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Towards a bicultural psychotherapy: Decolonising psychotherapy in hospice care

Hayden Mark Isaac

Auckland University of Technology, Aotearoa New Zealand

Correspondence
Hayden M. Isaac, School of Public Health and Psychosocial Health, Faculty of Health and Environmental Sciences, Auckland University of Technology, Private Bag 92006, Auckland 1142, Aotearoa New Zealand.
Email: hayden.isaac@gmail.com

Abstract

Discrepancies between hospice service usage and cancer rates in Māori, the indigenous peoples of Aotearoa New Zealand, raise several questions. There have been numerous studies into these discrepancies highlighting issues regarding the appropriateness of care in hospice services in Aotearoa for Māori. This paper explores these issues, accentuating some gaps in the literature—such as intergenerational trauma—as well as ways that Pākehā psychotherapists (New Zealander psychotherapists of European descent) can biculturally engage with Māori. The author encourages psychotherapists to become allies by embracing a Māori-centred approach to psychotherapy that brings both groups together as partners, while working through numerous post-colonial issues.

KEYWORDS

Aotearoa New Zealand, biculturalism, decolonisation, hospice, intergenerational trauma, Māori, psychotherapy

Glossary of Māori terms and phrases used in the article: *hapū*, primary kinship group; *hauora*, health or wellbeing; *iwi*, extended kinship grouping from a common ancestor; *kaitiakitanga*, guardianship; *kaupapa*, principle or policy; *kāwanatanga*, governance; *kete*, basket; *kōrero*, a discussion, conversation, or discourse; *kotahitanga*, building a sense of unity or collective action; *mana*, power, authority, the "spiritual" power in a person; *manaakitanga*, the spiritual expression of mana through hospitality and care; ōritetanga, equality; Pākehā, New Zealanders of European descent; *pōwhiri*, a Māori welcoming ceremony; *rangatiratanga*, sovereignty and agency; *ritenga*, customs; Te Ao Māori, the Māori world; Te reo Māori, the Māori language; *te tatau o te pō*, the door of the night or the entrance to the place of departed spirits; Te Tiriti o Waitangi/Te Tiriti, Te reo Māori version of The Treaty of Waitangi; *te whare tapa whā*, a Māori model of health; *tikanga*, practices; *tino rangatiratanga*, sovereignty; *wairuatanga*, the two streams, the known and unknown, the spiritual world; *whakapapa*, genealogy or lineage; *whānau*, family; *whānau ora*, a Māori health initiative driven by Māori values; *whanaungatanga*, a process of building and strengthening a sense of belonging, connection, relationship, relating well to others; *whare*, house or dwelling

1 | INTRODUCTION

Sitting in my therapy room in the hospice I practise at, smelling relaxing aromas drifting down the hallway, I reflected on my learnings of Māori health (the health of the indigenous peoples of Aotearoa) in my Master of Psychotherapy programme at Auckland University of Technology, Auckland, Aotearoa. At that time it struck me that my only patient of Māori descent had cancelled all their appointments with me, and I had been struggling to reconnect with them. Considering this, I dived into the literature, searching for a clearing of thought. In doing so, I began to encounter a range of research showing an increasing discrepancy in the rates of diseases—cancer, diabetes, etc.—between indigenous and non-indigenous peoples across the globe. As I explored this further, it seemed to reflect the situation in Aotearoa, where there is a significantly higher cancer diagnostic and mortality rate in patients of Māori descent than in non-Māori. For example, Cormack, Robson, Purdie, Ratima, and Brown's (2005) report showed that people in Aotearoa of Māori descent were 18% more likely to be diagnosed with cancer than non-Māori, and that this gap was increasing.

In this paper, I will explore ways Pākehā psychotherapists (New Zealander psychotherapists of European descent) can begin to address these issues in their practice, while calling for psychotherapists to act collectively as allies to advocate for larger structural and political changes. To do this, I will weave together a *kete* (basket) to hold this *kōrero* (conversation) using Te Tiriti o Waitangi (the Māori-language version of the Treaty of Waitangi) and *hauora*, Māori health and wellbeing models, with a Māori-centred framework. I will then explore the hospice setting in Aotearoa and the social realities of cancer for Māori, highlighting cancer as a health priority and discussing the appropriateness of cancer services. After this, I will explore psychotherapeutic engagement with people of Māori descent as a bicultural entanglement, highlighting some of the key aspects Pākehā psychotherapists need to be mindful of in bicultural therapeutic engagements. To conclude, I will weave in Margaret Morice's (2003) conceptualisations of Māori concepts in a therapeutic setting, creating a stepping stone for Pākehā psychotherapists to move towards the Māori world, before underlining the problematic nature of identity politics in bicultural engagements.

2 | TE KETE

In getting to the heart of this paper, I need to weave a *kete* that can hold this *kōrero* and can inform psychotherapeutic containers in bicultural engagements. Yet, the weaving process requires me to grab hold of, and leave out, numerous strands. Thus, the mere act of weaving puts me—a 32-year-old Pākehā, male, student psychotherapist from Feilding, Aotearoa—into a place of privilege, engendering an uncomfortable situation where my perception is to the fore. So, in this section, I am trying to weave a *kete* that captures the spirit of Te Tiriti and can be reworked with each encounter with a patient who identifies as Māori, as well as with each *iwi* (tribe) and *hapū* (subtribe) that is engaged with, to form an evolving bicultural *kōrero*. To do this, I will draw from four strands: Te Tiriti o Waitangi, Whānau Ora (Chant, 2011), Te Whare Tapa Whā (Durie, 1985), and kaupapa Māori. My hope is that this will inform psychotherapists, helping them create culturally safe psychotherapeutic containers for bicultural psychotherapeutic engagements and that this will allow Pākehā psychotherapists to become allies, advocating as a community for the structural changes that are needed to make services more appropriate for Māori.

