 The story within – myth and fairy tale in therapy

Silverman (2004) used a drama therapy approach working with adolescents and adults experiencing, eating disorders, anxiety, conduct disorders, social disorders, delinquency and victims of physical and sexual abuse. The aim of this programme was to guide the client through formation and exploration of a deep relationship with a carefully chosen myth or fairy tale character to work with difficult personal material. The methods used in this programme were the six part story method (6PSM) by Lahad (1992) and the creative process described earlier by Cristopher and Solomon (2000). In addition, interpretation of metaphors and symbols from the client's own personal experience were emphasised and explored. Silverman (2004) acknowledged that working with metaphors and fiction gave an entry into uncovering understandings of the client's world. The 6PSM allowed participants to project their feelings and thoughts collaboratively through a group discussion. The essential therapeutic component of this approach was that the client identified with one specific moment of the story to work with. This programme involved a personal quest similar to the heroic journey described by Campbell (2008) where the hero discovered important values about him or herself. The story within approach provided safety and distancing so clients were able to immerse themselves in the creative process leaving personal problems behind.

In this article Silverman (2004) described a 14 week group session that involved meeting once a week for 2 hours. In the final stages of the programme each client presented to the group a creative personal expression of their journey with the particular character that they had created. This was done by a performance, painting, sculpture, written or recited stories or any artistic medium. This process helped clients to learn why they had chosen their stories and characters and how they related to their own life.

The author stated that this process had been effective in both one to one and group therapy with clients who had failed to respond to other forms of therapy. However it also noted that when using this approach with clients that experienced

schizophrenia it needed to be modified to allow for differentiation between fantasy and reality. Silverman (2004) was able to describe outcomes of his programme through case studies. There was however no evidence of any formal research that has been done in regards to this therapy. This approach is similar to storytelling pakiwaitara in that it has a strong focus on psychodynamic theories presented earlier in this chapter and the use of creativity and role play is used. However a point of difference is how the story is directly applied to the clients own personal problems.

Next is the introduction of a programme that used a fantasy story based on a hero that was facilitated in the Counties Manukau area South Auckland, New Zealand.

2.2.11 Scapegoating and therapeutic storytelling intervention

Therapeutic storytelling Intervention (TSI) as a therapy working with emotionally disturbed children, and their families in the Counties Manukau Health (CMH) area, was introduced by Clarkson and Phillips (2006). The aim was to offer individual and family therapy. TSI involved the therapist telling a story described as a fantasy adventure asking the client to imaginatively join a journey of self-discovery. On this journey the child and their family who are listening, asked questions about the story. The therapeutic process lies in the relationship between the purpose built story, the guiding questions, and the interactions between the participants.

Clarkson and Philips (2006) presented three case studies of adolescent children referred to the mental health services due to their behavioural issues. The children's parents were involved in some counselling separately from the children. Outcomes of all case studies revealed positive changes in behaviour and attitudes with a positive shift in family relationship in two of the cases. All experiences of TSI were up lifting for the children.

This TSI therapy used by Clarkson and Philips (2006) did not use movement or drama therapy approaches. Instead, they used a listen to learn method based on psychodynamic understandings that aligned with Jung and the collective unconscious described earlier in this chapter (Corey, 2013). There was no published literature to be found that Clarkson and Philips (2006) had conducted any further research about this therapy. The authors found that adding this

therapeutic story intervention to more traditional family therapy helped to make the therapy more acceptable for families.

2.2.12 The mechanism of story making

A qualitative study was conducted in England by Dent-Brown and Wang (2006) seeking to answer the question “How do participants experience the 6PSM process?” Forty-nine participants were recruited using purposive sampling. Twelve participants with a diagnosis of border line personality disorder and thirteen participants without this diagnosis but who received care from mental health services and twenty-four mental health clinicians were recruited. The local research committee approved the study; participants gave informed consent and were informed they were free to withdraw at any time.

Participants had to follow a set of instructions to create and tell a fictional story using the 6PSM. Then participants were asked “How far the fictional story communicates something about their own life situation and for their subjective reaction to the story making processes?” Questions were tape-recorded, transcribed and analysed using a grounded theory method developed by Glaser and Strauss.

The results suggested that twenty-one of participants thought that the story was strongly relevant, and described experiencing an increase of emotions, and closely identified with a main character of the story. Eight participants thought the story was weakly relevant and nine thought the story was irrelevant. The authors suggested that further work was needed around the relevance of 6PSM that looks at complex psychological problems such as Borderline Personality Disorder.

This study is well set out with a clear methodology and methods that suit. It is the first piece of work that has mentioned getting ethics approval. By using the 6PSM the findings suggest how this approach can be used to facilitate creative thinking without any drama therapy modalities.

Having just discussed how Dent-Brown and Wang (2006) used the 6PSM with a mental health population we now look at the work of Crimmens who used the 6PSM with the elderly, children and disabled populations. The 6PSM was used in this study and outlined in appendix A.

2.3 Drama therapy and story making in special education

Crimmens (2006) study was New Zealand based and explored a traditional myths and legends programme, which was implemented to provide a set of structures for students and facilitators that included a beginning, middle, and end (Landy, 1986). Her work is based on the sesame approach described earlier in this chapter by Lindkvist (2007). The author worked in the care and education of students with special needs including those with learning and physical disabilities, behavioural and communication difficulties, sensory impairments, medical and related conditions. She used therapeutic stories from around the world within the context of drama therapy and part of the structure for her sessions included the 6PSM. Crimmens found the 6PSM to be an effective assessment tool to analyse stories and assess children who are distressed. Crimmens builds on the 6PSM not only to analyse stories but to assess for distress in a child population.

The use of props to assist understandings and stimulate participation in the cognitive impaired students was also discussed. According to Crimmens (2006) role play, playing with props and doing the task gave students the opportunity to explore metaphorically unconscious and conscious issues.

Crimmens (2006) implemented a study seeking to answer the question “Does participating in drama therapy sessions improve the overall attentiveness of students with an intellectual disability?” Key findings of her research indicated that high levels of attentiveness were present in all four of the target students for the duration of the observation period. Findings also indicated a range of social skills were taught, and practiced by the students during the sessions.

The work of Crimmens matches the drama therapy and sesame approach used in this study, however she has not worked with a mental health population in New Zealand. There were no published work that captured the outcomes of Crimmens study.

2.3.1 Our heroic adventure: Creating a personal mythology

This study described a clinical psychodynamic intervention used by Rubin (2009) in the counselling field. Rubin (2009) worked in one to one counselling therapy with high school students which used the students own story and then applied

psychodynamics theories. The student was provided with the opportunity to tell his own life story and the challenges as an unfolding personal myth or epic adventure. Rubin (2009) drew on theoretical approaches from the work of Joseph Campbell's (2008) concept of the hero's adventures. This intervention used symbols and archetypes, drawing from the work of Jung on the collective unconscious presented earlier (Corey, 2013). Rubin (2009) discussed how the work and function of myths, whether culturally or individually derived, provide a means for answering important existential questions such as "Who am I and Where do I fit in?" According to Ruben (2009), the use of Joseph Campbell's hero's journey and the archetypes of Jung provided a useful tool to use as an intervention to address clinical issues that clients present with.

The author presented a case study with a 17-year-old male student who attended high school in Miami, Florida, United State of America. The student was having problems with his dominant Father, which resulted in him being evicted from home. The student worked through Campbell's hero journey the initiation phase of Campbell's approach which ended up with good results of him returning home where there were negotiations with his parents.

Rubin (2009) implemented the concept of the collective unconscious of Jung as does storytelling/pakiwaitara but didn't mentioned using any warm-ups or myths and legends. This study builds on the anecdotal knowledge that supports using myths and legends for people experiencing stress, but not for a specific mental health population.

A description about other therapist using myths and legends that support this study is outlined next.

2.3.2 The spiritual power of fairy stories, myth and legends

The power of myths and legends is described by Walker (2010), as a therapeutic tool to engage children who were experiencing emotional and psychological distress in Chelsford in the United Kingdom. This paper acknowledged that young people have the capacity to bring to the surface feelings of faith and hope when in a distressed state. Walker (2010) appreciated the use of world myths, legends, and fairy stories as part of early child development offering a rich source of material to

draw on in therapy. In his paper, he discussed the important role childhood fairy stories had at bedtime, with good and evil featuring in a struggle and happy endings being the preferred outcome. He shared how this struggle between good and evil is a universal theme throughout fairy tales from around the world which help the listener or reader to make sense of who they are in the world. Walker (2010) recognised the importance myths and legends have in shaping the world today, uncovering understandings that are commonly embedded in culture around the world, such as animals taking on human qualities and vice versa.

Walker (2010) concluded by suggesting that mental health practitioners and counsellors need to consider the implementation of fairy tales, myths and legends for all troubled children and young adults from different cultural backgrounds. No research work was evident; however findings highlighted how fairy stories have a spiritual power that enabled emotional wellbeing, particularly with children.

2.3.3 Drama therapy to empower patients with schizophrenia:

This study was conducted by Reisman (2016), in New York, United States of America with a mixed ethnic population in a hospital setting with people experiencing mental illness. Reisman's (2016) work was based on the recovery model. Techniques used in this therapy, included the three stages of drama therapy as warm-ups to engage and prepare the patients for role play (Landy, 1986; Dunne, 1988; Bielanska et al., 1995; Crimmens, 2006; Reisman, 2016). This study also implemented the theoretical work of Winnicott's transitional space and Johnson's 'play space.' The therapist used the play space to take the role of a projective screen where the patients played powerful roles like doctors, and the therapist becomes the psychiatric patient. The drama therapy sessions involved each group playing with the theme of powerlessness and acting the journey of a psychiatric patient, who initially experienced cruelty and then in the end receiving human treatment. The author recognised that during this phase the sessions dealt with problems associated with the ward like complaints of slow discharges and harsh treatment.

Reisman (2016) used this same technique of developmental transformation drama therapy in both the United State of America and in Czechoslovakia in a psychiatric

hospital with different cultures and provided similar positive results of empowering and instilling hope.

Two case studies were presented of patients who lived with schizophrenia from institutions in two different countries with different health systems. People who live with schizophrenia were described as the most disempowered and stigmatised members of society. It was revealed how drama therapy empowered people who live with schizophrenia and helped them in their journey of recovery and integration into the community.

Reisman (2016), does not mention an ethics process or support for patients who had to re-enact their drama.

2.3.4 Case study

Presented by Feniger-Schaal (2016) is a case study using drama therapy with a 22-year-old male who had a diagnosis of moderate Intellectual Disability (ID) schizophrenia, and Obsessive Compulsive Disorder. The participant who was lonely and isolated had been evasive with his therapist, which made communication very challenging. The aim of the therapy was to improve communication skills, functioning, and to reduce his symptoms of anxiety. Also by using story making and storytelling, it was hoped that the client would be able to access and organise his inner reality. Feniger-Schaal (2016) recommended drama therapy for this young man as it would be a non-directed distant technique.

This process involved engaging with the client to think about his mental state and ability in using images and symbols. After eight months, a therapeutic relationship grew allowing the therapist and the client to progress further. The therapist took images that the client had chosen and made a story for him that integrated the main themes that stemmed from the images. The story was distant and stayed in the same metaphoric level that the client himself used. The therapist observed that the client seemed relatively active with some sense of determination and feeling of a stronger self where he managed to put aside his obsessive tendencies and anxiety.

This case study suggested that drama therapy, using stories, images, metaphors and non-direct projective work offered an important vehicle for psychological

change for individuals with intellectual disabilities. This therapy implemented the work of Landy (1986) using aesthetic distancing, which is a concept described by the balance point where the client engages emotionally (feels) and cognitively (thinks) with his material.

The use of stories, images, metaphors and non-direct projective work was applied in this study and is similar to what is used in the storytelling/pakiwaitara programme. However this case study was for one person and not for a group. It took eight months for this study to produce some results. There was no mention the use of myths and legends, warm-ups, mimes, movement, or the use of props.

2.4 Summary of the literature

This literature review showed that there have been and are groups of health professionals using therapeutic models, and approaches around the world with a range of client groups of different ages, and conditions, based on drama therapy, and myths and legends. The literature review indicated that using one or more modalities that storytelling/pakiwaitara implements has had positive outcomes. The majority of these studies have been carried out in mental health hospitals and outpatient clinic settings with only a few in the community, some with children, and other populations that do not have a diagnosed mental health conditions.

The main emphasis in literature pre 1990s was focused on working directly with the unconscious and was anecdotal, based on staff or therapists' observations. The introduction of the sesame approach to storytelling provided an approach that was friendly and non-invasive, and gave a way for the opportunity to work with personal material in a non-direct way. The outcomes of psychodynamic groups and approaches revealed positive outcomes in regards of symptoms relief.

