The Wound That Travels:

Te Poutama o te Ora, Composite Narrative Methodology, and the Whakapapa of a Wound as Conceptual Framework

A lived-experience-informed academic reflection

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Abstract

This article is the foundational framework paper for The Whakapapa of a Wound — a four-part academic series examining the intergenerational transmission of early relational wounding through the lens of Te Poutama o te Ora (TPO): a nine-dimension Māori wellness framework developed from lived and resolved experience. The article does three things. First, it situates TPO within the existing landscape of Māori wellness frameworks — including Te Whare Tapa Whā (Durie, 1984), Te Pae Māhutonga (Durie, 1998), and the Meihana Model (Rochford, 2004) — and articulates why a nine-dimension framework is warranted by the complexity of the presenting experiences the series addresses. Second, it defends the use of composite narrative methodology — the figure of Mere as a practitioner-facing pedagogical device — as a legitimate and culturally coherent approach to knowledge generation, grounded in kaupapa Māori epistemology and narrative inquiry traditions. Third, it formally names the Whakapapa of a Wound as a conceptual framework in its own right: distinguishing it from the Adverse Childhood Experiences (ACEs) model, from deficit-framed approaches to Māori wellbeing, and from purely clinical trauma frameworks — and locating it within a kaupapa Māori understanding of healing as whakapapa-tracing rather than symptom management.

Keywords: *Te Poutama o te Ora, Māori wellness frameworks, kaupapa Māori, composite narrative methodology, whakapapa of a wound, intergenerational trauma, epigenetics, conceptual framework*

Introduction: Why This Article Exists

Every series needs a ground to stand on. The four articles that follow this one carry substantial empirical weight — drawing on epigenetic science, developmental

neuroscience, attachment research, and the Aotearoa evidence base on Tamariki Māori in care. But evidence, however robust, does not interpret itself. The decisions that determine how evidence is gathered, whose experience is centred, what conceptual vocabulary is used to name the patterns that emerge, and what healing is understood to require — these are not methodological footnotes. They are the epistemological architecture of the work itself.

This article makes that architecture visible. It answers three questions that any reader engaging seriously with the series deserves to have answered directly. First: where does Te Poutama o te Ora sit in relation to the frameworks that preceded it, and what is the case for nine dimensions when four or six have served Māori wellness discourse well for decades? Second: why is a composite narrative figure — Mere, a wāhine Māori in her forties — used as the primary vehicle for a series that claims academic rigour, and what is the methodological justification for that choice? Third: what precisely is meant by the Whakapapa of a Wound as a conceptual framework — what does it claim, what does it distinguish itself from, and why does naming it matter?

These are not rhetorical questions. They have substantive answers, and those answers change how the series should be read and used.

Te Poutama o te Ora Within the Māori Wellness Framework Landscape

The frameworks that preceded it

Māori wellness frameworks emerged in response to a clinical and policy landscape that had, for most of its history in Aotearoa, treated Māori health through a biomedical or individually-deficit lens — one that consistently produced poor outcomes, eroded cultural identity, and failed to account for the structural and historical determinants of Māori wellbeing (Walker, 1990). The frameworks developed from the 1980s onward were, in this sense, acts of intellectual and cultural resistance as much as they were clinical innovations.

Tā Mason Durie's Te Whare Tapa Whā (1984) established the foundational principle: wellbeing is holistic and cannot be adequately understood or addressed through any

single dimension. The metaphor of the wharenui — four walls, each necessary for structural integrity — provided Māori and mainstream health practitioners with a framework that was both culturally grounded and clinically accessible. Te Taha Tinana, Te Taha Hinengaro, Te Taha Wairua, and Te Taha Whānau together offered a four-dimensional account of health that explicitly named dimensions the biomedical model had consistently ignored.

Te Pae Māhutonga (Durie, 1998) extended this thinking into the community domain. Organised around the metaphor of the Southern Cross constellation, the framework addressed the conditions for community wellness — leadership (ngā manukura), autonomy, cultural identity, social participation, and the interface with the wider environment. Te Pae Māhutonga is primarily oriented toward collective and community-level analysis rather than the individual and whānau journey, and it introduced the concept of Māori autonomy and self-determination as a health variable — a significant epistemological contribution that remains relevant.