2.1 | Te Tiriti o Waitangi

Te Tiriti o Waitangi is the founding document of Aotearoa, which originally aimed to bring Māori and Pākehā together into a bicultural relationship. There has been, however, controversy surrounding this document, as the original te reo Māori (Māori language) and English versions construe the conceptualisation of governance of/for Māori differently (Crocket, 2013). However, Healy, Huygens, and Murphy (2012) argued that the te reo Māori version, Te Tiriti, has more standing in international law as the contra proferentem rule establishes that any clausal ambiguity in treaties and contracts should be interpreted to the disadvantage of the party that proposed the clause; Te Tiriti is closer to the initial instructions that were given to the group of people who wrote it; and finally, the representative of the British Monarch, Lieutenant Governor William Hobson, signed the te reo Māori version before sending it off to England for the Queen's signature. Thus, this paper will draw from Te Tiriti instead of the English translation.

Te Tiriti contains one preamble, three articles, and one oral clause. The preamble discusses the intent to establish a relationship between Māori and the British Crown. The first article names *kāwanatanga* (governance), as well as structures and systems that facilitate Māori decision making. The second article affirms Māori *tino rangatiratanga* (sovereignty), which in this context upholds Māori leadership, participation, and autonomy. The third article discusses *ōritetanga* (equality), affirming the right of Māori to have the same privileges as British citizens. *Ōritetanga* has been more recently expanded to include the legal responsibility for governmental institutions to make efforts to reach health and social equality by reducing systemic inequities in health and health outcomes, as well as health service use and access. The oral clause *tikanga* (practices)—also referred to as *ritenga* (customs) or *wairuatanga* (spirituality)—guarantees Māori the right to engage in and practice their own *tikanga* and spiritual beliefs (Healy et al., 2012).

2.2 | Whānau Ora

Whānau Ora is a Māori-led government-funded attempt to embody hauora Māori initiatives in the health sector in Aotearoa. Whānau Ora steps away from more individualistic models of health care, and toward ways to support each patient through their *whānau* (extended family) as a community of health professionals. In doing so, it aims to increase the wellbeing of both Te Ao Māori (the Māori world) and the peoples of Aotearoa as a whole (Chant, 2011).

2.3 | Te Whare Tapa Whā

Durie's (1985) hauora Māori model, Te Whare Tapa Whā, described a person's sense of wellbeing as having four components comparable with the four walls of a *whare* (house)—*taha tinana* (physical health), *taha wairua* (spiritual health), *taha whānau* (family health), and *taha hinengaro* (mental health). Te Whare Tapa Whā is currently built into Hospice New Zealand's (2012) standards of care and seems to fit easily because this model is similar to the holistic understandings of health that underpin many of Hospice's core values.

2.4 | Kaupapa Māori

Cram, McCreanor, Smith, Nairn, and Johnstone (2006) noted that a kaupapa Māori framework includes a number of different Māori principles and concepts, such as te reo Māori (the Māori language), *aroha ki te tangata* (the love of the people and allowing people to meet on their own terms), *manaaki ki te tangata* (sharing and being a generous host), *kia tupato* (being culturally safe and cautious), *kaua e takahia te mana o te tangata* (not trampling on the *mana* (authority) of others), *kia mahaki* (being humble), *whakapapa* (genealogy), *whānau* (extended family), and *tikanga* (practices).

2.5 | The Weave

In binding these strands together, a *kete* is created to hold the bicultural space between Pākehā psychotherapists and Māori. Te Tiriti outlines the importance of partnership, highlighting the need to work with patients as partners when engaging with them. It suggests that therapeutic engagements need to be living and breathing, adapting to whoever walks into the room, creating the therapeutic engagement together, while mindfully navigating possible power disparities in bicultural dyads through principles like *tino rangatiratanga* and *ōritetanga*. Te Whare Tapa Whā and Whānau Ora provide a starting point to holistically weave a bicultural psychotherapeutic approach, while helping therapists see the larger context in which each patient is embedded. Furthermore, kaupapa Māori brings core understandings around love, respect, and *whakapapa* into the weave, creating a *kete* that wholeheartedly embraces Māori. In all, this weave aims to dethrone me, as the author of this paper, and other psychotherapists from being experts and turn us into fellow journeyers, walking with our patients for a time while providing the appropriate support and care our Māori patients need on their journey with cancer.

3 | CANCER AS A MĀORI HEALTH PRIORITY

Now that I have woven together a *kete*, I will venture into cancer as a *hauora* priority. To do this, we need to explore the *whakapapa* of hospice services in Aotearoa, and how this health priority and hospice in Aotearoa came to be.

3.1 | Weaving the Histories of Colonialism and Hospice Together

The diversity of histories in Aotearoa is highlighted through the myriad of engagements between various settlers and the different Māori *iwi* and *hapū*, who all have their own ways of being. Thus, when colonial forces came to Aotearoa, there was a diverse array of experiences between the groups, depending on who were interacting, and the intent and actions of each party—such as missionaries, explorers, traders, etc. (Rochford, 2004). Whatever their intentions, the newcomers also introduced diseases, alcohol, and muskets to Māori, causing harm amongst te ao Māori. In part, this harm motivated Māori leaders to gather in 1835 to construct a Declaration of Independence, creating an independent Māori state. Then, in 1840, Māori leaders and the British Crown met to sign Te Tiriti o Waitangi, to form a way for them to work together, creating the foundations of colonial state New Zealand (Crocket, 2013).