Literature post 1990 included only a few studies with sound methodologies, most were one off descriptions of an intervention programme. This review revealed a paucity of evidence based literature that demonstrated understandings of therapeutic storytelling with an adult mental health population internationally or in New Zealand. None of the client groups identified in the literature review matched those in this study. There was only one study found that used a recovery model and that was set in the United States of America. Only two studies were

source that mentioned working with ethnic groups, one in America and the other in Czechoslovakia. A central consideration for all mental health interventions in New Zealand, is that they should be culturally appropriate for Maaori, non Maaori and other indigenous or minority groups.

Having identified the above gaps in the literature, the need for this study emerged. Developing evidence to support the use of and understandings of storytelling/pakiwaitara in a New Zealand, adult mental health recovery context is clearly needed. This will build on literature that collectively reports outcomes for this type of therapy for mental health populations. It is hoped that findings of this study will guide the future use of this intervention in New Zealand and internationally.

Chapter 3 Methods

This chapter describes the post positivist paradigm, ontology, epistemology and methodology used to answer the research question. A description of why a qualitative descriptive methodology and the methods used is also presented. This is followed by a discussion of ethical and cultural considerations, the recruitment process, data collection and the analysis process. This chapter concludes with a description of how trustworthiness was maintained throughout the study.

3.1 Research question

“Does participating in Storytelling/Pakiwaitara change participants life experiences in their journey of recovery?”

3.2 Post positivist paradigm

This study sits under the umbrella of the post positivist paradigm which seeks to understand what it is like to be human and what meaning people attach to the events of their lives (Grant & Giddings, 2002). The post positivist paradigm emerged when the credibility of the positivist paradigm was questioned due to the methods implemented which included removing the context of the phenomena studied.

The positivist paradigm reduces the generality of findings and excludes the meaning and purpose people attach to activities and it does not align with what the research question of this study was seeking to understand. For this reason, a post positivist approach was chosen for this study.

3.3 Ontology/epistemology

A paradigm is characterised by ontology, epistemology and methodology (Weaver & Olson, 2006). Ontology is referred by Grant and Giddings (2002) as the most basic beliefs about what kind of being a human is and the nature of reality. The ontological perspective used in this study was relativism. A relativist, Ratima (2003), pointed out “there are multiple realities or perceptions that are shaped by our historical, cultural, and social backgrounds” (p. 9). This ontological perspective was the basis for developing the epistemology in this study, which defines the nature of the relationship between the enquirer and the known, what

counts as knowledge, and in what basis we can make knowledge claims (Grant & Giddings, 2002). Ratima (2003) described the work of Cram saying, “the subjective view is that an individual’s knowledge is personal and differs from others individual experience of knowledge” (p. 10).

3.4 Qualitative descriptive methodology

Methodology is defined by Carter and Little (2007) as a theory of analysis of how research and analysis should proceed. A qualitative descriptive methodology was selected for this study with the aim of exploring and capturing the experiences of participants who had taken part in the therapeutic storytelling groups. Grant and Giddings (2002) inform us that the assumptions of post positivism presents the view that there is no one single truth, that there are multiple and competing views.

In qualitative descriptive studies the researcher relates and interacts with participants to capture and understand the meaning of the experience (Grant & Gidding, 2002). Polit and Berk (2005) highlighted that qualitative studies ensure the voices and interpretations of those under study are crucial in understanding the phenomena of interest, and that the researchers’ subjective interaction in the study is also crucial because it is essential in accessing truth. The relationship is inter-subjective with the researcher acting as listener and interpreter of the data given by participants. Grant and Giddings (2002) confirmed “the researcher’s interpretation is fore fronted in the analysis process” (p.17). According to Sandelowski (2000) researchers conducting descriptive studies seek descriptive validity, which is an accurate accounting of events and interpretive validity, which is the accurate account of the meaning participants attribute to the event. Carter and Little (2007) mentioned that qualitative research is a social research in which questions are designed according to the phenomena observed by the researcher to identify human’s experience of participants.

Constructivism also aligns with this assumption and underpins this study. According to Ratima (2003) constructivism claims that there are multiple realities and that knowledge is subjectively and locally constructed. Therefore the researcher and the group being studied are closely linked, and the values of the researcher are reflected in the knowledge constructed (Ratima, 2003). Polit and Beck (2005) assume that reality is a construction of humans’ minds that are social,

and subjectively constructed. Ratima (2003) identified a methodology question in the work of Guba and Lincoln 1994 as “How can the inquirer (would be knower) go about finding out whatever she/he believes can be knowing” (p.10). For these reasons the above philosophical perspectives have been chosen as the basis to capture participants’ experiences in relation to the researcher relativity. The researcher of this study appreciates the personal experiences of participants that were shared in the interview process.

Initially when embarking on this research study an appreciative inquiry (AI) methodology was considered. The aim of AI was to look for the positive experiences of the participants and everybody involved in the therapeutic storytelling programme.

AI is an approach that seeks to understand the social world (Reed, 2007). Its roots lie in action research and researchers aim to find out the strengths and what is going well for the organisation. This methodology wouldn’t have provided the data needed to answer the research question in this study as it did not seek to capture the experience of participants. AI is designed to improve the way organisations and groups function.

Qualitative descriptive methods were deemed to be user friendly. The researcher is familiar with, and can fully interact with participants, and is able to collect and analyse data by not moving too far away from the raw data (Sandelowski, 2000).

3.5 Research methods

In this section I will discuss the methods and procedures used in this study, which includes ethics approval, cultural considerations and how participants were selected and recruited. The collection and analysis of the data will be outlined along with the procedures to ensure trustworthiness of this study.

3.6 Ethical approval of the study

The Auckland University of Technology Ethics Committee (AUTC) approved this study on the 02/09/2014 approval number 14/215 (Appendix B & C). Locality assessment approval was granted from the Counties Manukau District Health Board Research committee office on the 16/03/15 (Appendix D). The Counties

Manukau District Health Board Maaori research committee also approved this study on 15/01/16 (Appendix E). Approval was gained from Counties Manukau Health managers to contact clients from their teams who had been participating in storytelling/pakiwaitara.

3.7 Ethical principles

3.7.1 Informed and voluntary participation

Voluntary participation and informed signed consent was obtained from participants to ensure that coercion did not occur in the study (Appendix F). Participants were informed that pseudonyms would be used so they would not be identified.

3.7.2 Minimisation of participants stress/harm

Limited discomfort was likely to be experienced by participants however, they had the support of their community mental health team or key workers should any matters arise during the study.

3.8 Cultural considerations

As mentioned already the consultation and approval from the Counties Manukau District Health Board Maaori Research Committee was granted prior to starting this study. This therapeutic storytelling programme had diverse cultures involved e.g. Maaori, New Zealand European, Pacific Islanders and acknowledged the Treaty/Tiritiri of Waitangi as a governing document. Partnership, participation and protection were considered in the design of this study.

Partnership was demonstrated by consulting with the Kaumatua of Counties Manukau Health to identify the benefits and interest of this study to the local tangata whaiora/maori clients. A partnership was established with Te Puna Waioara, the Maaori Mental Health Service at Counties Manukau Health as a means to recruit participants. Participation was demonstrated by ensuring Maaori were invited to participate in this study and share their experiences. Protection was insured through the process of written informed consent, offering mental health follow up and monitoring when necessary. Participants were offered a karakia⁶ to

⁶ A prayer (Ryan, 2008)

open and close the interviews and family/whanau were invited to interviews to give support. Participants had the choice to be interviewed in their own homes if they chose to.

3.9 Recruitment of participants

In qualitative research non-probability sampling is the method of choice for the researcher to recruit participants for the study. The most common form of non-probability sampling in qualitative research according to Merriam (2009) is purposive sampling. Purposive sampling was used in this study and according to Merriam (2009) is “based in the assumption that the researcher wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned” (p. 77). It included recruiting participants because of their special experience and competence, in this instance the participants experience in participating in the therapeutic storytelling programme. According to Polit and Beck (2005) naturalistic methods of inquiry attempt to deal with the issues of human complexity by exploring it directly.

3.10 Recruitment process

Potential participants were contacted face to face/kanohi ki te kanohi by a Community peer support worker who delivered a letter (Appendix G) with an invitation and information sheet about the study (Appendix H). The Community peer support worker did not discuss the content of the letter with participants.

Once a potential participant agreed to participate in the study, they returned a signed letter to the researcher via their peer support worker, in an envelope provided. After a two week stand down period the researcher contacted participants who were interested in the study via a phone call. This was to set up an appointment to meet in a place of their choice and provide more information about the study. All participants chose to be interviewed at their own mental health clinic. Polit and Beck (2005) stated that the selection of an appropriate setting is important because qualitative studies take place in a naturalistic setting.

Once the researcher and participant were introduced to each other more information about the study was provided. Participants were informed that they could withdraw from the study at any time before completion of data collection

without any effect on the health care they were receiving. Once participants agreed to be involved, informed signed consent was gained. The researcher also advised participants that they could have access to their transcript of the interview if they chose to. Participants were provided with a \$20 gift card as acknowledgement for participation in the study after the interviews had taken place.

3.11 Participants

In total eight participants were recruited to this study. Maaori participants made more than 75% of the participants interviewed. Only seven interviews were transcribed as the eighth interview did not record due to a technical fault. Also included in the interviews was one staff member who facilitated the workshops. By involving a staff member, it was possible to uncover impressions of people's experiences.

3.11.1 Overview of participants

There were four females and five males. Seven participants identified themselves as being Maaori and one as a New Zealand European. Participants from this study live with a mental illness and were under the care of specialist community mental health teams at the time these interviews took place.

Table 1. Participant Details

Pseudonym	Age	Diagnosis	No. of sessions attended
Tui	50 years old	Depression	6 sessions
Hone	21 years old	Schizophrenia	52 sessions
Rangi	45 years old	Schizophrenia	6 sessions
Tania	35 years old	Bi-Polar	52 sessions
Mary	40 years old	Schizophrenia	6 sessions
Paul	55 years old	Schizophrenia	6 sessions
Joan	64 years old	n/a	52 sessions

According to the Diagnostic and Statistical Manual of Mental Disorders (DSMV, 2013) a mental illness is characterised by a range of cognitive, behavioural and emotional dysfunctions. This can include a diagnosis of schizophrenia, Bi-Polar

and depression. See Table 2 for a range of symptoms or barriers that participants have to overcome to participate in the programme.

Table 2. Range of symptoms that participants of storytelling/pakiwaitara experience

<p>Non-reactive affect</p> <ul style="list-style-type: none"> Lack of facial expression Restricted spontaneous movements Lack of expressive gestures Poor eye contact Limited engagement Inappropriate facial expressions Monotone inflections <p>Alogia</p> <ul style="list-style-type: none"> Lack of dialogue Limited content of conversation Pausing while talking Lack of verbal response <p>Avolition-apathy</p> <ul style="list-style-type: none"> Impaired grooming and hygiene Lack of persistence in productivity Physical anergia <p>Anhedonia-asociality</p> <ul style="list-style-type: none"> Few recreational interests/activities Impaired intimacy/closeness Few relationships with friends/peers <p>Attention</p> <ul style="list-style-type: none"> Social inattentiveness Inattentiveness when under pressure <p>By Polar</p> <ul style="list-style-type: none"> Abnormal elevated, irritable mood Increased goal directly activities or energy Inflated self- steam or grandiosity Decreased need for sleep Moore talkative or the need to keep talking Flight of ideas Thought racing 	<p>Delusions</p> <ul style="list-style-type: none"> Fixed false beliefs that are not amenable to change. A bizarre delusion is the belief of an outside force has removed his or her internal organs without leaving any scars. <p>Hallucinations</p> <ul style="list-style-type: none"> Perceptions like experience that occurs without an external stimulus. Auditory hallucinations are the most common in schizophrenia and are experience in voices. <p>Positive formal thought disorder</p> <ul style="list-style-type: none"> Disorganised thinking is typically inferred from individual speech. The individual may shift from one topic to another (Lose association) which makes it difficult to understand and having a normal conversation will be difficult for the person who experience. <p>Panic attack</p> <p>Bizarre behaviour</p> <ul style="list-style-type: none"> Clothing appearance Social sexual behaviour Aggressive – agitated Repetitive – stereotyped <p>Anxiety</p> <ul style="list-style-type: none"> Phobia of going outside Phobia of being around people Specific Phobias Post-traumatic stress <p>Depression</p> <ul style="list-style-type: none"> Insomnia Sadness of mood Poor concentration Fatigue Irritability Hopelessness Poor memory Delusions Suicide attempts
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Source: Diagnostic and Statistical Manual of Mental Disorders DSMV (2013),

3.11.2 Inclusion criteria

Inclusion criteria were applied to ensure that the participants would best reflect the people who attended storytelling/pakiwaitara groups.