The Meihana Model (Rochford, 2004) represented a significant development in the clinical integration of Māori wellness concepts. Drawing on Te Whare Tapa Whā and extending it to eight dimensions — including taura here (connection to significant others), wairua, tinana, hinengaro, ngākau (emotional self), and environmental and spiritual dimensions — the Meihana Model was developed specifically for clinical assessment contexts, enabling practitioners to map presenting concerns across cultural and biomedical domains simultaneously. Its clinical utility has been documented particularly within mental health settings.

Each of these frameworks represents a genuine contribution to the understanding of Māori wellbeing. Te Poutama o te Ora does not position itself in opposition to any of them. It is grounded in the tradition they established — holistic, culturally centred, resistant to deficit framing — and it acknowledges a direct intellectual whakapapa to Te Whare Tapa Whā in particular.

What TPO adds: the case for nine dimensions

The question of why nine dimensions requires a direct answer. Frameworks are not improved simply by adding dimensions, and complexity is not inherently a virtue. The

argument for TPO's nine-dimension structure rests on the specific nature of the presenting experiences it was developed to address.

Te Poutama o te Ora emerged not from a theoretical exercise but from lived and resolved experience — specifically, from what the author describes as Matapihi Kirihou: the plastic window backstory that forms the origin narrative of the framework (I'Anson, 2025). It was developed by and for people whose experiences of disconnection, wounding, and recovery had revealed specific gaps in existing frameworks — gaps that became visible precisely because existing frameworks, excellent as they are, were not designed with the full complexity of intergenerational trauma, economic precarity, digital-world navigation, and the specific forms of cultural exile experienced by urban Māori in corporate environments in mind.

The four dimensions that most clearly distinguish TPO from its predecessors are Taha Matihiko (digital and informational wellness), Taha Pūtea (financial wellness) and Taha Kai (gut and food wellness), Taha Auaha (creative wellness).

The inclusion of Taha Matihiko acknowledges a contemporary reality: the digital world is not merely a communication tool. For many people — particularly those navigating recovery, isolation, reconnection with whakapapa, or the demands of modern employment — it is the primary environment through which identity is performed, relationships are maintained, information is accessed, and vulnerability is both expressed and exploited. A wellness framework that does not account for this dimension is incomplete for the people TPO was built to serve.

The inclusion of Taha Pūtea is a direct acknowledgement that poverty is not a background variable in Māori wellbeing — it is a primary determinant, inseparable from the colonial history that produced it, and one whose effects on nervous system regulation, relational capacity, identity, and spiritual wellbeing are direct and well-documented (Walker, 1990; Reid & Robson, 2007). A wellness framework that treats financial reality as external to its scope leaves a significant portion of the presenting wound unaddressed.

The inclusion of Taha Kai carries the same logic: the body is not a container for wellness — it is the site where colonisation landed first and most literally. When land was taken, food sovereignty went with it. What Māori ate, how they ate, and the

relational and spiritual meanings embedded in that eating were systematically dismantled. A wellness framework that treats nutrition as lifestyle advice, rather than as a dimension shaped by intergenerational food trauma, gut-identity disruption, and ongoing economic marginalisation, addresses the symptom while leaving the wound intact. Taha Kai names the Puku-Tuakiri connection as foundational — that what we consume shapes who we become — and in doing so, brings the body's most basic function back into the healing conversation where it belongs.

Taha Auaha – creativity is not a hobby — it is one of the primary languages through which identity forms, heals, and transmits itself across generations. When colonisation silenced te Reo, and severed Māori from the artistic and expressive traditions that had held their world together, it did not simply remove cultural activities — it removed the mechanisms by which a people make meaning, grieve, resist, and know themselves. TPO treats creativity as enrichment or self-care, rather than as a dimension shaped by generations of enforced silence, stolen expression, and the ongoing muting of indigenous voice, addresses the surface while leaving the deeper wound untouched. Taha Auaha names the Auaha-Tuakiri connection as foundational — that to create is to become, and to have one's creative expression suppressed is to have one's very self-interrupted — and in doing so, restores what colonisation most strategically removed: the right to tell your own story, in your forms, on your terms.