The signing of Te Tiriti ensured a short period of cooperation and stability, before tensions rose. It became apparent that there were different understandings of Te Tiriti, engendering the New Zealand land wars, where various *iwi* and the New Zealand Crown battled for sovereignty and land. As Māori and the New Zealand Crown fought, new immigrants arrived, continuing to clamour for land and bringing further sickness with them, causing the Māori population to rapidly decline (Rochford, 2004). In the mid-1800s a group of Māori women heard about the Sisters of Mercy in Ireland, who were working with the sick and the poor from any creed, race, or culture. These Māori women wrote to the Sisters of Mercy, inviting them to come to Aotearoa to help Māori deal with the health needs they were confronted with. With this invitation, the Sisters came to Aotearoa on April 9, 1850 to set up a hospital in Epsom, Auckland (Mercy Hospice Auckland, 2017).

Despite these attempts by Māori to address their growing health concerns, conditions continued to deteriorate. In 1877, colonial courts ruled that Te Tiriti was void and began to confiscate Māori land, forcing Māori to immigrate into urban settings, while te reo Māori and some Māori ways of being, including *hauora* (health) practices were criminalised (Crocket, 2013). This created what some have described as a cultural genocide (Pihama et al., 2014). It created a diverse myriad of realities, where many people of Māori descent became isolated and alienated from both Māori and Pākehā worlds through the traumatic and brutal stripping away of Māori ways of being. As a result, there was a huge loss of culture, language, and wellbeing, sending many Māori into poverty. In the 1970s, however, Te Tiriti o Waitangi was reinstituted, shifting Aotearoa's bicultural landscape into a period of reconciliation (Crocket, 2013). While the collapse and restoration of Te Tiriti was occurring, the beginnings of Mercy Hospice were established in 1952, which became a part of Mercy Hospital in 1979 and moved to its current site in Collage Hill, Ponsonby, Auckland, in 2007 (Mercy Hospice Auckland, 2017). This coincided with the creation of other hospice institutions from a large range of religious and secular world views—such as Mary Potter Hospice (2017) and Amitabha Hospice Trust (n.d.)—which opened their doors in the 1970s and 1980s.

3.2 | The suitability of hospice services for Māori

Despite the invitation to the Sisters of Mercy and the reinstitution of Te Tiriti, the process of colonialisation has led to huge discrepancies between the incidence and mortality rates of cancer in Māori compared to non-Māori. Numerous reports show that the rates of cancer among Māori are approximately 18% higher than among non-Māori and the mortality rate is around 50–78% higher. This is in contrast to the percentage of Māori who access cancer services, uncovering a disparity between the number of Māori diagnosed with cancer as against those who access treatment (Ministry of Health, 2015; Robson, Purdie, & Cormack, 2006; Soeberg et al., 2012).

Since the 1990s, there has been a wealth of research into this disparity, outlaying many of the possible issues around cultural appropriateness of hospices for Māori suffering with cancer. Most of these reports show that many modern-day hospices target middle-class Pākehā and fail to culturally mirror and hold those who fall outside of this group. Hill, Sarfati, Robson, and Blakely (2013) suggested that hospices often fail to provide culturally safe and appropriate places for Māori, causing accruing detriments that deter Māori from accessing hospice services. Cormack et al. (2005) and the Ministry of Health's (2001) New Zealand Palliative Care Strategy suggested that some failures stem from issues like institutional racism, Māori not feeling culturally mirrored, public perception, transport, cost, communication, opening hours, and a lack of coordination between Māori and non-Māori service providers. Slater et al. (2015) similarly stated that a large portion of hospices have not been responsive to Māori needs. They said that many hospices have created environments that favour individualistic decision making and communication through a proliferation of pamphlets, with little emphasis on relationships with local *iwi* and *hapū*, local *rongoā* (medicine) healers, as well as little inclusion of traditional Māori healing practices like *mirimiri* (Māori massage).

While these reports speak to many of the different reasons for the discrepancy in service usage amongst Māori, they miss out on one of the key elements of kaupapa Māori, *whakapapa*. These reports appear to miss some of the issues surrounding the transmission of trauma through the generations from colonisation, also known as intergenerational trauma.

Intergenerational trauma is a complex phenomenon that has increasingly become of interest to researchers. Researchers have shown that past traumatic events—like colonialism, genocide, and war—are transmitted down through the generations, impacting both the physical and mental health of their children. Shabad (1993) showed that historical trauma impacts the future generation's ability to handle crises and suggested that it increases the likelihood of mental illnesses like anxiety and depression. Baider et al. (2000) submitted that the transmission of trauma impacts the ability of descendants of Holocaust survivors to deal with cancer. They found that second-generation Holocaust survivors were more likely to fatalistically accept their condition and avoid services that could potentially treat and/or prevent their cancer in order to ensure that their culture and people survive. While this survival mechanism is highly adaptive and would have shielded their communities from structurally racist institutions, they said that it now has wider implications in regard to seeking treatment, support, and early diagnosis, as well as increasing the likelihood of emotional and psychic distress in people and their families when facing cancer.