- Participants who lived with a mental illness, and have attended the storytelling/pakiwaitara in the last three years and participated in a minimum of six sessions.
- English speaking aged between 18 and 65 years old and receiving mental health care from either adult Intensive Community Team or Te Puna Waioira.
- A staff member was to be recruited with more than three years' experience of facilitating this programme.

3.11.3 Exclusion criteria

Potential participants that were in hospital or unwell were excluded from the study as they would not be able to give informed written consent.

To reduce the possibility of coercion and to address any possible power imbalance issues, participants who are or were under the researcher's case load were also excluded.

3.12 Data collection

Data was collected by using semi-structured interviews, which were recorded, and lasted approximately sixty minutes. Semi-structured interview questions were, used to guide and shape the interview process (see Appendix I) and the emphasis of the questions was related directly to the research question and were conversational in nature. At the beginning and end of each interview a karakia was offered.

3.13 Transcribing the data

Interviews were downloaded onto a computer and then transcribed verbatim. The interviews were transcribed by a typist who completed a confidentiality agreement (see Appendix J & K). Once the interviews were transcribed and checked for accuracy by listening to the tapes and re-reading the transcription, data analysis began.

Data collected from the study was kept on a lap top protected by a pass word. Hard copies will be kept under lock key in the researcher's office for at least six years. Consent forms will be stored for six years at the primary supervisor's office at the Auckland University of Technology (AUT) in a locked drawer.

3.14 Data analysis

Thematic coding was utilised to analyse the data. According to Carpenter and Sutto (2008) thematic analysis is seen as the foundational approach to qualitative analysis. In addition Caelli, Ray & Mills (2003) affirmed that thematic analysis is the status quo of qualitative analysis. Braun and Clark (2006) outlined six phases that involved working directly with the raw data and were selected for the analysis of this study.

3.14.1 One: Familiarise yourself with the data

Transcribed data was read numerous times by the researcher to become familiar. Different ideas that emerged from the data were written down allowing a rich description of participants' experience. According to Braun and Clark (2006) this process is called immersion and requires repeated reading of the data and reading the data in an active way.

3.14.2 Two: Generating initial codes

This phase involved the production of different codes (Braun & Clark, 2006). Participants' raw data was set up in pages divided into three vertical columns. In the first vertical column was the entire participant transcribed raw data. Themes were written in the middle column leaving the third column for the codes. Braun and Clark (2006) identified the need to code for as many potential themes/patterns as possible, about 130 codes were identified. The analysis was discussed with supervisors to ensure clarity and accuracy.

3.14.3 Three: Searching for sub-themes

Once the data was coded the researcher highlighted in different colours common codes which were identified and grouped into subthemes. The basis of repeated patterns across the data set helped to build a rich framework of participants' experience. This phase according to Braun and Clark (2006) involves combining different codes to form a theme. During this phase, consideration is given to the relationship between themes. After reading the coded data numerous times eleven subthemes emerged, they were; Inclusion, gaining cultural knowledge/skills through myths and legends, trust, hope, wellbeing, identity, appreciation, social, belonging, expressive therapy themes and safe environment (see Appendix M).

3.14.4 Four: Reviewing themes

This phase involved two levels of reviewing and refining themes (Braun & Clark, 2006). The first level was reading all collated extracts from the raw data for each theme and looking and checking for coherent patterns. I went back to the coding of each subtheme numerous times to see how they aligned with my research question and to see if I had missed any relevant information from the data. Braun and Clark (2006) stated that there are potential pitfalls of failing to actually analyse all the data. During this process sixty eight codes dropped out of the analysis due to being similar to other codes. As a result of the process new subthemes were confirmed. Some of them were different from the initial subthemes that emerged. They were: social inclusion, trust/safe environment, cultural knowledge/catching up, identity, wellbeing, hope, connecting with others, appreciation, honour, privilege, proud people and teamwork.

3.14.5 Five: Defining and naming the main themes

This phase according to Braun and Clark (2006) involves identifying the essence of what main themes are all about and what they capture. By reviewing the second set of subthemes three main themes emerged which identify the essence of the experience of being involved in storytelling/pakiwaitara workshops. They were: Breaking barriers, Creating positive memories and Becoming another person.

3.15 Trustworthiness

Trustworthiness is used in qualitative research to measure the quality of the research. Polit and Beck (2005) defined trustworthiness as “the degree of confidence qualitative researchers have in their data, using the criteria of credibility, transferability, dependability and confirmability” (p. 734). Lincoln and Guba introduced the idea of trustworthiness in the 80’s to provide naturalistic researchers to explore new ways of expressing validity, reliability and generalizability outside the conventional inquiry (Thorne, Kirkham & MacDonald-Emes, 1997). Each of the four criteria identified by Polit and Beck (2005) were considered in relation to this study and are discussed below.

3.15.1 Credibility

Credibility in qualitative research refers to confidence in how well the data and process analysed address the intended focus.

This included: focus of the study, selection of context, participants and approach to gathering data (Graneheim and Lundman, 2004). According to Thorne, et al, (1997) credibility is demonstrated through a number of strategies: member checking, peer debriefing, prolonged engagement, persistent observation and audit trials. Regarding the credibility applied to this study purposive sampling was used to ensure appropriate participants were able to share their understandings about their experiences (Tuckett, 2005). Semi-structured interviews were carried out in a place of a participant's choice with signed informed consent to ensure all participants felt comfortable and empowered. Ethics approval and Maaori consultation meant that the processes used were transparent and ethical. Interviews were recorded then transcribed and repeatedly checked by the researcher to capture accurate accounts of participants' experiences. An inductive approach was implemented using the analysis of the raw data to match thematic analysis (Thomas, 2006). In addition, a facilitator was included as a participant in the study to allow for another perspective of the experience to be observed and documented. Regular discussion about the research process and emerging findings occurred with AUT research supervisors.

3.15.2 Transferability

Transferability is defined by Polit and Beck (2005) as the extent to which findings can be transferred to other settings or group studies and analogous to generalizability. Transferability can be compared with external validity, which refers to the generalizability of enquiry. A thick description of the research project was provided to ensure readers could fully understand the context, methods, details of participants, data collection and analysis of this study, where the raw data will be stored and for how long.

3.15.3 Dependability

Dependability is defined by Polit and Beck (2005) as a criterion for evaluating data quality in qualitative data, referring to the stability of data overtime and over conditions. Dependability is achieved through a process of auditing. This process in the research ensures that is logical, traceable, and clearly documented (Thorne, et al., 1997). Peer review with AUT researchers who were experienced in research to guide this study was part of ensuring dependability.

Description of the methodology, data gathering, the process of analysis and interpretation were described in full in this chapter and are open for audit. Data was thoroughly discussed with researchers' supervisors.

3.15.4 Confirmability

Confirmability is defined by Polit and Beck (2005) as a criterion for evaluating data quality with qualitative data, referring to the objective or neutrality of the data.

Tobin and Begley (2004) reaffirmed that confirmability is concerned with "establishing that data and interpretation of the findings are not figments of the inquirer's imagination, but clearly derived from the data" (p. 392). This process ensures, by applying thematic coding, that findings stay close to the raw data.

Reflexivity is defined by Polit and Beck (2005) as critical self-reflection about one's own biases, preferences and preconceptions. Objectivity and confirmability has been addressed to ensure that trustworthiness has been rigorously applied in this study. Reflexivity was applied to highlight my position as the principal researcher of this study. My intentions, experience, beliefs, knowledge and assumptions were discussed through a presupposition interview with an AUT staff member before this study was carried out. My prepositions emerge after facilitating this therapy for the last 12 years. Participating and observing my assumption were that this programme does help participants in their journey of recovery and that dance, mimes, the role play, the hero, the 6psm and all the activities facilitated by the programme helped participants become more confident and assertive and that the myth and legends helped them to connect with their ancestry and their past. To counteract any possible bias and that the result of this study was rigorous and transparent, due to been the principal facilitator of this programme and also the one who carried out the interviews and data analysis I sought advised from CMH

and it was decided that I interview clients from another service that were assisting to the programme facilitated by another staff member. In other words researcher didn't present the programme to participants that were interview for this study. Objectivity and confirmability has been addressed to ensure that trustworthiness has been rigorously applied in this study.

3.16 Conclusion

In this chapter I have identified the research question followed by a description of the post positivist paradigm, ontology, epistemology and methodology that underpins this study. The qualitative descriptive approach used in this research was thoroughly explained. Methods applied to this research included purposive sampling, semi-structured interviews, ethics approval, selection criteria, recruitment processes, and how data was collected and analysed. Strategies to ensure the trustworthiness of this study were also presented and discussed. The next chapter presents the findings that have emerged from the data and main themes are supported by exerts from the raw data.

Chapter 4 Findings

In this chapter findings uncovered from the raw data will be presented. As described in the methodology chapter thematic analysis was used as an analysis method. Review of this raw data uncovered three main themes: Breaking barriers; Creating positive memories; and Becoming another person. It is important to note that these themes are interconnected with each other in answering the research question and provide clarity around how participants' experiences link to recovery will become clearer. The main themes are supported by a group of sub themes which also emerged from the raw data. Findings presented in this chapter emerged from the statements of each participant's lived experiences while participating in the therapeutic storytelling programme.

4.1 Breaking barriers

Breaking barriers was the first main theme in which participants described how they overcame barriers and challenges related to their mental health by engaging in the programme.

An example of this is when Tui stated:

My mental illness used to make me feel as though I'm hopeless but this programme broke all those barriers. It made me think I'm a person worth something in this world instead of being nothing.

Through engagement in the programme Tui was able to see himself in this world. We hear that this experience gave him an identity.

Tania also commented:

My head was like everywhere and my mental illness at the time wasn't too good. I wasn't feeling the best... but I would turn up and I would take part and slowly started feeling better. I wouldn't feel so nervous about participating or about meeting new people.

Tania overcame her feelings of nervousness and was able to initiate ideas and focus which was initially a barrier for her. It also supported her recovery and enabled her to form relationships.

Hone responded: *"It was a bit challenging but the more I did it, the easier it became"*
Rangi's comments were: *"I felt actually out of my shell, that was good for me something new that I haven't done before".*

Tui, Tania, Hone and Rangi all acknowledged the challenges that they were able to face and overcome. Participants' statements presented understandings about the barriers they had to overcome and what this meant for them. Three subthemes emerged from the first main theme in the analysis: Social inclusion, Trust/Safe environment and Cultural knowledge. These subthemes draw on what the participants experienced as part of breaking through the challenges and obstacles as part of participation.

4.1.1 Social inclusion

This first subtheme, social inclusion, captures aspects of what it was like for participants to be included in this programme and being able to disclose some of their issues, where they felt listened to and appreciated by others in the group.

Mary was very appreciative about being included in programme and stated:

There are not many things in mental health that I participate in. I got a good feeling by being included and participating. The other people in the group made me feel even more special because yea I was never one to believe in acceptance, because I was so busy putting my head down, feeling very alone, very frightened and all those bad feelings that I felt. I was stuck inside a cage, in a trap and I couldn't smile or talk to others. I just felt sad and very responsible for the falling down of my family and feeling very bad about myself. It was so awesome for me to experience having a break from feeling like that and to be included.

Initially Mary infers that she did not feel any stigma by attending this programme and was accepted. Mary's experience shares that being in the programme allowed her a space to reflect on how she felt. Part of this depicts a change in how Mary views the world and was given an awareness of her family problems that she carried. She experienced a sense of freedom through being accepted. By participating and feeling included by other group members Mary experienced the opportunity to have a break from feeling alone. This impacted on her physical way of being in the world as she could now hold her head up and see the world.

Rangi's experience of taking part made him feel included: *"Being part of the action and part of the group was good and that helped me that day"*.

Paul who lives by himself in the community, and experiences voices and intense religious beliefs, shared that:

It helped me to recover to the extent that I could participate and I wasn't excluded because I don't like being excluded out of things.

These experiences of being included gave a sense that this was a space where there were no judgements around their actions. Through being included, participants were able to participate and this allowed an inclusive perspective of life. Through being socially included participants overcame fear, guilt, low self-worth, social exclusion and became confident, and more aware of themselves and their environment. The second sub theme now follows that looks at safe environment and trust.

4.1.2 Safe environment:trust

This subtheme emerged from participant's experiences of being in an environment where they felt safe to participate, learn new skills, engage with others and were able to be creative. These factors promoted a sense of self, of belonging and trusting relationships.

Participants were able to get involved in a constructively positive way when they were exposed to new challenges such as disclosure about themselves, dancing or acting and being creative. Being in a space that was non-judgemental, where participants were able to interact with each other in a way that was valued, safe and trusting was important to them. Here are some participants' descriptions about their experiences which reflect this sub theme.