Taha Tuakiri — identity wellness — is placed at the centre of the nine-dimension structure rather than as one dimension among equals. This is a deliberate architectural choice. The series that follows this paper consistently demonstrates that without the recovery of a grounded, whakapapa-rooted sense of identity, the work in every other dimension will be partial. The nervous system cannot regulate without a self to regulate from. The relational world cannot be healed without a self that knows it has the right to receive, as well as to give. The spiritual dimension cannot be inhabited without a self that understands its own whakapapa of worth.

Framework	Dimensions	Core Emphasis	Relationship to TPO
Te Whare Tapa Whā (Durie, 1984)	4	Holistic health across four	Foundational. TPO extends the holistic principle into nine dimensions with explicit

Framework	Dimensions	Core Emphasis	Relationship to TPO
		dimensions of the wharenui	whakapapa and digital dimensions
Te Pae Māhutonga (Durie, 1998)	6	Community wellness and Māori autonomy; ngā manukura (leadership) as driver	Community-level framing; TPO addresses the individual and whānau journey with greater developmental specificity
Meihana Model (Rochford, 2004)	8	Clinical assessment integrating Māori worldview with biomedical dimensions	Assessment focus; TPO is a transformation framework — from wound to stairway — not primarily an assessment tool
Te Poutama o te Ora (I'Anson, 2025)	9	Nine-dimension wellness journey grounded in lived and resolved experience; whakapapa of distress as entry point	Synthesises and extends prior frameworks; adds taha matihiko, taha pūtea, taha kai and explicit intergenerational/epigenetic lens

Table 1. Comparison of major Māori wellness frameworks. TPO = Te Poutama o te Ora.

Kaupapa Māori as Epistemological Foundation

The series is grounded in kaupapa Māori — a term that refers not merely to Māori subject matter, but to a set of epistemological commitments about whose knowledge counts, how knowledge is generated, who it serves, and what it is for. Smith's (1999) foundational text articulates the decolonising project of kaupapa Māori research: the refusal to treat Māori people, culture, and experience as objects of inquiry for the benefit of non-Māori knowledge systems, and the insistence that Māori knowledge frameworks have their own internal validity that does not require Western academic validation to be considered rigorous.

For this series, the kaupapa Māori grounding has several specific implications. First, the whakapapa of the framework matters. Te Poutama o te Ora did not emerge from

a research institution, a policy mandate, or a funding cycle. It emerged from an eleven-year cave season; a site of praxis; mauri oho — a period of deep personal reckoning following redundancy, during which the author processed and resolved experiences of cultural exile, economic precarity, accumulated grief, and inherited wounding. That origin does not make it less rigorous. In the kaupapa Māori tradition, knowledge that arises from lived and resolved experience carries its own form of authority — one that is in many ways more appropriate to the healing context than knowledge abstracted from a researcher's distance (Bishop, 1996; Pihama, 2001).

Second, kaupapa Māori requires that the knowledge generated serves the people it is about. The series has been written in two registers — academic and blog — precisely because the knowledge being offered belongs to the communities who are described in it, and those communities should not require academic credentials to access it. The blog versions do not simplify the academic versions; they translate the same knowledge into the language appropriate to its most important audience. This is not a concession. It is a methodological commitment.

Third, kaupapa Māori holds that the researcher is not separate from the researched. The author of this series is not a disinterested observer of the phenomena described. She carries whakapapa through both Ngāti Porou rāua ko Ngāti Whakatere and through lineages of healing work across four generations. The knowledge in this series is not knowledge about Māori experience from the outside. It is knowledge from within — shaped by the author's own whakapapa, her own wound, and the resolution of that wound that produced the framework. Reid and Robson (2007) argue that this positionality is not a limitation to be managed but a resource to be named. This article names it.

Composite Narrative as Methodology: The Figure of Mere

The tradition of narrative inquiry

Narrative inquiry — the use of story as a primary vehicle for knowledge generation and transmission — has a long and legitimate standing in qualitative research. Clandinin and Connelly (2000) describe narrative inquiry as the study of experience as story, in which the researcher and participant together construct meaning through narrative that neither could access through abstract analysis alone. Narratives are

not merely data containers; they are epistemological forms that carry relational, temporal, and embodied knowledge in ways that propositional language cannot replicate.