While Shabad (1993) and Baider et al. (2000) did not focus on the impact that intergenerational trauma has on the relationship Māori have with hospice and cancer services, Pihama et al. (2014) and Durie (2001) showed that similar phenomena occur in a more generalised perspective amongst Māori through parent–infant attachment. Woodard (2008) added to the *korero* by exploring the impact the experience of colonisation has had on the identity of Māori. He suggested that it potentially divides and fragments the sense of *mana ake* (the uniquely ecologically integrated, interconnected sense of self) in Māori, transforming the Māori sense of self into an isolated and objectified "Other". Woodard theorised that this process can lead to a crisis of self as Māori internalise identities that are projected from the "Oppressor" through the generations, creating a divided self and the sense of alienation, hopelessness, and despair. While there needs to be further research into how intergenerational trauma affects bicultural engagements in hospice services in Aotearoa, the combination of these articles seems to suggest that there might be numerous relational and intergenerational issues at play. It suggests that intergenerational trauma and postcolonial dynamics could feed some of the failures by hospice services to provide culturally appropriate care, that these processes could create a historically justifiable mistrust of Pākehā institutions, and that they could affect how Māori patients and their *whānau* manage cancer.

Altogether, these discrepancies highlight some of the major governmental and social failings to uphold Te Tiriti o Waitangi when it comes to hospice care. These failings are complex, potentially making it challenging for health professionals to fully address them in their practices. These reports accentuate the complexity of the issues surrounding this health priority that extends far beyond the reach of the individual, emphasising the need for Pākehā psychotherapists to act with the wider community. It also highlights the need for Pākehā psychotherapists to act at different levels and advocate as a community to help develop a healthcare service that is better suited for the needs of Māori. It uncovers the need for Pākehā psychotherapists to develop Māori-centred practices that can safely hold their Māori patients and better meet their needs.

4 | THE BICULTURAL THERAPEUTIC ENGAGEMENT

To address these issues in therapeutic engagement, it seems that bicultural therapeutic dyads need to engage in a multidimensional and bilateral therapeutic approach that embraces *kaupapa* Māori. Bringing psychotherapeutic literature into the weave, Malan's (1979) triangle of insight suggested that some of the phenomena that unfold within the therapeutic relationship reflect those that have unfolded in the past and in wider society. While Malan's triangle's consideration of past relationships mainly focuses on parental relationships, the *kōrero* around transgenerational trauma above submits that the residue of historical trauma is transmitted through one's *whakapapa*, and through parent–child relationships. Thus, the combination of Malan's triangle of insight and transgenerational trauma theory suggests that my Pākehā maleness, for example, could unconsciously recreate wider and historical colonial and postcolonial dynamics in bicultural psychotherapeutic engagements, as well as reflecting larger/current bicultural dynamics in Aotearoa. In other words, it seems Pākehā psychotherapists could become a symbol of larger patriarchal dynamics in Aotearoa when working with Māori.

In considering these potential transferential aspects in bicultural psychotherapeutic engagements alongside the other dynamics highlighted above, it becomes apparent that these dynamics could engender complex interactions as bicultural psychotherapeutic dyads attempt to navigate a range of seemingly entangled phenomena and dissonances that could arise as the therapist's and the patient's worlds meet. Extrapolating from my own experiences practising in hospice services and the literature referred to above, some of these phenomena could include:

1. The appropriateness of the psychotherapist's approach. For example, the cultural need for some Māori for *whānaungatanga* (a process where participants introduce themselves while finding commonality through various experiential, geographical, and genealogical connections to build and strengthen a sense of connection) when first meeting could clash with therapeutic stances where the psychotherapists disclose very little of themselves.
2. The appropriateness of the institution that the dyad is embedded in, as highlighted above.
3. Various postcolonial and bicultural transferences and enactments.
4. Unconscious racial biases within the therapist.
5. The diverse range of understandings, beliefs, and practices between each *iwi* and *hapū*, especially surrounding death and dying (see Nikora, Masters, & Te Awekotuku, 2012; Rochford, 2004), requires psychotherapists to follow their Māori patients to create a therapeutic environment that is suitable to that particular patient.
6. Dissonances between cultural differences amongst patients using the service. For example, some patients' need for space and quiet could clash with other patients' need to have their *whānau* around them while in inpatient care.
7. The inclusion of Whānau Ora in this psychotherapeutic *kete* means that therapists need to think about ways to support the patient's *whānau* in caring for him or her (see Chant, 2011). This could involve the need for practitioners to facilitate discussions between different members of the *whānau* and to work as a community with other health service providers such as social workers, to ensure the best possible care.
8. Issues stemming from facing into what Koti (2013) refers to as *te tatau o te pō* (the door of the night, or the entrance to the place of departed spirits). Some of these issues could include the changing roles in their *whānau*, coming to terms with changes in ability, planning and putting in place the support they need, processing existential anxieties, coming to terms with unprocessed trauma, etc.

However, because there is little research into this particular entanglement, it is difficult to lay out an extensive list on the basis of it. Additionally, my extrapolation process generates a potential danger that I, as a Pākehā, might unwittingly objectify patients whom I perceive to be Māori into what Woodard (2008) refers to as the fix projected Other, and thus reinforce colonial processes. This, nevertheless, highlights the need for further research in this area that gives Māori a voice, and for Pākehā practitioners to start where they are by reflecting on and processing the impact that our own positionality could have in bicultural psychotherapeutic engagements. The hope is that this will create a space where the psychotherapeutic practitioner can recognise his or her own racially charged projections and biases, allowing the Pākehā psychotherapist to appropriately meet the needs of Māori suffering with cancer.