Rangi was very appreciative of the environment stated that:

All the little things we did... the dancing, the exercises, everything, it was like different and it was a good environment to partake... there was no violence, no swearing or talking over any one. It was a good group. It was a laid back place for you to go to.

This statement informs us that Rangi felt safe and at ease being in the group. Rangi noticed how there was respect for each other, no swearing or talking over that

gave him the confidence to participate and be appreciative of what the workshop offered. Also of note is how the movement through dance and exercises supported Rangi to feel at ease in this environment.

Tania stated:

It was a different experience. Doing something to do with my culture in a place where I usually was going to funerals. Funerals were my only experience of being in a Marae and every time I thought about a Marae, I thought about funerals. Doing something like these workshops in a Marae and having a lot of fun made me realise that Maraes are not just for funerals they are for all kind of things, meetings, learning about your family ancestry, celebrations and all that kind of thing... but this gave it a whole new experience so definitely has been good.

Tania shared how going back to the Marae environment to do this programme helped her overcome her negative childhood memories about being on the Marae. It gave her opportunities to gain a more perspective and knowledge about her culture and what happens at the Marae.

Hone stated:

Yeah its makes me feel good, it brings us together as a group and it gives us the opportunity to trust each other. During the process of being in an acute psychiatric hospital and shutting everyone out and not being, you think you are not able to trust people ever again...I lost that...but doing the workshop it gives you that chance and you can again rely on people and trust them.

Here, Hone related how the programme helped him in his recovery by regaining the ability to make new friends, being able to trust people again and feel part of a group in the community. This is in contrast to his experience in hospital, when he infers he was lost and disconnected from others. Through being able to trust he has connected with himself, others and his community.

Hone also affirmed how the environment made it a safe place to participate:

Peers and tutors they make it a friendly environment to be around and you could almost be best mates with them. Getting to meet friendly people. It's good to feel welcome.

For Hone, an important part of the environment was the sense of being welcomed and the positive attitudes of others which facilitated engagement.

Tania's initial response to joining the group was: "*I had no idea about what others illness was, it didn't matter anyway but at the time it seemed... I'm going to be in this room with a bunch of crazy people*".

After she had participated in the group she commented:

I really had a good experience. I actually got to become very good friends with some of the people. The experience was really good for me... you know we would go around the group and say how we felt.

Here, we see how Tania was hesitant about coming to the group and how the programme provided an environment where participants could chose to initiate trusting relationships, and appreciate one another's work. Part of this was participants being able to give and receive positive compliments from peers, and feeling comfortable in the environment to share their own stories of their journeys, their strengths, weakness, and coping skills. Tania expressed how she felt and this was of benefit to her.

4.1.3 Cultural knowledge: Catching up with the myth

The third subtheme captures participants' experiences in gaining cultural knowledge. The processes of this programme (outlined in Appendix A) helped participants to connect to the past through viewing their own culture from a different perspective in their own self learning about their own myths and legends.

Tui, who had never been on a Marae stated that he felt awesome:

At last I can catch up to the Maui myth. I enjoyed learning about what our ancestors believed in. They had a lot of myths and legends that I didn't know nothing about and when I got to hearing the stories it felt good...brought outlooks on my Maaori language and how people were in those days. The myth treated me to the point where I went to the library and I got a book out on Tangaroa, was awesome to read...the programme it made me go and look it up.

Tui shared that he learnt a lot through this cultural experience. He related his learnings to the Maaori language and connected to his past through the stories. He said that after the group he was motivated to further his cultural knowledge. The

programme opened up a pathway of meaningful learning and seeking understanding for him.

Tania also shared her experiences about her life journey, and how the programme gave her the opportunity to learn about the positive side of her culture through myths and legends.

Basically I went away from New Zealand for a long time, coming back home without having any background in Maaori studies. The stories when you hear them and what they meant...they have really strong emotions involved in them... about love, strengths, honour, kindness.. a lot to do with those simple values...actually used to make me feel... which was difficult at that time because I wasn't feeling anything.

Here Tania described how being exposed to her cultural knowledge made it possible for her to alter her emotional state through values she identified with in the stories. The meaning that she gained from the myths enabled her to feel certain emotions again at a time in her life when she thought that she had lost the capacity to feel those emotions. She indicated that there was a positive emotional shift.

Paul, who identifies himself as being of European descendant, appreciated the Maaori myths and stated,

My knowledge of the Maaori culture is not that great, but I did learn. Looking back into all those years when Maaori had their myth and their legends. I have always been fascinated by the Maaori culture and other Gods they have. It's good reminiscing about the past. The class we had on the Maaori culture did help me to recover.

Paul has not been able to specifically identify what it was about the knowledge of Maaori culture that helped him recover. It seemed that his fascination with the past was ignited and that it was the new cultural knowledge he gained that in some way supported his recovery.

Rangi was familiar with some of the myths and was able to build on her cultural knowledge:

Reinforced what I already knew and that was good to know. I now am more knowledgeable about our ancestors, myths and the Gods, mainly with Tane because he splits the parents apart.

As mentioned in the last sub theme this programme gave the opportunity for participants who had never been to a Marae, to experience what was like being on a Marae and to learn Maaori protocols. Tui talks about his experience:

Its carvings... and also learning what you have to do in a Marae like taking your shoes off and all that, those are the basics things you learn and respecting others while you are in the Marae. Since I have been in recovery I have learnt a lot of things especially through storytelling.

Tui affirms here that Maaori Tikanga⁷ was knowledge that he experienced and gained during the programme and through being on a Marae. This highlights the value of using a Marae as a venue for this programme as it reinforced cultural values that promoted recovery.

Cultural knowledge/catching up with the myth emerged as a significant theme. The programme increased cultural knowledge through Maaori tikanga and the myths and legends. The above experiences of participants reflected how the myth/legends helped to increase knowledge of their ancestry. It gave them a sense of pride and connection about where they come from and highlights the importance of connecting the past with the here and now.

4.1.4 First main theme summary

Breaking barriers was the theme that emerged as the foundation of the programme where participants felt safe to engage and learn. As mentioned in the methodology chapter many participants had a diagnosis of schizophrenia and experienced symptoms such as: Alogia which is lack of enjoyment, social avoidance, agoraphobia which is not being able to get out of the house, paranoia which is being frightened of people and anxiety which is increased level of fear or anticipation of some threat. These were major barriers and challenges that participants overcame as described in this first main theme.

⁷ Maaori meanings, customs, obligations and conditions (Ryan, 2008)

The three sub themes each uncovered different understandings of the initial stages of the therapeutic process of the programme. Social inclusion was described by participants as being a major aspect in their recovery. They felt that being included in the group, made significant changes in the way they were feeling at the time. By participating in groups, feeling welcome, accepted by others, and being listened to helped them to appreciate and empathise with other participants. Participant's experiences uncovered understandings that before coming to the programme they had presumptions of the other group members being 'crazy' which made it difficult for them to socialise. Being able to participate and mingle with others gave them the courage to disclose their feelings, and illnesses with others. Also an appreciation of experiencing others and listening to their stories in a safe environment gave them a sense of being included. These factors supported participants to keep involved in the programme.

Running the programme at the Marae emerged as a positive cultural place where participants connected with their ancestors, learnt about their culture and protocols, which seemed to encourage participation. Participants described a safe environment as somewhere they could socialise and build trusting relationships, experience feelings of being free of violence, respect others and connect with the Marae carvings. By being in a safe environment participants had the opportunity to demystify and overcome negative experiences from their past and realised that they were not the only ones that lived with a mental illness. The environment also gave a sense of being included and belonging in their community and that people cared about them.

Trust was described as a sub theme that helped to overcome social barriers developed before or during their illness. Some participants had lost their ability to trust and socialise with other people and acknowledged that the programme helped them to initiate and create trusting relationships. Increasing cultural knowledge emerged strongly as participants felt that by listening and discussing myths and legends they were able to learn about their past and connect to the present. Seeing how their ancestors dealt with their lives they were able to look for answers in their own lives and feel proud of where they come from and what their ancestors believed. Providing a safe environment in a Marae setting had significant impact for the Maaori participants. Their experiences demonstrated

that they felt safe, that they weren't been stood over or felt threatened or forced to participate. The participants pointed to that in other areas of engagement in their lives they have felt unsafe and threatened which perhaps has limited their ability to overcome challenges and barriers. Being in a safe environment promoted feelings of participation and engagement doing activities, where they experienced enjoyment in a space learning new things about themselves and their culture.

The second main theme will be discussed next. Creating positive memories, which highlights the unique opportunities the programme provided in participant's journey of recovery.

4.2 Creating positive memories

This theme uncovers participants' positive memories that were experienced while participating in the storytelling/pakiwaitara groups. The data also sheds light on how positive experiences impacted on the three subthemes: wellbeing, teamwork and connecting with others.

4.2.1 Wellbeing

Wellbeing is defined in population health studies by Seligman (2013) who presented five measurable elements that count towards measuring wellbeing. They are positive emotions, engagement, relationships, meaning, and achievement (PERMA). Participants gained feelings of wellbeing while participating in this programme.

Rangi responded how he felt while being at the group while interacting with others in the group:

I was always happy participating it was good break just being stress free, the whole group was stress free. I enjoyed how the dancing kept me physical and mellow. I felt paranoid going to the programme, but the programme helped me to stay focused.

Here, Rangi described his experience as a place where it was relaxing and comfortable for him to be and that the movement from dancing had helped him to get into this space. He overcame his mental health challenges and felt good.

It was unusual to do mimes, games and dancing, so that really got me out of the square...and that was good for me...something new

that I haven't done before. It was pretty hard for me to get out of my comfort zone but I enjoyed.

Rangi was also able to find pleasure from trying something new and experienced a sense of achievement.

Paul expressed how he felt by participating:

I went to storytelling and found it very satisfying. It was quite enlightening and I had a good time when I was actually doing it.

Paul enjoyed engaging in the group work and gained a sense of achievement, a sense of meaning through doing.

Tui and Tania share how they felt when they were going to storytelling.

Tui: I felt happy that I was going to go to Storytelling It made me feel awesome actually... to participate in storytelling. It made me feel well; it put my mental health behind me. I didn't feel as though I had a mental illness. Storytelling woke me up and made me feel good about myself.

Tania: I really enjoyed getting ready, it was exciting, and it was lovely. It was a positive experience and really lovely to study those stories.

The idea of looking forward to going to the programme gave Tui and Tania positive emotions that put them in a space where they participated with ease. There was a focus on feeling good and experiencing wellbeing.

Here Tui talks about how participating in the group helped him to gain a sense of achievement where he could relate to other people and be happy at the same time:

We have to act out a part and that was a challenge as I have never acted out anything. It was making me laugh, and doing it made me feel good.

Tania and Hone relate their experience to wellbeing.

Tania: I got to become really good friends with other people, we would dance around, everyone has their own little piece, and they have fun. It helped myself to relax and cheer up. I wouldn't feel so nervous by going around the group and saying how you felt. It helped me to cope with my anxiety a lot better and to come out of myself. I suddenly felt as though I had this veil lifted off me... it help me to

heal. When I first started doing creativity I expressed myself through music. You know...

Hone: I enjoyed myself, it is good to develop creativity...it is so much fun...It helps your creativity flourish. The karakia the myths...the dancing is good. The chance to try other things and doing it together is such a highlight, it does feel good... yea. The challenge that was given to me was to thank them for the welcoming, the more I did it the easier it became. We just come out together and played our role, the rest of the class claps and they say well done, it's a kind of rewarding and when you finish acting your part it's a good feeling because everyone appreciated what each group has done.

Both Tania and Hone mention that dancing was good for them. In their everyday routines neither of them do much physical activity. They express how the group supported them to overcome mental health obstacles such as anxiety, being in different environments and doing unfamiliar activities. By overcoming their anxiety they experienced a sense of achievement and wellbeing. For Tania, part of this experience could be described as spiritual as she feels a veil lifting, or, she likens it as another way of being. Hone and Tania also draw attention to being part of a positive group experience, where forming trusting relationships was significant.

Hone now shares how the programme has helped him in his recovery: *"Yes it has helped me feel good. It has grown in me. It's good for the mind and good for the soul".* Hone again infers a spiritual connection that supports his wellbeing".

Mary also shares how she felt by engaging with others in the group.

I was able to tell the group why I chose black feathers because I was saying good bye to my dad...I was able to say that in the group and expressed that. I was grieving for my dad, the day of the play and was able to say and express that in the group. I smiled and laughed that day I forgot my sorrow, I had fun.

Mary connected with her personal values and she felt that part of her experiencing wellbeing, was having the opportunity to express and disclose her grieving issues and make decisions for herself, while also having fun.