In the Māori tradition, this understanding is not a recent methodological innovation. It is the epistemological inheritance of a culture in which whakapapa, waiata, kōrero, and the sustained oral tradition have always been the primary vehicles for the transmission of knowledge about who we are, what happened to us, and what it takes to heal. The story of Mere is, in this sense, not a departure from academic convention. It is a return to the form of knowledge transmission that Māori have always known to be most effective for the kind of knowledge this series carries.

Composite case methodology

The specific methodological device used in this series is the composite narrative — a figure constructed from the convergent patterns of multiple real experiences, presented as a single coherent story for pedagogical and analytical purposes. This is not a fictional device. It is a synthesis of real patterns rendered accessible through the narrative arc of a single figure.

Josselson (2013) describes the ethical and analytical justification for composite figures in qualitative research: they protect the privacy of identifiable individuals while preserving the integrity of the patterns their experiences reveal. They enable the researcher to foreground the structural and relational dynamics at work without reducing those dynamics to the particularities of any single person's history. Composite cases are widely used in clinical training, in medical education, and in trauma-informed practice contexts — precisely because the patterns they illuminate are pedagogically more accessible than the raw complexity of individual histories.

Mere is constructed from the convergent experiences of wāhine Māori — and wāhine of other backgrounds who recognise themselves in the pattern — whom the author has encountered across years of crisis counselling, community work, and the development of Te Poutama o te Ora. She is not any one person. She is the distillation of a recognisable whakapapa of experience: differential regard in childhood; parentification; the epigenetic patterning of chronic stress; the relational

template that replicate the original wound in adult partnerships; and the transmission of that wound to a new generation.

The test of a composite figure is not whether she is real in the biographical sense, but whether she is true — whether the patterns her story reveals are accurately drawn from the evidence and from the lived experience of the community she represents. Mere meets this test. Practitioners who work with women in these circumstances will recognise her immediately. That recognition is itself a form of validity.

Why a wāhine Māori

The choice to centre a wāhine Māori in this series is not incidental. The series addresses phenomena — differential regard, parentification, epigenetic transmission of stress, intergenerational care involvement — that disproportionately affect Māori women and their whānau in Aotearoa. To abstract those phenomena from the cultural and historical context in which they occur at the highest rates would be to do what clinical literature has too frequently done: generalise from a norm that is not universal and treat cultural specificity as a complicating variable rather than as the context within which the wound must be understood.

Colonisation, the deliberate suppression of te Reo Māori and tikanga, the disruption of whānau structures through urbanisation and economic marginalisation, and the specific form of over-responsibility that falls on Māori women in underfunded communities — these are not peripheral to the wound the series describes. They are its structural conditions. Centring Mere as a wāhine Māori ensures that those conditions remain visible throughout.

The Whakapapa of a Wound: Naming a Conceptual Framework

What it is not

The Whakapapa of a Wound is not the ACEs framework, though it draws on ACEs research extensively. The ACEs model (Felitti et al., 1998) is a powerful epidemiological tool that demonstrated the dose-response relationship between adverse childhood experiences and adult health outcomes. Its contribution to shifting

clinical and policy discourse from 'what is wrong with you' toward 'what happened to you' has been significant and lasting.

However, the ACEs framework has limitations that are relevant here. It operates primarily as an inventory — a count of adverse experiences that predicts aggregate risk. It does not, by design, account for the cultural dimensions of adversity, the intergenerational transmission mechanisms beyond direct child experience, the differential impact of colonial history on specific communities, or the healing pathways available within those communities. It is a Western epidemiological instrument applied to populations whose experience of adversity cannot be fully captured by its categories (Brave Heart et al., 2011). The Whakapapa of a Wound extends beyond the ACEs framework by insisting that the wound be understood in its full cultural, ancestral, and epigenetic depth — not merely as a count of adverse events, but as a lineage that can be traced, and that can, with the right conditions, be given a different ending.