Pākehā psychotherapists, therefore, need to become mindful of how these unconscious and conscious dynamics could play out between bicultural dyads both within and outside the psychotherapeutic room. It seems as though Pākehā psychotherapists need to actively engage with their own racial and ethnic identity, disentangling it from the perceived indigenous Other to become aware of their own part in bicultural entanglements. This is so that, when wider and historical bicultural relationships permeate the therapeutic engagement with Māori patients, we are aware of what Leary (2000) referred to as racial enactments, affording us the ability to work through the pain of the post-colonial world and intergenerational trauma when it comes in to our psychotherapeutic engagements, enabling us to transcend colonial oppression and transform how we view Māori, and/or their socially constructed identity, from an objectifiable and projected Other into an ecologically imbedded Indigenous sense of nationhood, as Woodard (2008) suggested. The hope is that this will help erode some of our unconscious biases against Māori, helping Pākehā psychotherapists meet their patients who identify as Māori, while becoming allies by giving voice to Māori in larger institutional, social, and political arenas. Thus, in this section, I will explore some of the historical and racial relationships that may enter the therapeutic space when working biculturally with Māori, before going into some ways we can bridge this gap as we help support patients on their journey with cancer through a Māori-centred psychotherapy.

4.1 | Racial enactments

In reflecting on my own positionality in bicultural engagements, a co-created entanglement emerged, where my own sense of Pākehāness seems deeply interconnected with Māoridom and the social, generational, and geographical environments that these identities grew out of. This suggests that it becomes important to consider the colonial histories of this land and begin to reflect on how this could be unconsciously embedded in Pākehā psychotherapists in Aotearoa.

Looking back, Tuffin (2008) noted that the idea that Europeans are superior to Indigenous populations was at the heart of many of the different historical intentions and actions of Pākehā in their engagement with Māoridom. This sense of superiority can be found throughout the history of the so-called White man's world. For example, Rudyard Kipling's poem, “The White Man's Burden” (1899, cited in Fordham University, 1997), proclaimed the “white man's” moral obligation to save and rule the poor helpless uncivilised “savages” through industrialisation as the Philippine–American war broke out in 1899. Kipling's poem sent forth a call for the United States of America to implement colonial control in the Philippine Islands. It was subsequently read out by Senator Benjamin Tillman on the Senate floor just before the signing of the 1898 Treaty of Paris that brought a shift in colonial rule in the Philippines from Spain to the United States (Murphy, 2010). Thus, Kipling's poem seemingly denotes a dichotomy between the colonised and the coloniser, where the coloniser is the all-knowing, omnipotent saviour who needs to rescue the poor helpless “savage”. This is shown in the following two stanzas of the poem below.

Take up the White Man's burden—
Send forth the best ye breed—
Go bind your sons to exile

To serve your captives' need;
To wait in heavy harness,
On fluttered folk and wild—
Your new-caught, sullen peoples,
Half-devil and half-child. (para. 1)

Take up the White Man's burden—
The savage wars of peace—
Fill full the mouth of Famine
And bid the sickness cease;
And when your goal is nearest
The end for others sought,
Watch sloth and heathen Folly
Bring all your hopes to nought.
(Kipling, 1899, cited in Fordham University, 1997, para. 3)

Stacking this saviour complex against the *kete* woven above, it seems as though the desire of Pākehā to take on the responsibility of removing barriers to accessing hospice services, instead of exploring the appropriateness of our services with Māori, could potentially further the colonisation process and undermine some of the key aspects of Te Tiriti by eroding the sense of partnership and self-governance, or *tino rangatiratanga*. This saviour–savage power dynamic nonetheless sets up a dichotomy where Māori become viewed as what Foucault (2001) described as impure beings who need to be treated by all-knowing pure or righteous saviours that oppress the impure Other while building the Oppressor's sense of power. This seems to point towards a power complex within the Oppressor where the coloniser needs the colonised so that he might feel a sense of superiority and powerfulness. Thus, when therapeutically engaging with patients of Māori descent, there is a potential danger of reinforcing this historical dynamic by rushing in to save the seemingly helpless Māori Other and unconsciously feeding the colonisation process. This highlights the need for a Te Tiriti-styled partnership in bicultural therapeutic engagements, and continual reflection of the myriad of interactions within and outside the psychotherapy room.

The complexity surrounding colonisation only increases when you delve deeper into the power dynamics between the Pākehā world and Māoridom from a psychotherapeutic perspective. In the process of colonisation in Aotearoa, colonial forces infantilised Māori, splitting them into two socially perceived groups—"bad Māori", the troublemakers and stirrers, and "good Māori", those who have successfully assimilated into Pākehā culture (McCreanor, 1997, p. 42). From a Kleinian perspective (see Klein, 1930, 1935), this dichotomisation of Māori by Pākehā creates a good/bad split where the "bad Māori Other" is projected onto and blamed for the racial disharmony and social problems in Aotearoa, instead of Pākehā owning their part in the greater racial dynamics and seeing the Other's own unique subjectivity. Because of this, as a Pākehā, I have found that it becomes easy to play into subtle dynamics of racism. It would be easy for me to say that I accept everyone, while ignoring the various barriers that I unconsciously put between myself and Māori, the cultural appropriateness of my practice for Māori, as well as other racial enactments that could occur in bicultural psychotherapeutic engagements. It would be easy to blame Māori for their lack of involvement in the hospice services because Pākehā therapists have good intentions. It would be easy for me, as a Pākehā male, to continue my life saying that I am not racist, while projecting my own sense of responsibility and guilt onto people I perceive to be Māori rather than looking at and processing how deeper bicultural difficulties are playing out in the room and in the larger structures I am embedded in—rather than exploring how I am unconsciously reinforcing historical colonial processes instead of becoming an ally for Māori.