This sub theme highlights the important role of the therapeutic storytelling programme on people's wellbeing. Some participants described how they were

able to put their mental illness behind them. The programme worked as an intervention where participants were able to overcome mental health symptoms such as anxiety, inability to socialize, ineffective communication, limited self-expression, engagement and difficulty with leaving their homes. This increased wellness, promoted an environment where participants felt joy and achieved new things in their lives and could look at themselves in a new healthy way. They were also enabled to form positive relationships, while achieving a sense of meaning with other people that have similar illnesses. This appeared to support wellbeing and hope for the future.

4.2.2 Team work

Team work is the second subtheme and focuses on how participants felt when they were part of a team. This occurred while they were working together doing a range of activities in the groups.

Tania stated that she likes to have different roles in the group. *“Everyone got their own little piece. I enjoyed giving ideas to the group. Why don’t we do it this way? I kind of supervised”*. Tania was not confident at making decisions in her daily life, yet in this group was enabled to take a lead role helping to support others to engage.

Joan, the facilitator, also noticed participants working well in groups. *“When they use the fabrics and they get into groups of threes, they take part of a story and act; they are very comfortable with it”*

Paul also commented about how he felt when working with others:

I remember that particular part when we used to throw the ball of wool around to each other...It was very interesting. We all had different things, we re-enacted those myths and legends, putting on different costumes and I think it was quite an experience, it was really good, it felt enjoyable.

It is noticeable that Paul uses the third person inclusive pronoun “we” and it seems that this experience of being with others doing this programme made him feel good. Paul does not usually involve himself in any kind of team or community type of activity. However he particularly enjoyed having the opportunity to interact with others on this occasion. Tui also affirms how he enjoyed this interaction with

others. *"Now I can act and also participate in groups...interact with other people, it was a benefit. I like the role playing it got me out there too",*

Rangi stated how he felt working as a group:

It was quite a good group, everyone was free flowing. Being part of the action and part of the group was good, it was a good play acting out part of the story, no one would judge you if you were right or wrong, it was good to hear other people in the group.

Again from Rangi's perspective he identified that the actions were a medium that made it possible for him to do and experience being in a group. He felt so great to be in the moment. One can feel how this is an enlightening memory for him and that it enhanced his wellbeing.

Hone also appreciates working with others. *"The group usually asked each other... we work it out together, it feels your mate has done his part and you have done yours, we just come together and play our roles".* Hone describes how they worked as a team, problem solving, listening to each other and worked together taking on the roles they needed to get the activity done.

Tui mentions more about how he experienced a sense of belonging:

I'm not keen on being in a group but this storytelling group made me feel good about myself as I could interact with other people. Doing the story and everything, so yes it was a benefit and gave me a lot of skills.

Not only did this experience increase Tui's self-worth it also allowed him to use his communication skills so he could interact with others in the group.

Team work was a very significant indicator and enabled group members to know each other's talents by taking on different roles. They experienced being part of a team where no one was judged on their performance, and there were opportunities to have collective discussions. This was evident in the group work, when for example discussing who was going to take on a particular role.

4.2.3 Connecting with others

This subtheme looks at participants who previously found it difficult to connect with others and how once they made connections. It is of note that participants were interested to remain connected with each other outside of this programme.

Tania explores how she valued making friends:

I found that I formed friendships with people from pakiwaitara where I first met them. The experience was a really good for me. We would go around the group and say how we felt and you know there were little activities that you say how we felt about, just checking in. The whole experience connecting with other people that also have similar mental illness and had also their own apprehensions was good.

Here Tania described how the group process enabled her to initiate conversations with others in the group. This infers that she usually has difficulty in doing this. She enjoyed hearing others express and share about themselves, their mental illness and their struggles. This process supported her to connect with others and she reflected on others experiences of their mental health issues.

Rangi reflects, here, that he is not the only one who lives with a mental illness and he appears to feel positively in being among others who live with a mental illness.

I observed that a lot of people are like myself but they were a keen bunch of people really ready to get on with the programme and have fun and I enjoyed that fun too.

Also acknowledged by Rangi was how the group helped him to feel part of the group. "I was pretty paranoid going there, but after a while got used to it and fitted in". Rangi does not usually mix with others, as he feels paranoid. The programme made him feel connected to others through the activities. Rangi goes on to establish connections and relationships that he did not think were perhaps possible for him to make:

It was awesome just to the point at least I have made friends as before I wouldn't go to a programme like that, I would stay at home. The people are good, everyone was polite, everyone has the same conditions no one is better than the other person, it was good to hear other people in the group they knew what they were doing and saying, I enjoyed my mates.

Similar to Tania, Rangi valued being able to connect with others who have a lived experience of mental illness similar to themselves. He also connects by hearing what others in the group had to say.

Tui and Mary both felt welcome and able to engage and be part of the group. They both felt that by connecting with others they were able to see themselves as better people.

Tui: *The people in the group were like me and made me feel as though you are welcome to the group. It was awesome to the point at least I have made friends. So I would go back if I had a chance. When I was going to the programme it made me feel as though I'm a person that has feelings and that cares.*

Mary: *I didn't really believe in myself that much at the time... the clients they helped too, before I never understood other clients... I couldn't see past my own nose and my own eyesight. They were having fun and laughing and they were all doing well. I was part of it and I didn't have to go outside and have a cigarette and feel rejected again. I was happy to participate cause it was easy. I was included that's why.*

Mary acknowledged how she felt about herself before meeting group members.

Mary felt connected to the group by sharing the fun and the laughter. She also stated that she did not need to escape because she was not experiencing rejection. Instead Mary felt happy and included by having fun, while participating.

Joan the staff facilitator also felt connected with group members. She said *"I felt even with all the whaiora that came, that we had much in common, we were connected"*.

Connecting with other group members was a pleasurable and enabling experience that allowed positive memories to be created.

4.2.4 Summary main theme two

Creating positive memories enabled the analysis of the positive outcomes and interaction between participants. These included doing the programme, meeting and working with different people and having fun. These will all create positive memories. Wellbeing was the first subtheme and participants shared that they experienced a decrease in some of their mental health symptoms while doing the

programme. They felt stress free, less paranoid and happier by being able to express themselves and also being able to vent feelings of grief.

Team work was the second subtheme that highlighted how group members experienced being together as a team, could create positive memories.

Participants were able to act, dance and play without fear of prejudice in a safe environment and have collective discussions which facilitated teamwork.

Connecting was the third subtheme. Findings consisted of how group members had the opportunity to initiate and maintain connections with each other while they were interacting in the programme. Some of the participants described how prior to doing the programme they did not have the confidence to mix with others. Participating in the programme created an opportunity to make friends because they felt welcome, included, listened to, affirmed and where they enjoyed the social gathering. All of which helped to create positive memories.

4.3 Becoming another person

Becoming another person is the third and final theme. The name of this theme emerged through the language, feelings and aspirations that participants shared. Through participants experiences while doing the programme they felt hopeful of re integrating into the community and being able to make new friends and to live normal lives. Three subthemes emerged; the first is the 'Hope' where participants felt privileged and honoured to be in the programme. The second subtheme was 'Appreciation' where participants appreciated many different aspects and processes involved in the programme. Finally the third subtheme was 'Identity' which is related to experiences of gathering cultural understandings.

4.3.1 Hope/privilege/honour

This subtheme provides and inspires a vision and direction for the future, it reflects participants' limited opportunity to participate in many community activities, and how they felt when they were invited. Participants usually receive negative types of mail e.g. Bills and notices to attend court in regards to Mental Health Act. As presented in (Appendix L) an invitation was sent to each group member inviting them to the programme each week.

Tui acknowledged that when receiving the invitation he felt hopeful.

Storytelling was about life, how it was created and came to be a myth for the future. It was good to know the title of the story it gave me some tools to use in my life.

One can hear the hope and connection Tui makes in looking to the future and living his life. He found useful strategies to help him in his life.

Hone also asserts that: *"It's always something to look forward"* and he stated how he felt hopeful about relying on people again. *"It gives you that belief on relying on people again. It gives you that chance to become someone"*.

Rangi commented: *"I would like to go back and share what I know"*.

Tui shared: *"My first invitation it was awesome"*.

Hone also articulated how he felt when he received the invitation: *"It was like a privilege"*.

Rangi responded very seriously and said: *"I felt honoured that they kept sending me letters of invitation"*.

Tania also echoed *"I enjoyed getting those invitations; I really like the paintings in the invitations"*.

Mary stated what she thought when receiving the invitation *"Would be something nice and interesting to go to"*

These descriptions demonstrate a sense of being valued by receiving an invitation and being included. The statements also reflect and describe participants' positive, hopeful feelings and sense of privilege about being formally invited and highlight the value of sending an invitation through the mail.

Next Rangi and Hone shared experiences that convey feeling a sense of becoming another person with a better future. Hone comments *"It's like we've given a chance to become someone"*. Rangi affirms this *"It's given me another chance to get another life, being another person, given me a chance to become someone and to become a better person"*.

Tania was excited as she stated that *"It instils that feeling inside of you"*. She inferred that she was inspired and looking forward. Hone was also animated when he shared a similar feeling: *"Some of the stories are magical and inspiring"*.

This subtheme instils the belief that becoming a different person is possible. Participants shared how they were hopeful at becoming better people and gaining new tools and skills for the future. Tui shares:

Storytelling is making me recover well....it puts a few skills that I never had before. Now I can act and participate in groups....I can interact with other people. It is giving me tools to use that I never had before like relaxing, breathing and learning how to cope with stress...

4.3.2 Appreciation

Participants took the opportunity to give an account of how they appreciated being involved in the programme and were able to give appreciative comments about other participants in the group.

Paul commented:

I really enjoyed and liked participating in that event, I think it was a different experience, it was really good.

Tui described positive feedback about the programme:

I'm not keen on being in a group but this storytelling made me feel good, it made me feel well...I have never acted out anything and made me feel good, the feedback it was good I did enjoyed that.

Tui indicated that doing something he had not done before made him feel good, and that his previous experiences of being in groups have not always been so positive. He felt affirmed by others in the group.

Hone also felt supported and acknowledged by the group. *"The rest of the class clap and they said well done. Just being there and being able to make friends and do this together is such a highlight"*.

Tania also appreciated others in the group:

One person in particular, I believed really benefited from the group, you start seeing him really getting into it, enjoying it, everyone basically did, it had an effect on everyone, proud people, workers got involved they were really into it, they love it they have fun.

Here Tania identified different group members that she valued and observed them developing a sense of security. She is appreciative of the level of engagement of staff in particular and that it was of value for her to be able to share this experience with them.

Paul commented *"I find it quite enlightening...just having that chance to participate in those groups it was something I really cherished"*. Paul's comment sheds awareness on how participation was a key aspect that made him feel important, content, part of the community, and infers that he does not usually have opportunities to be included in these types of group activities.

The importance of receiving and giving appreciation is well supported by the above statements where participants appreciated the programme and the other group members. Participants described feelings for the opportunity to participate in a community group where they were able to work with others and be respected for their contribution.

4.3.3 Identity

In this subtheme, participants revealed feeling proud about learning where they came from, and who they are. Most participants identified themselves as being Maaori while at the same time not really knowing what this meant. During the group programme participants were exposed to their own Maaori myths and legends and took part in collective discussions about the stories.

Hone stated: *"Being a Maaori I could relate to the stories."*

Tania identified:

What it has done it's given me a sense of pride. It helped me you know, ... so yeah definitely has had an impact in my life.

Tui's comment reflected a sense of gaining identity: *"When I was going to the programme it made me feel as though I'm a person that has feelings and that cares"*. Tui was able to identify with the personal values that he held.

Tania: *Definitely it's based on being yourself. Everyone has the same conditions there, no one is better than the other person. I was participating very well. Everyone was polite. The way we studied the stories really helped us to enjoy where we come from. I guess not having that pride...because I didn't have a sense of that kind of feeling about my own culture. I was given another opportunity to see my culture from another light. I feel more proud of who I am and where I have come from...a different light instead of always seeing the negative which I had experienced.*

Tania expressed the enjoyable experience when she found out where she came from through the myths and legends and appreciated the opportunity given to see her culture from another perspective. The above statement from Tania demonstrated that Maaori myths and legends aided Tania to gain a sense of who she is and demystified negative experiences from her culture and shed light on the positive values and helped her acknowledge her identity.

The participants indicated that they felt that the stories helped them to identify with their own culture and feel a sense of being proud of where they come from and who they were as people in the world.

4.3.4 Summary of becoming another person

Becoming another person emerged directly from participants statements where they provided lived experience about their journey while participating in this therapeutic storytelling programme. Emerging from the first subtheme of Hope/Privilege/Honour are emotions from the appreciation of receiving an invitation. Hope was described by participants as the inspiration that the mythical stories are magical and inspiring and that the programme did provide a sense of hope of, for example, becoming a better person after discovering that they were people that had feelings, and that they have worth in this world and can aspire to a better future.