The Whakapapa of a Wound is also not a deficit framework. Deficit framing — the habit of explaining Māori health outcomes primarily through the lens of Māori disadvantage, dysfunction, or incapacity — has been one of the most persistent and damaging features of mainstream Māori health research and policy (Smith, 1999; Reid & Robson, 2007). It locates the problem in the individual or the community rather than in the history that produced the conditions they are navigating. The Whakapapa of a Wound framework refuses this location. It consistently traces the presenting wound back to its structural and historical origins — and it insists that what looks like individual failure, when examined through the full length of its whakapapa, reveals itself as a predictable and understandable response to conditions not of the individual's choosing.

Finally, the Whakapapa of a Wound is not a purely clinical framework. Clinical trauma frameworks — including Herman's (1992) Complex PTSD model, Van der Kolk's (2014) body-based approaches, and the Neurosequential Model of Therapeutics — are drawn upon in the series as evidence for the biological and psychological mechanisms through which the wound operates. But the Whakapapa of a Wound framework encompasses more than clinical intervention. It encompasses cultural reconnection, identity recovery, epigenetic healing through sustained

relational safety, community-level change, and the spiritual reckoning that is, for many Māori, the most fundamental dimension of what healing requires.

What it is

The Whakapapa of a Wound is a conceptual framework for tracing the lineage of presenting distress — in individuals, in whānau, and in communities — back to its origins, and forward to the conditions required for its transformation. It holds three epistemological commitments simultaneously.

First: a wound that has a whakapapa is not a verdict. It is a history. The individual presenting with the symptoms of that wound — anxiety, relational dysfunction, substance use, suicidality, difficulty sustaining employment or safe housing — is not broken. They are carrying something that was given to them before they had the capacity to refuse it, in conditions shaped by forces much larger than any individual choice. This reframe is not therapeutic sentiment. It is the accurate account of what the epigenetic, developmental, and intergenerational research consistently demonstrates (Yehuda & Lehrner, 2018; Weaver et al., 2004; Shonkoff et al., 2012).

Second: what has a whakapapa can have a different ending. The whakapapa metaphor is not only a tool for tracing origins. It is a tool for understanding possibility. Māori understand whakapapa as a living reality — not a fixed record but a dynamic lineage that is continuously shaped by the choices, the healing, and the transmission of the living. What the body learned can, under the right conditions, be unlearned. What was transmitted can, with sufficient healing, be transformed before it travels further. The series is built on this conviction — not as optimism, but as the evidence-based conclusion of epigenetic research on the reversibility of stress-induced gene expression changes (McEwen, 2007).

Third: the healing of the wound requires attention to its full whakapapa — not only its psychological dimension, its biological dimension, its cultural or spiritual or relational dimension. The wound does not live in one dimension. It lives across all of them. A framework that addresses fewer than the full complexity of its expression will leave the wound somewhere to retreat to. Te Poutama o te Ora's nine-dimension structure is the operational expression of this commitment.

Why naming the framework matters

Academic frameworks perform a specific function that clinical language and community knowledge, on their own, cannot. They provide a shared, citable vocabulary that enables practitioners, researchers, educators, and policymakers to refer to a defined set of concepts, argue from common epistemological ground, and build cumulative knowledge across contexts and time.

Naming the Whakapapa of a Wound as a conceptual framework — distinct from but in relationship with TPO, from ACEs, and from clinical trauma models — creates that vocabulary. It enables a counsellor in a community health service, a kaupapa Māori researcher in a university, a social worker within the Oranga Tamariki system, and a pastor in a Māori community all to be working from the same epistemological ground when they use this series. It enables the patterns the series describes to be recognised, named, and responded to consistently across those different contexts.

Naming also performs an act of intellectual sovereignty. The knowledge in this series has a specific origin: four generations of healing work; an eleven-year cave season; the development of a framework from lived experience. That knowledge deserves the same standing as knowledge generated through institutional research programmes — not because the institutional form of research is without value, but because the lived form of knowledge has its own rigour, its own validity, and its own claim to be named and cited.

The Architecture of the Series

The four articles that follow this framework paper are designed to be read in sequence, though each stands independently. Together, they trace a single wound through four temporal and analytical dimensions — formation, biology, relational expression, and intergenerational transmission — in a structure that mirrors the whakapapa it is describing.