In summary, this uncovers numerous potential countertransferential dynamics—like longing to fix and/or blaming the objectified Other—that Pākehā psychotherapists need to be mindful of when psychotherapeutically engaging with Māori. This narrative also highlights the importance of incorporating Te Tiriti in psychotherapeutic practices, as well as other activities such as cultural supervision that attempt to step away from conscious and unconscious feelings of superiority. If these dynamics are handled with care, they can nonetheless provide an opportunity for the therapeutic dyads to have new relational experiences, allowing the dyad to work through some of the colonial process and intergenerational trauma, as well as the array of other potential issues that may arise in the therapeutic journey, integrating each other's sense of self in the process.

4.2 | The therapeutic space as a bicultural encounter

In terms of a bicultural psychotherapeutic framework for engagements between Pākehā psychotherapists and Māori patients, the *kete* that I have begun to weave in this paper constitutes the beginnings of a container for bicultural psychotherapeutic journeys. This framework enables the therapeutic dyad to fashion a relationship, which curiously explores and works through the different elements and enactments that emerge in the process.

In weaving this psychotherapeutic *kete*, I have found Margaret Morice's (2003) conceptualisations of Māori concepts in the psychotherapeutic engagement add depth. Morice's dissertation took the *pōwhiri* (a welcoming ceremony) as an encounter ritual, while extending some of its key elements into the therapeutic setting. She suggested that, in a Māori-centred psychotherapy, the patient becomes an honoured guest who is welcomed wholeheartedly by the therapist into the therapeutic space. According to Morice, this evokes the Māori concept of *manaakitanga*—the spiritual expression of *mana* (power or authority) through hospitality and care. She stated that, in the therapeutic space, *manaakitanga* can be shown through the simple act of the therapist being ready and prepared to welcome his or her patients while attending to their comfort and needs, through the deepest attention to emotional truths that often get overlooked and avoided in everyday life, through the containment and embracing of the patient's pain and suffering, and it can include the process of *whānaungatanga*. In the process, Morice suggested, this creates a sense of *whānaunga*, of belonging, strengthening the ties in the therapeutic dyad, creating a special kind of *kaupapa whānau* where the patient feels at home, as well as of a *kotahitanga*, the building or strengthening of the sense of unity and connection, similar to the psychotherapeutic conceptualisation of the working alliance.

Alongside this, Morice (2003) stated that *kaitiakitanga* is another part of the therapeutic relationship, where the therapist takes on the guardianship of the patient. According to Morice, this becomes particularly important in the therapeutic relationship when certain transferences, or enactments, start to negatively impact the psychotherapeutic process. Morice states that in these enactments, it becomes the therapist's role to stand up against the darkness that these dynamics may engender, creating a new experience as the dyad works through the enactment. In turn, this will help the client develop new abilities to deal with their current situation as therapists become allies in the wider arena advocating alongside their patients in partnership. This sits beside her (2003) understandings of *rangatiratanga*, or self-determination and agency, which, she noted, plays out in the therapeutic relationship in numerous ways. This happens through the therapist modelling a sense of power and authority to create a stable base through their capacity to lead, while at the same time creating an environment that engenders a sense of agency and empowerment in the patient by attentively listening to and following his or her needs.

And finally, *wairuatanga* (spirituality), which literally translates as two streams, or figuratively the known and the unknowable. Morice (2003) suggested that, in the therapy room, this is engendered through a sense of openness, imagination, reverie, creativity, a sense of connection to the wider universe, and being open to the present moment and emotionally available to your patient.

Weaving Morice's (2003) application of Māori concepts into bicultural psychotherapeutic engagements seems to further weave a psychotherapeutic *kete* that affords bicultural dyads the opportunity to journey together. These different threads provide a framework that calls for Pākehā psychotherapists to create a sense of *whanaungatanga*, which can be easily expanded to help facilitate discussion with the patient's *whānau*, when appropriate. They suggest that Pākehā psychotherapists need to carefully follow and pay deep attention to their patient's truths and needs in the spirit of Te Tiriti. In turn, this builds a sense of *rangatiratanga* and *mana*, subverting any unconscious attempts to gain power through oppression into an expression of *mana* through attentively meeting the patient's needs. It calls for Pākehā psychotherapists to take hold of their sense of *kaitiakitanga* by advocating for the needs of their patients in the institutions they are embedded in, and facing up to, and reflecting on, the different enactments and unconscious biases that may arise during the engagement. Morice's application of *wairuatanga* helps the psychotherapeutic dyad to appropriately express/symbolise their journey towards the great unknown, *te tatau o te pō*, as the journeyer's spirit faces the veil of death and the mystery beyond. In all, the application of these Māori principles allows the potential for the therapeutic relationship to naturally evolve as the dyad goes deeper into its therapeutic journey together, rather than following concrete steps which are full of assumptions and do not allow flexibility. In other words, it allows Pākehā psychotherapists to adapt their practices in a way that flows with the patient, working through any possible enactments, while supporting the different walls of wellbeing so that they can face into their journey together.