Appreciation is the second sub theme, in which group members had time to be appreciative of others work, staff and the programme as a whole. Identity was the final subtheme which uncovered participant's limited understandings of knowing who they were or where they came from. These issues appeared to be important to their recovery. Participants felt that by listening to myths and legends, and the

way in which they were told, gave them a sense of pride and connected them to where they came from and who they were.

4.4 Conclusion

Findings described how group members had to overcome barriers and difficulties to be able to get to the programme and participate. Group members had the opportunity to participate in a programme, where they felt safe, were able to make connections, initiate trusting relationships with others and interact to their full potential. They liked having fun, dancing, acting, listening to myths and legends, doing mime and working as a team in a safe environment. Group members had the opportunity to learn about culturally relevant Maaori myths and legends on the Marae, which is a safe cultural environment. Through this process participants' were able to identify with the myths and feel proud of who they are and where they come from. Positive memories were created that promoted wellbeing and hope experienced which was important to the participants. Becoming another person was a theme that instilled a sense of feeling proud/privileged and honoured to be invited and included in the programme. After breaking barriers of living with a mental illness and identifying who they are through their own myths, participants seemed to gain a sense of confidence about themselves and their personal gains in discovering that they are people that have feelings. This theme highlighted how it's possible to become a different person while living with a mental illness.

Chapter 5 Discussion

5.1 Introduction

This research sought to explore how the experience of participating in storytelling/pakiwaitara groups changed participants' life experience in their journey of recovery. Three main themes were uncovered produced from rich data from the participants: Breaking barriers, Creating positive memories, and Becoming another person. All the themes are interconnected. This chapter provides a synopsis of the findings, which are linked and discussed in relation to the literature and in particular the recovery literature. Strengths and limitations of this study are also discussed, including implications for practice and further research.

5.2 Synopsis of findings: The journey of recovery

Breaking barriers was the first theme identified in this research and was related to personal obstacles and challenges that participants overcame to leave their homes and interact with others in the programme. Barriers also included personal stigma from living with a mental illness, feelings of hopelessness, being socially excluded and having difficulty trusting other people. Findings showed how the experience of taking part in the group helped participants to develop relationships where they connected with new people, felt accepted, listened to, and developed a sense of belonging where they could trust others. Findings also indicated how participants increased their cultural knowledge, and through seeing how their ancestors dealt with their lives were able to transfer these values into their own lives through reading and listening to the myths and legends. For Maaori holding the groups on a Marae was a significant place that enabled participants to connect with their culture.

Findings affirmed how the programme helped participants in their recovery, by being able to make new friends, participate in discussions during the programme and disclose feelings about their illness and lives events. These findings align with ideas proposed by Le Boutillier et al. (2011) who suggested that each individual comes to terms with and overcomes challenges and barriers related to having a mental illness. One of the recovery processes identified by Leamy, Bird, Le

Boutillier, Williams, and Slade (2011) was around connectedness and the Marae was seen by some participants as a safe environment for making connections and being able to learn. These findings align with writings by Murphy (2012) and Curtis, Copeland and Palmer (2002) on how recovery is an approach that changes ones values and provides education. Participating in the programme seemed to initiate this.

Creating positive memories was the second theme and findings uncovered how participants experienced positive interactions with others, created meaningful relationships and how participants were supported by others. Participants experienced positive emotions, engagement in relationships that were meaningful, and feeling a sense of achievement, this aligns with a sense of wellbeing as defined by Seligman (2013). Participants shared they felt less anxiety, stress and paranoia which allowed them to experience positive emotions. Understandings were revealed about how working together doing different activities provided the opportunity to experience working as team. How the opportunity to be social, act, role play, laugh, dance, and complete tasks as a team, enabled a sense of belonging.

These findings resonate with literature described by Le Boutillier, et al. (2011) who highlighted that positive participation in community activities enables a sense of living a normal life even with a mental illness and is an essential part of recovery. Pakiwaitara enabled a process where group members were able to reclaim the role of being a healthy person which was identified by Curtis, et al. (2002) as an important part of recovery. The recovery report of Le Boutillier, et al. (2011) identified that it is important to explore and consider the person's strengths, accomplishments ways of relaxing, having fun, ways of calming down, personal heroes, and achievements. Participants' experiences resonated with these ideas from Le Boutillier et al. (2011) in that participants identified a sense of connectedness, support from others, and being part of the community. Recovery studies from Le Boutillier, et al. (2011) also identified that when people are able to tell their own recovery stories it provided the opportunity to share how they have worked through challenges in their lives. How by creating this as a positive experience through learning is important, and some of these aspects were reflected in the findings.

Understandings from the final theme: Becoming another person, revealed that through the processes of engaging in the programme, participants experienced a range of different ways of being. These included: feeling honoured, privileged and hopeful which enabled them to get out of the house, work together as a group, connect, interact with other people, dance, act, role play, be creative, and feel good about themselves. A significant process was when they received the invitation by post to participate in the programme. Also being on the Marae helped some participants to overcome past negative cultural experiences. Being exposed to Maaori myths and legends on a Marae enabled some participants who were Maaori to view their culture from a different perspective; they felt proud of who they were and where they came from. The mythical stories were full of inspirations, which provided a sense of hope for the future, of becoming a better person, being able to trust people, becoming someone, listening and talking to others, and having something to appreciate that was meaningful to look forward to doing. Findings revealed how taking part in the programme supported participants to experience another way of being by gaining confidence, being included, and connecting with others. Also highlighted was that through storytelling/pakiwaitara participants discovered that they were people that had feelings and were worth something in this world. These feelings gave rise to new horizons and developing as a person.

These findings fit with the recovery model discussed by Le Boutillier et al. (2011) who found that community integration starts outside mental health services. This occurred when participants took part in the programme in a community space and experienced another way of being. Aspects of recovery align with having an identity that are consistent in this study. These included seeing oneself as someone other than a sick person, learning about one's self and building on strengths and developing social and cultural roles (Curtis et al., 2002; Le Boutillier et al., 2011).

Facilitating, fostering, and promoting hope to individuals who live with a mental illness is important because it provides the opportunity to instil hope for the future (Le Boutillier et al., 2011; Murphy, 2012). Participants identified that taking part in the groups created a sense of believing in the possibility of a new identity or role, being motivated to change, and having dreams and inspirations for the future.

In summary the findings reflected that engagement in the programme facilitated participants to break many of the barriers and challenges they had encountered previously. It was revealed that learning about culture through the myths and legends in a positive cultural environment afforded a sense of connectedness and positive identity. New meaningful relationships were established through the opportunity to be in a safe trusting environment which helped create positive memories. Developing feelings of a sense of worth gave rise to hopeful new horizons and becoming a better person. These findings are embedded in recovery principles and demonstrate how participants' lives were transformed and supported in their recovery journeys.

5.3 Alignment with existing literature

Findings from this study align with the anecdotal reports and literature that storytelling/pakiwaitara supports and provides opportunities that enabled a range of recovery processes and principles for adults who live with a mental illness in the community (Bielanska et al., 1995; Cherrington, 2002; Clarkson & Philips, 2006; Crimmens, 2006; Dunne, 1998; Feniger-Schaal, 2016; Johnson, 1984; Rubin, 2009; Trafford & Perks, 1987; Walker, 2010; Wilkinson et al., 1998). This study builds on recent literature presented by Reisman (2016) whose work was embedded in recovery, reflecting many of the core findings from Riesman's study.

5.4 Transformations

Findings uncovered that participants experienced a process of transformation. Initial comments from participants expressed how hopeless they felt living with a mental illness, and how storytelling/pakiwaitara broke all those barriers. According to Reisman (2016) personal stigma is defined by internalisation of negative stereotype and self-blame, and is common among people living with a mental illness. Using different modalities Fontana and Valente (1993) in their work with children also confirmed that drama therapy using myths and legends in conjunction of reversal therapy allowed clients to recognise barriers and correct them.

5.5 Strengths and limitations

By choosing a qualitative descriptive methodology it was possible for this vulnerable population to have their voice heard. Using a qualitative descriptive methodology meant also that the method could be adapted to suit this vulnerable population. Careful planning of the thesis ensured that the topic was clearly presented including descriptions of the context, structure, settings, framework and background.

Synthesis of the literature reviewed identified clear gaps in the current body of research in this area, making the findings of this study to be of value for guiding others in this field and supporting the use of drama therapy interventions in mental health community populations. By acknowledging and gathering cultural understandings from participants from a Maaori ethnicity this study has the potential to add to the body of literature that focuses on indigenous populations.

A limitation that was carefully considered was whether my own assumptions would influence, the findings. This was addressed at the beginning of the research through a pre-suppositions interview and discussed in supervision. However, the researchers' knowledge and involvement in interviews and analysis was also a strength as it brought expertise to this topic.

5.6 Implications for practice and programme design

This study provides findings that demonstrate how the use of storytelling/pakiwaitara as intervention contributed to recovery in an adult mental health population that lives in the community. The use of drama therapy using myths and legends based on a sesame approach promoted recovery for the people that participated in the study. This intervention can be utilised by any health professional working in any field of practice as it provides many opportunities to engage clients/Tangata whaiora with the facilitator, services and the community.

It is proposed that other services and health professionals using this therapy understand the theoretical underpinnings and processes used to support positive results in enabling recovery.

The findings revealed that this therapy work well with the indigenous population in New Zealand in facilitating recovery, within New Zealand health services. It is suggested that with increased understandings of the health benefits this type of intervention that it become more widely used by health professionals. In addition, it is time-effective as it is run in a group and so could be an attractive option for some agencies.

5.7.1 Psychodynamic understandings

The psychodynamic theories in this study provided the opportunity for participants to experience wellbeing in their journey of recovery. This aligned with the work of Wilkinson et al. (1998) who also used the sesame approach that enabled clients with dementia to experience a more positive meaningful perspective in their life. This study identified how much fun and hopeful experiences can be facilitated through this programme.

Drama therapy theories applied in this programme used metaphors and images based on the collective unconscious that worked with in a non-intrusive way. These psychodynamic theories using a non-intrusive approach have also been applied successfully in other studies (Corey, 2013; Crimmens, 2006; Hyde & McGuiness, 1992; Lindkvist, 2007; Ruddy & Dent-Brown, 2008). This study suggests that the sesame approach is a non-intrusive way to facilitate recovery with adults living in the community experiencing mental illness.

By using the theoretical understandings describing the use of archetypes (Hyde & McGuiness, 1992) of a hero, for example Maui⁸. Participants were able to articulated specific Maaori gods that they identified as heroes and recalled personal attributes of these specific gods. The use of the six part story method informed by Lahad (1992) was a useful structure that provided a forum where participants discussed, shared and connected with each other and with the myths (Crimmens, 2006; Dent-Brown & Wang, 2006; Silverman, 2004).

It was evident in the literature that psychodynamic theories and techniques offered opportunities for the participants to experience emotional and physical

⁸ Archetypal hero throughout Polynesia (King, 1997)

relief, integration and personal growth, in their journey of recovery. This aligned with the findings of Johnson (1984) and Reisman (2016) who emphasised that drama therapy was useful to empower people who live with schizophrenia in their recovery and integration into the community. In relation to the findings of this study, drama therapy was part of helping participants gain satisfaction, happiness, putting their mental health issues behind them, and making them feel good about themselves. Participating in the group allowed individuals who experienced mental illness, to engage in a gradual safe nonthreatening flexible exploration of their issues of everyday life. The process of the role play with characters from myths and legends from past times provided the function of distancing and provided emotional safety for group members, which is similar to the findings from Landy (1994) that for people with schizophrenia, drama therapy allowed an integration of reality and fantasy.

5.6.2 Creativity

Creativity was an aspect that was interwoven throughout the findings when participants shared their experiences of role play, acting and hearing the stories. It was apparent in the literature that creativity is an important part of the psyche function (Christopher & Salomon, 2000). The work of Silverman (2004) and Wilkinson et al. (1998) successfully implemented the creative processes and attributed this as part of the success of their studies. This same claim is made for this study. The sesame approach is symbolic and placed importance on the creative use of the imagination which relates back to the findings in this study where participants acknowledged being in touch with their creativity. Participants voiced that they enjoyed being given the opportunity to do creative activities and were able to express themselves. The programme encouraged them to develop their creativity and they flourished.