Part One — The Whakapapa of Not Being Good Enough: Anxiety as a Deep-Rooted Weed — examines anxiety not as a disorder to be managed but as a surface manifestation of an underground root system: the belief of chronic inadequacy planted before the child had words to name it. Drawing on the weed metaphor as both a clinical and culturally grounded reframing, it traces the whakapapa of the “not good enough” wound through early relational experience, colonial imposition of

inadequacy, and the internalisation of systemic harm as personal failure. It introduces dimensional autophagy and the Maramataka as the central TPO mechanisms through which the root of anxiety is identified, uprooted, and replaced with a truth that is wairua-deep. The goal is not symptom reduction but a flourishing self that has always been enough.

Part Two — When Love Became a Debt — addresses the epigenetic and psychological consequences of early relational insufficiency, the clinical phenomenon of parentification, and the ACEs dose-response relationship. It is the biological and psychological foundation of the series.

Part Three — I Keep Choosing the Same Person with a Different Face — examines the neuroscience of trauma bonding, the formation and persistence of relational templates, and the way debt-based love from childhood shapes partner selection and relational dynamics in adulthood. It addresses the question that many practitioners encounter most frequently: why does this person keep choosing the same relationship?

Part Four — Why Am I Not With My Mum and Dad? — turns toward the children. It addresses the over-representation of tamariki Māori in Aotearoa's care and protection system through the lens of intergenerational epigenetic transmission, developmental vulnerability across specific neurological windows, and the Oranga Tamariki paradox: a system that intervenes to protect tamariki from a parent's wound but rarely has the resources to heal the wound itself.

Each article concludes with a section applying Te Poutama o te Ora as a healing framework — not as a generic recommendation, but as a specific map of the dimensions within which the wound of that article lives, and the work required to address it.

Implications for Practice, Education, and Research

For practitioners — counsellors, clinical supervisors, community health workers, social workers, crisis counsellors — the primary implication of this series is a reorientation of the entry question. The question is not 'what is wrong with this person?' It is 'what is the whakapapa of this wound — and what does that whakapapa tell us about what healing will require?'

That question changes the assessment process. It changes the treatment planning. It changes the language used with clients. And it changes what is considered an adequate response: not symptom management, but the sustained, multi-dimensional, culturally grounded journey that TPO describes.

For educators — in counselling training programmes, social work education, and kaupapa Māori contexts — the composite figure of Mere provides a teaching tool of specific value. She makes visible the full whakapapa of a presenting pattern that students might otherwise encounter only in fragments: the anxiety, the substance use, the relational dysfunction, the parenting difficulties — each typically addressed in a separate module, as if they were unrelated. Mere makes the connections visible. She demonstrates why siloed responses produce siloed results.

For researchers, the series models a form of knowledge generation — kaupapa Māori grounded, composite narrative methodology, practitioner-facing academic rigour — that is itself a contribution to the methodological literature on Māori wellness research. It demonstrates that frameworks emerging from lived experience can be held to academic standards without losing the voice, the cultural groundedness, or the practical orientation that makes them useful to the communities they serve.

Conclusion

This article has done three things. It has situated Te Poutama o te Ora within the landscape of Māori wellness frameworks and made the case for its nine-dimension structure as a response to the specific complexity of the experiences the series addresses. It has defended the composite narrative methodology — the figure of Mere — as a kaupapa Māori-grounded, evidence-consistent, and pedagogically rigorous approach to knowledge generation and transmission. And it has formally named the Whakapapa of a Wound as a conceptual framework: distinguishing it from ACEs, from deficit framing, and from purely clinical models; and articulating its three core epistemological commitments.

The series that follows rests on this ground. It is not a ground that was constructed for the purpose of academic credibility. It is a ground that was built, over many years and through many difficult seasons, from the lived experience of healing — of sitting

with people whose wounds had whakapapa, of tracing that whakapapa back far enough to understand them, and of finding, in that understanding, the conditions for something genuinely different to grow.

> *"What has a whakapapa — a lineage, an origin, a pattern — can also have a different ending. That is not optimism. It is the conclusion of the evidence, and the conviction of the healer who has walked the path."*

Nōu reira, tēnā koutou, tēnā koutou, tēnā koutou katoa.

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