4.3 | The blurring of the bicultural lines—a sociological critique

This bicultural *kōrero*, however, can easily evoke what Crocket (2013) called a relational dichotomy between "Māoriness and Pākehāness" (p. 62). It highlights the complexity around the identity politics in bicultural relationships. This dichotomy runs the risk of becoming exclusionary and culturally normative, excluding people who fall between or outside of these racial and ethnic identities, as well as those who hold a multitude of ethnic and racial identities. This situation becomes even more complex when you explore the diversity in each ethnic and racial identity. Thus, it becomes important to be wary of any assumptions that may rise within the psychotherapy and the dyad, and to tentatively explore what identities and ways of being each patient feels connected to.

Considering the blurred nature of the Pākehā–Māori bicultural dichotomy, Charles Taylor's (2004) conceptualisation of social imaginaries becomes helpful. It helps to view the sense of group belonging in a way that upholds both the blurred nature of group identities, as well as the collective experiences of the group. Taylor theorised that groups are threaded together through shared experiences and ways of being, and that society as a whole contains a myriad of these entangled groupings that bleed into one another. Coming back to the context of this essay, this concept transforms the idea of Māori from a concrete grouping with clearly defined boundaries into a shared/unifying experience. Thus, in the context of working with Māori patients, it helps Pākehā psychotherapists to view Māori identity as a thread that uniquely weaves each Māori patient into the larger socially imagined group. It helps psychotherapists to empower their Māori patients to name what being Māori means to them, rather than eliciting unconscious power dynamics where the psychotherapist defines who is and is not Māori. Therefore, it becomes important for therapists to follow their patients to discover how they are connected to their identities, rather than coming in with our own assumptions. So, while this therapeutic *kete* attempts to step towards people of Māori descent, it is important to act in partnership as an ally, and let the therapeutic relationship naturally evolve into something that is suited for each patient.

5 | CONCLUSION

This *kōrero* has discussed some of the concerns facing Pākehā psychotherapists working with Māori patients with cancer, exploring the appropriateness of many hospice services for Māori. The weaving of this *kete* has uncovered several issues around access and the aptness of hospice services for people of Māori descent. It has also uncovered a need for further research into the impact that transgenerational trauma has on Māori patients' journeys with cancer in Aotearoa and the enmeshed phenomena that bicultural psychotherapeutic dyads may face. Despite this, it has created a call for Pākehā psychotherapists to act as a community and become allies, advocating for structural changes in hospices in Aotearoa to create services that are more culturally suitable for Māori. This exploration also has highlighted the need for Pākehā psychotherapists to create spaces where Māori feel welcomed. As shown, this can be done through the inclusion of key Māori concepts in a therapeutic manner, while using understandings around Te Whare Tapa Whā (Durie, 1985), Whānau Ora (Chant, 2011), and Morice's (2003) model of Māori psychotherapy. This gives Pākehā psychotherapists several key principles to assist bicultural dyads to work through the various racial enactments that may occur on our journey, while inviting patients as Te Tiriti partners to help develop each engagement into one that is more suitable for the needs of each Māori patient.

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CONFLICT OF INTEREST STATEMENT

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REFERENCES

Amitabha Hospice Trust. (n.d.). Our history. Retrieved from https://www2.amitabhahospice.org/who-we-are/our-history/

Baider, L., Peretz, T., Hadani, P. E., Perry, S., Avramoz, R., & De-Nour, A. K. (2000). Transmission of response to trauma? Second-generation Holocaust survivors' reaction to cancer. *The American Journal of Psychiatry*, *157*(6), 904–910. Retrieved from https://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.157.6.904

Chant, L. (2011). Whānau Ora Hauora: Māori models for kotahitanga/co-operative coexistence with non-Māori. *AlterNative*, *7*(2), 111–122. https://doi.org/10.1177/117718011100700204

Cormack, D., Robson, B., Purdie, G., Ratima, M., & Brown, R. (2005). *Access to cancer services for Māori*. Wellington, New Zealand: Ministry of Health. Retrieved from http://www.health.govt.nz/publication/access-cancer-services-M%C4%81ori

Cram, F., McCreanor, T., Smith, L., Nairn, R., & Johnstone, R. (2006). Kaupapa Māori research and Pākehā social science: Epistemological tensions in a study of Māori health. *Hūlili*, *3*(1), 41–68.

Crocket, A. (2013). Exploring the meaning of the Treaty of Waitangi for counselling. *New Zealand Journal of Counselling*, *33*(1), 54–67.

Durie, M. (1985). A Māori perspective of health. *Social Science & Medicine*, *20*(5), 483–486. https://doi.org/10.1016/0277-9536(85)90363-6

Durie, M. (2001). *Mauri ora: The dynamics of Māori health*. Melbourne, Australia: Oxford University Press.

Fordham University. (1997). Modern history sourcebook: Rudyard Kipling, The White Man's Burden, 1899. Retrieved from https://sourcebooks.fordham.edu/halsall/mod/kipling.asp

Foucault, M. (2001). *Madness and civilization: A history of insanity in the age of reason* (R. Howard, Trans.). London, UK: Routledge.

Healy, S., Huygens, I., & Murphy, T. (2012). *Ngāpuhi speaks*. Whangarei, New Zealand: Network Waitangi Whangarei, Te Kawariki.