5.6.3 Myths and legends

Participants' experiences revealed how they were interested in heroes like Maui and other gods such as Tangaroa⁹. Participants took the opportunity to select, act, and imitate the hero's actions, qualities, thoughts, feelings and behaviours. These

⁹ Maaori guardian of the sea (Ryan, 2008)

heroes guided the participants in the role play of characters (Hyde & McGuiness, 1992; Rubin, 2009; Walker, 2010). The work of Silverman (2004) acknowledged that when his clients identified with a character of the myth or fairy tale they were provided with a structure to solve their own difficulties in life. This aligns well with how participants were able to identify themselves with a hero as a role model, in many cultures people are expected to take mythical gods or heroes as their role models. For example King (1997) identified that “Maui was an archetypal hero throughout Polynesia” (p.10). Findings revealed that participants wanted to explore myths and that some were more active once they had been connected back to the myth. The value of storytelling and findings from this study resonate with how participants chose a mythical hero which took them on in a journey of discovery and problem solving that both Cherrington (2002) and Royal (2000) described in their work. Group members learnt about the hero’s journey, they described being able to transfer values and knowledge to implement in their everyday lives.

5.7.4 Maaori cultural knowledge

Cultural knowledge was facilitated by providing participants stories of Maaori myths and legends in a Marae environment. According to Durie (2011) the Marae provides better understandings of Maaori thinking, feelings, and behaviours. Findings in this study also revealed that participants did enjoy the Maui myths, Maaori language, the carvings, learning about their ancestors, and how their people lived in days gone by. The importance of myths and legends in humankind was acknowledged by Fontana and Valente (1993) and by psychodynamic theorists such as Jung and Von Franz (1980). Findings highlighted that by being exposed to cultural knowledge some participants identified with the stories and were able to connect with their emotions. Findings revealed that the way the stories were presented in the programme, by using pictures and acting them out, made it a fun experience and enabled some participants to connect to where they came from. It also provided an opportunity for them to see their culture from another point of view. Non Maaori participants were fascinated about the Maaori culture and their Gods and were also able to make connections and acknowledged how it helped them in their recovery journey.

The archetypes and symbols of myths and legends used in storytelling/pakiwaitara groups helped participants to activate the dormant archetypes that lay in a quiet state in their unconscious; this is supported by the research work conducted by Rubin (2009). Being on the Marae and seeing the cultural carvings played an important part in the process where the archetype assumed a determinable shape. These theoretical understandings aligned with findings discussed previously about the hero and visual cultural carvings at the Marae providing symbolic expression of archetypal themes. Another example of an archetypal symbol that was activated was when a participant in the study described using black feathers from the props provided, to express feelings of grief and loss of her father that she had been carrying for a long time. By expressing her sad feelings through the symbolic use of the black feathers, she was able to tell the group how she felt.

5.7 Summary

In summary all the literature that was accessed and reviewed supported the use of either drama based therapies or the use of myths and legends as a way of increasing health in a range of populations. It was clear that interventions based on psychodynamic theories have withstood the test of time and developed more non-intrusive approaches, such as the sesame approach. Core findings presented in the synopsis are reflected in all the outcomes from the literature reviewed and aligned with recovery principles. Creativity emerged as a significant process that was part of the programme and allowed participants to experience another way of being and to flourish. Links were established from the literature on how myths and legends were identified as an enabling medium that facilitated connections and developed cultural knowledge. Part of this cultural knowledge uncovered the powerful effect for Maaori to be on a Marae. What became clear was there had not been a similar study to this one in New Zealand run in the community using a recovery approach, with a population of adults experiencing a range of mental illnesses with a focus on cultural and ethnic considerations. This study therefore builds on anecdotal and historical literature reviewed and makes claim that

recovery is facilitated through engagement in a programme like storytelling/pakiwaitara.

5.8 Future research

This research builds on the paucity of historic and current evidence about therapies that implement drama therapy, and myths and legends for people with mental health issues. There is even less evidence of using this type of intervention with ethnic populations, or where the therapy is community based or that uses cultural venues. It is recommended that future research be undertaken that incorporates a quantitative methodology to gain more quantifiable data to support the use of this therapy. It is also suggested that future research be done to identify if engagement in storytelling/pakiwaitara influenced participant's usual daily occupations and routines. By exploring a change in daily routines it could be a significant area to gain better understandings that link to overall wellbeing. Findings from this study revealed that the programme helped participants to get out of the house. It is also suggested that by replicating this study with similar or different populations to strengthen understandings and to add to the knowledge base. It is hoped that the findings from this research will build on current knowledge providing evidence to influence health professionals' practice.

5.9 Conclusion

I embarked in this journey with my own assumptions from years of facilitating this programme. The initial aim was to facilitate storytelling/pakiwaitara to help clients to engage with the service, and increase community engagement. Storytelling/pakiwaitara provided an opportunity for participants to engage in their internal world in a social cultural context and understand more about themselves. Findings of this study revealed this programme transformed participants in their journey of recovery, by breaking barriers, creating positive memories and becoming another person.

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Appendices

Appendix A: Pakiwaitara

Storytelling/Pakiwaitara workshops process

The storytelling workshops are held in a local community venue. At the venue there are other activities open to the public. The venue needs enough space for group members to be able to move and good lighting. Below is an outline of the process involved in running the group.

The group arrives at a set time and gather sitting on chairs in a circle.

A welcome begins with a prayer /karakia or a song. If there is a new member a name round is done. This procedure does more than help group members know/learn one another's name. It acknowledges their membership into the group and invites them to be part of it (Coles, 2005). Group guidelines are established jointly and written on a white board. This is very important to set at the beginning of the session to ensure physical and emotional safety and that respect and confidentiality are maintained. Confidentiality is always defined and usually means that personal sharing remains in the group. Objectives for the group are reviewed as follows: to gain understanding of the story, to develop creativity and have fun.

The warm up is next. It engages the group in the activation of the creative process and leads to the main event with themes related to the main event working in small groups and individually. This part of the group process can be compared to the warm up that a performer or an athlete goes through in preparation for performance (Landy, 1986). Warm ups according to Landy (1994) are actions that prepare participants to engage in the creative process of the role enactment. Warm ups are used to activate the creative process e.g. deep breathing exercises, these exercises focus on stretching the diaphragm. Also stretching the muscles to lessen the tension levels of the body. After the warm up is finished, group members gather around to give feedback.

Facilitators encourage group members to give positive feedback about the warm ups. This encourages group members to share learning strategies (Coles, 2005).

The main event involves telling the story and acting the story out in small groups. After the warm ups are complete facilitators read the myth/legend "How Maui slowed the sun". This story is a good medium to use because has got a lot of archetypal material e. g. prayers/, hero, weaving, chanting, flax, the sun, magic powers language, marae, and tricks. The story is told by using either an overhead projector or pictures this process helps participants to process the myth and legend by using their five senses and prepares participants to identify and take a role of a person or object in the story.

When participants take on a role it is their choice to choose which role they going to take or this can be a group discussion. Landy (1994) quoted “that he/she will express both interpersonal conflicts and intrapsychic tensions” (p, 130). It is imperative that when participants choose their role it is their choice because the role play is an opportunity for participants to explore metaphorically conscious and unconscious issues (Crimmens, 2006).

After the story is told, group members divide into groups and the story is divided into parts. Each group gets given part of the story to act out by using drama and props that they have chosen. They practice in groups and then share their performance back to the group.

During this stage groups participants have the opportunity to identify and project their thoughts, feelings and behaviours onto another person or object by working with safe non-intrusive and non-invasive techniques which involve using movement, mime, myth and the role play in drama therapy. (Landy, 1994) points out “Acting is a form of projection where the actors enter the body, mind and the spirit of another” (p. 108). After the group ends acting the myth of “How Maui slowed the sun” participants gather around as a group and thoroughly discuss the story in depth by using the six part story method. This is described by (Brown, & Wang, 2006; Lahad, 1992) as a projective tool that is very effective when working with myths and legends in which the participant creates his or her own character. In this case Maui is the hero and his goal is to slow the sun but also there are obstacles to overcome so the hero goes and ask for help to complete his task (Crimmens, 2006). This stage involves exploring for possible solutions and may include personal feelings that lead to asking for help from other participants.

The use of the 6PSM is to identify coping strategies Brown and Wang(2006).

The six part story method

The six part story method is a good tool to implement in the storytelling/pakiwaitara because it prompts participants to get involved in positive group discussions and responses. Participants take the opportunity to project their feelings and thoughts collaboratively with group members by using the six part story method of the story. This method is extensively discussed step by step as a group. Members are invited to pick a main character to explore and reflect their own personal material in a non-invasive way by projecting to persons or objects of the story. There is no right or wrong way of interpreting this process. Participants have the opportunity to ask questions using the 6PSM and further discussion of the story. Themes emerge around team work, believing in themselves, trusting their leader and using nature to problem solve.

Human characteristics used in the story are also discussed and can include determination, courage, strength, faith and admiration. When talking about processing the story Yontef and Jacobs (2005) believed that while listening to the story the process of assimilation allows the listener to select and keep what is useful. According to Von Franz (1980) that through reflection, psyche energy from the projected object flows back to the person and raises the level of consciousness. This process can be fun where there is a lot of discussion and laughter as a group in a formal manner where the disclosure is done in a collective way.

By going through the six part story method participants learn to problem solve their own issues by going back to the past and bringing it to the present. Participants identify with a hero in his quest of overcoming his obstacles for a better quality of life (Crimmens, 2006).

The six part story method of the story as mentioned by (Brown, & Wang, 2006; Crimmens, 2006; Lahad, 1992) has been adapted for storytelling/pakiwaitara workshops:

The hero.

The Task.

Obstacle.

Supports.

How obstacles are overcome.

What happens next?

(Crimmens, 2006) quoted "This model is the beginning of reality that challenges participants in their overall experience" this means that what determines success is the balance between obstacles and support (p,30).

The next part includes a freeze frame. This involves taking part in the story and getting all the group members to act out a part of the story and then freeze. This provides an opportunity to work on the story as a whole group and also for group members to have the opportunity to play another role different from when they worked in the two groups.

Closure

The group concludes with a stabiliser, this stage involves coming out of character and orientating the group back to time and place. According to Landy (1994) closure is when participants leave the session and re-enter the everyday world. This stage involves coming out of character and guiding group members back to time and place, providing safe closure. The group then shares a kai /food, cleans up and goes home.

Appendix B: AUT approval

13 December 2013

Lucho Aguilera
50 Wharf Road
RD 4
Pukekohe
AUCKLAND 2679



Private Bag 92006
Auckland 1020, NZ

T: +64 9 921 9999
www.aut.ac.nz

Dear Lucho

Thank you for submitting your PGR1 Research Proposal application for the Master of Health Science.

Your proposal has been reviewed and approved by the Faculty of Health and Environmental Sciences Postgraduate and Research Committee 5 December 2013 meeting. Details are:

Current programme:	Master of Health Science
Enrolment:	Thesis Part-time enrolment:
Student ID	0794132
Topic:	The experiences of participants in therapeutic storytelling groups/ te roopu pakiwaitara who live with severe mental illness in the community: A qualitative descriptive study.
Primary supervisor:	Kirk Reed
Secondary supervisor:	Josie Goulding
Start date:	6 January 2014
Expected completion date:	1 January 2016

For more information about the programme of study, please refer to the *Postgraduate Handbook*.

The AUT website for forms and handbooks is:

<http://www.aut.ac.nz/study-at-aut/current-students/postgraduate-support>

Yours sincerely

A handwritten signature in black ink, appearing to read 'Erica Hinckson'.

Associate Professor Erica Hinckson
Associate Dean (Postgraduate)
Postgraduate and Research Office
Faculty of Health and Environmental Sciences

Cc Primary supervisor Dr Kirk Reed
Cc Secondary supervisor Josie Goulding

Appendix C: Ethics approval



2 September 2014

Kirk Reed
Faculty of Health and Environmental Sciences

Dear Kirk

Re Ethics Application: **14/215 The experience of participants in therapeutic storytelling group/Te roopu pakiwaitara who live with severe mental illness in the community: A descriptive qualitative study.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECS).

Your ethics application has been approved for three years until 1 September 2017.

As part of the ethics approval process, you are required to submit the following to AUTECS:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 1 September 2017;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 1 September 2017 or on completion of the project.

It is a condition of approval that AUTECS is notified of any adverse events or if the research does not commence. AUTECS approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTECS grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

A handwritten signature in black ink, appearing to read 'K O'Connor', is written over a light blue horizontal line.

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Lucho Aguilera laaguilera@middlemore.co.nz

Auckland University of Technology Ethics Committee

WA305P Level 5 WA Building City Campus

Private Bag 92008 Auckland 1142 Ph: +64-9-921-9999 ext 8216 email ethics@aut.ac.nz

Appendix D: CMH approval



16 March 2015

Dear Lucho

Thank you for the information you supplied to the CMH Research Office regarding your research proposal:

Research Registration Number: 2013

Ethics Reference Number: AUTech 14/215

Research Project Title: The experience of participants in therapeutic story telling groups / te roopu pakiwaitara who live with severe mental illness in the community: a qualitative descriptive study

I am pleased to inform you that the CMH Research Committee and Director of Hospital Services have approved this research with you as the CMH Co-ordinating Investigator.

Your study is approved until the date specified on your ethics application.

Amendments:

- All amendments to your study must be submitted to the Research Office for review.
- Any substantial amendment (as defined in the *Standard Operating Procedures for HDECs*, May 2012) must also be submitted to the Ethics Committee for approval.

All external reporting requirements must be adhered to.

Please note that failure to submit amendments and external reports may result in the withdrawal of Ethical and CMH Organisational approval.

We wish you well in your project. Please inform the Research Office when you have completed your study (including when a study is terminated early) and provide us with a brief final report (1-2 pages) which we will disseminate locally.

Yours sincerely



Dr Shamshad Karatela

Research Advisor

Counties Manukau Health

Under delegated authority from CMH Research Committee and Director of Hospital Services

Appendix E: CMH Maaori committee approval

15/01/2015

Ref: January_app_02

Lucho Aguilera
6/17 Lambie drive Manukau

Laaguilera@middlemore.co.nz

Teenaa koe Lucho

Ngaa mihi rangatira mo ouu whakaaro ki teenei kaupapa rangahau hauora

Re: *The experience of participants in therapeutic storytelling group / Te roopu pakiwaitara who live with severe mental illness in the community: A descriptive qualitative study.*

The Counties Manukau Maaori Research Review Committee reviewed your research application at its meeting on December 2014 and offer the following comments:

- a. We commend the outlined conditions in the ATEC approval and that you have now attained service approval.

The CMDHB Maaori Research Review Committee has appreciated the opportunity to engage with you regarding the relevance of this research for Maaori. The committee is able to approve your research project to be conducted in the auspices of CMDHB.

We wish you every success in your research and the Committee would appreciate a copy of any research publications produced as an outcome of this research.

Kia piki te ora,



Karla Rika-Heke
Chair
Maaori Research Review Committee
CMDHB

Appendix F: Consent form



Consent Form

For use when interviews are involved

Project title: The Experience of participants in therapeutic storytelling group /
Te roopu pakiwaitara

Project Supervisor: Kirk Reed/Josie Goulding

Researcher: Lucho Aguilera

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated September 2014
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interview and that it will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....
.....
.....

Date :

Note: The Participant should retain a copy of this form.

Appendix G: Invitation letter



Date

Dear

Hi my name is Lucho Aguilera and thank you for your interest in my study that looks at finding out your experiences of being involved in Storytelling / Pakiwaitara workshops

Along with this letter is an information sheet and consent form. I am very happy to go over this in person or over the phone to answer any questions.

It is important that you understand that it is your choice to join the study. Choosing not to participate will not affect the relationship you have with Storytelling/Pakiwaitara in any way.

To join in this study you will need to read information sheet and if you are interested you need signed this document bellow and give it to your support worker to hand it over to me the researcher who will contact you to discussed it further.

Thank you for your interest in this study.

Sincerely

Lucho Aguilera

Principal Researcher

Phone: Work 092613700

.....
Cut here and enclosed and give it to your peer support.

Please contact me to discuss the information I have received and what I need to do to be involved in your study that looks at finding out my experiences of being involved in Storytelling /Pakiwaitara.

Name.....

Signature.....Date.....



Participant Information Sheet

Project Title: The experience of participants in therapeutic storytelling group / pakiwaitara.

Hi my name is Lucho Aguilera and I'm the facilitator of this study

An Invitation

You are invited to take part in this study looking at the value of participating in a monthly storytelling/pakiwaitara workshop. Participation in this study is voluntary and you are able to withdraw at any time without it affecting any of your future health care.

What is the purpose of this research?

This study seeks to explore the experience of participating in storytelling/pakiwaitara workshops.

Inclusion criteria

You could be included in the study if you have attended the programme in the last five years, age 18 to 65 years old and are able to communicate clearly in English.

Exclusion criteria What will happen in this research?

If you are acutely unwell or in hospital you can not take part or if you are in the researchers case load you will not be included in this study.

You will be selected and interviewed individually in a place of your choice whether is your home or a place of your choice. It is planned that two meetings will take place. The first is to meet and talk through the information sheets and gain informed signed consent. The second visit is an interview that is expected to take no more than one

and half hours. If necessary you may be asked for an extra interview. You are able to bring a support person/people/whanaau with you.

.. The focus of these questions will be around telling your experiences and about what you valued about being involved in the story telling/pakiwaitara workshops.

What are the discomforts and risks?

If you are feeling unwell at the time of the interview it is better to wait until you are feeling well before being interviewed. You may feel upset recalling your experiences of participating in the Storytelling/Pakiwaitara workshops. Also if you feel uncomfortable before or during the interview please let your nurse known.

How will these discomforts and risks be alleviated?

If you feel upset during any part of the study you should let your Community Support Worker Known

What are the benefits?

The immediate benefit is that you will have an opportunity to express your experiences of the storytelling/pakiwaitara workshops. This will help us to understand more about this workshops

How will my privacy be protected?

Interview recordings will only be available to the transcriber, researcher and his supervisors. Your name will not be used so you will not be able to be identified as participating in this study or in any written work.

What are the costs of participating in this research?

Your time is very valuable in this study and much appreciated. Individual interviews will go for approximately a one and a half hour.

How do I agree to participate in this research?

After being informed about the study by your Community Support Worker and you showing interest in participating you need to either post the stamped letter supply by the researcher, phoned the researcher or electronically contact the researcher by electronic mail.. The researcher will get in contact with you and arrange a time for a meeting to discuss this information sheet and to tell you more about the research.

Can I withdraw from the study?

Yes any time before completion of data collection if you wish to do so.

Will I receive feedback on the results of this research?

Yes a summary of outcomes will be sent to all participants upon the completion of the study if requested.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Kirk Reed Head of Occupational Science and Occupational Therapy AUT.

Kirk.reed@aut.ac.nz Phone 09 9219156.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Kate O'Connor. ethics@aut.ac.nz, 9219999 Ext. 6038

Whom do I contact for further information about this research?

Researcher Contact Details:

Lucho Aguilera 092613700 (Extension 5743). E-Mail. laaguilera@middlemore.co.nz

Project Supervisor Contact Details:

Dr Kirk Reed Head of Occupational Science and Occupational Therapy AUT.

Kirk.Reed@aut.auc.nz Ph 09 9219156

Maaori Health Support

If you have any concerns relating to Maaori Health arising from this study please contact the Manager at Te Puna Waiora / Maaori Mental Health Services, CMDHB on 2595099

General support

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact an Independent Health and Disability Advocate:

Free phone: 0800 555 050

Free fax: 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@hdc.org.nz

Please feel free to contact a member of the research team if you wish to discuss matters further.

Appendix I: Guided interview questions

Guided interview questions



Hi how are you? Thank you for agreeing to take part in this interview.

Would you like to start with a prayer/karakia.

- 1 Can you tell me a favourite memory from the storytelling/pakiwaitara workshop?
- 2 What was it like for you when you received the invitation to participate in the storytelling/pakiwaitara workshop?
- 3 What can you tell me about your experiences while participating in storytelling/pakiwaitara workshop?
- 4 Can you tell me what it was like for you when you found out the title of the Story, and How did it make you feel?
- 5 Focusing on the whole storytelling/pakiwaitara workshop. E.g. The karakia, group gathering, the name movement, dancing, warm ups, the six part story method, The main event, closure and sharing of kai. Can you tell me what skills if any, you think have gained?
- 6 Can you tell me if taking part storytelling/pakiwaitara has helped you in your day to day life?
- 7 Can you give me some examples?
- 8 Can you tell me how taking part in storytelling/pakiwaitara has affected your mental health and wellbeing?
- 9 Can you tell me how you describe your health and wellbeing/recovery in relation to your involvement in the storytelling/pakiwaitara workshop.
- 10 Is there anything else that you would like to say about your experience?
- 11 What was it like for you when given feedback about the group ?

Thank you very much for your time.

Offer to close the interview with a prayer/Karakia.

Confidentiality Agreement



For someone transcribing data, e.g. audio-tapes of interviews.

Project title: The Experience of participants in therapeutic storytelling group / Te roopu pakiwaitara who live with severe mental illness in the community: A descriptive qualitative study

Project Supervisor: Dr Kirk Reed

Researcher: Lucho Aguilera

- ✓ I understand that all the material I will be asked to transcribe is confidential.
- ✓ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ✓ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature:

Transcriber's name: Jennifer Stembridge de Aguilera

Transcriber's Contact Details (if appropriate):

...jastembridge@middlemore.co.nz.....

.....

Date: 22nd April

Project Supervisor's Contact Details (if appropriate):

Dr Kirk Reed

Ph 09 9219156

...Kirk.Reed@aut.auc.nz.....

Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTC Reference number *type the AUTC reference number*

Note: The Transcriber should retain a copy of this form.

Confidentiality Agreement



For someone typing data, e.g. notes of interviews.

Project title: The Experience of participants in therapeutic storytelling group / Te roopu pakiwaitara who live with severe mental illness in the community: A descriptive qualitative study

Project Supervisor: Dr Kirk Reed *h*

Researcher: Lucho Aguilera

- ✓ I understand that all the material I will be asked to type is confidential.
- ✓ I understand that the contents of the notes or recordings can only be discussed with the researchers.
- ✓ I will not keep any copies of the transcripts nor allow third parties access to them.

Typist's signature:

Typist's name: Jennifer Stemberidge de Aguilera

Typist's Contact Details (if appropriate):

...jastemberidge@middlemore.co.nz..

Date: 22nd April

Project Supervisor's Contact Details (if appropriate):

...Dr Kirk Reed

Ph 09 9219156

...Kirk.Reed@aut.auc.nz

Appendix L: Workshop Invitation



Appendix M: Reviewing themes

Inclusion

✓
 Enjoyment
 Acceptance
 Trust
 Team work
 Leadership
 Respect
 Confidence
 Looking forward
 Being included
 Role playing
 Expression
 Reflections
 Wants to stay connected
 Gained skills
 Occupation
 Belonging
 Fun
 Safe environment (marae)

✓
 Gained cultural knowledge/skills
 Through myths and legends
 Identity with his culture
 Gained skills
 Appreciation towards other culture
 Self worse
 Cultural identity
 Projection
 Given confidence
 Appreciation of the programme
 Brought back childhood memories

Trust

✓
 Safe environment (marae)
 Appreciation towards others
 Connecting with others
 Acceptance
 Team work
 Leadership
 Respect
 Confidence
 Looking forward
 Being included
 Wants to stay connected
 Reflections
 Appreciation of the programme
 Role playing
 Expression
 Belonging
 Fun
 Relief of emotions
 Gained social support
 Reflecting

Hope

✓
 Looking forward
 Wants to stay connected

Safe environment

✓
 Safe environment
 Enjoyment
 Appreciation towards others
 Appreciation towards the programme
 Connecting with others
 Identity with his culture
 Acceptance
 Trust
 Team work
 Leadership
 Respect
 Creativity
 Confidence
 Looking forward
 Hope
 Gained skills
 Being included
 Wants to stay connected
 Gained cultural knowledge
 Brought back positive memories
 Creating positive memories
 Occupation
 Self worse
 Cultural identity
 Projection
 Belonging
 Fun
 Relief of emotions
 Gained social support
 Role playing
 Insight/understanding
 Gained confidence

Identity

✓
 Gained cultural knowledge/skills
 Through myths and legends
 Brought back childhood memories
 Identity with his culture
 Leadership
 Appreciation towards other culture
 Cultural identity
 Self worse

Appreciation

✓
 Safe environment
 Appreciation towards others
 Appreciation towards the programme
 Being included
 Wants to stay connected
 Appreciation towards other culture
 Creating positive memories
 Expression
 Belonging
 Gained confidence
 Enjoyment

Social

✓
 Enjoyment
 Appreciation towards others
 Appreciation towards the programme
 Team work
 Leadership
 Respect
 Confidence
 Being included
 Wants to stay connected
 Role playing
 Expression
 Belonging
 Social support
 Confidence

Safe environment

✓
 Safe environment
 Appreciation towards others
 Connecting with others
 Identity with his culture
 Acceptance
 Trust
 Leadership
 Team work
 Creativity
 Respect
 Confidence
 Appreciation towards the programme
 Gained skills
 Being included
 Wants to stay connected
 Creating positive memories
 Self worse
 Cultural identity
 Relief of emotions
 Gained social support
 Self awareness
 Insight/understandings

Expressive therapy themes

✓
 Lifting the shadows
 Symbolic
 Role playing
 Safe environment (marae)
 Wants to stay connected
 Projection
 Brought back childhood memories
 Creating positive memories
 Gained cultural knowledge
 Through myths and legends
 Identity with his culture
 Cultural identity
 Relief of emotions

SAFE ENVIRONMENTS

✓
 + Marae