Hill, S., Sarfati, D., Robson, B., & Blakely, T. (2013). Indigenous inequalities in cancer: What role for health care? *Australia New Zealand Journal of Surgery*, *83*(1–2), 36–41. https://doi.org/10.1111/ans.12041

Hospice New Zealand (2012). *Hospice New Zealand standards for palliative care: Quality review and programme guide 2012*. Wellington, NZ: Author. Retrieved from http://www.hospice.org.nz/cms_show_download.php?id=647

Klein, M. (1930). The importance of symbol-formation in the development of the ego. *International Journal of Psychoanalysis*, *11*, 24–39.

Klein, M. (1935). A contribution to the psychogenesis of manic-depressive states. *International Journal of Psychoanalysis*, *16*, 145–174.

Koti, D. M. (2013). Te tatau o te pō: Perceptions and experience of palliative care and hospice, a Māori perspective. (Master's thesis). Massey University, Palmerston North, New Zealand. Retrieved from http://hdl.handle.net/10179/5462

Leary, K. (2000). Racial enactments in dynamic treatment. *Psychodynamic Dialogues*, *10*(4), 639–653. https://doi.org/10.1080/10481881009348573

Malan, D. (1979). *Individual psychotherapy and the science of psychodynamics*. London, UK: Butterworth.

Mary Potter Hospice. (2017). *Our history*. Retrieved August 23, 2017, from http://marypotter.org.nz/about-us/our-history/

McCreanor, T. (1997). When racism stepped ashore: Antecedents of anti-Māori discourse in Aotearoa. *New Zealand Journal of Psychology*, *26*(1), 36–44. Retrieved from http://www.psychology.org.nz/wp-content/uploads/NZJP-Vol261-1997-4-McCreanor.pdf

Mercy Hospice Auckland. (2017). *Mercy Heritage*. Retrieved from https://www.mercyhospice.org.nz/about/heritage.asp

Ministry of Health (2001). *The New Zealand palliative care strategy*. Wellington, NZ: Author. Retrieved from https://www.health.govt.nz/system/files/documents/publications/palliativecarestrategy.pdf

Ministry of Health. (2015). *Tatau kahukura Māori health statistics: Cancer*. Retrieved from http://www.health.govt.nz/our-work/populations/M%C4%81ori-health/tatau-kahukura-M%C4%81ori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/cancer

Morice, M. P. (2003). *Towards a Māori psychotherapy: The therapeutic relationship and Māori concepts of relationship* (Unpublished master's dissertation). Auckland University of Technology, Auckland, New Zealand.

Murphy, G. (2010). *Shadowing the white man's burden: U.S. imperialism and the problem of the color line*. New York, NY: New York University Press.

Nikora, L. W., Masters, B., & Te Awekotuku, N. (2012). Final arrangements following death: Māori indigenous decision making and tangi. *Journal of Community and Applied Social Psychology*, *22*(5), 400–413. https://doi.org/10.1002/casp.2112

Pihama, L., Reynolds, P., Smith, C., Reid, J., Smith, L. T., & Te Nana, R. (2014). Positioning historical trauma theory within Aotearoa New Zealand. *AlterNative*, *10*(3), 249–261. https://doi.org/10.1177/117718011401000304

Robson, B., Purdie, G., & Cormack, D. (2006). *Unequal impact: Māori and non-Māori cancer statistics 1996–2001*. Wellington: Ministry of Health. Retrieved from http://www.health.govt.nz/publication/unequal-impact-maori-and-non-maori-cancer-statistics-1996-2001

Rochford, T. (2004). Te whare tapa whā: A Māori model of a unified theory of health. *The Journal of Primary Prevention*, *25*(1), 41–57. https://doi.org/10.1023/B:JOPP.0000039938.39574.9e

Shabad, P. (1993). Repetition and incomplete mourning: The intergenerational transmission of traumatic themes. *Psychoanalytic Psychology*, *10*(1), 61–75. https://doi.org/10.1037/h0079419

Slater, T., Matheson, A., Davis, C., Earp, R., Gellartly, K., Holdaway, M., & Ellison-Loschmann, L. (2015). Exploring Māori cancer patients', their families', community and hospice views of hospice care. *International Journal of Palliative Nursing*, *21*(9), 439–444. https://doi.org/10.12968/ijpn.2015.21.9.439

Soeberg, M., Blakely, T., Sarfati, D., Tobias, M., Costilla, R., Carter, K., & Atkinson, J. (2012). *Cancer trends: Trends in cancer survival by ethnic and socioeconomic group, New Zealand 1991–2004*. Wellington: University of Otago and Ministry of Health. Retrieved from https://www.health.govt.nz/system/files/documents/publications/cancer-trends-survival-ethnic-socioeconomic-1991-2004_1.pdf

Taylor, C. (2004). *Modern social imaginaries*. Durham, NC: Duke University Press.

Tuffin, K. (2008). Racist discourse in New Zealand and Australia: Reviewing the last 20 years. *Social and Personality Psychology Compass*, *2*(2), 591–607. https://doi.org/10.1111/j.1751-9004.2007.00071.x

Woodard, W. (2008). *Entering the void: Exploring the relationship of colonisation and the experience of the self for Indigenous Peoples of Aotearoa, and implications for clinical practice*. (Master's dissertation). Auckland University of Technology, Auckland, New Zealand. Retrieved from http://hdl.handle.net/10292/500

Hayden M. Isaac was born and grew up in small-town, Aotearoa, then travelled extensively from 2005 to 2010. On returning to Aotearoa, he completed his BMus with first class honours in Ethnomusicology at Victoria University of Wellington and is currently a Master of Psychotherapy student at the Auckland University of Technology while working in early childhood education. Hayden is interested in a range of topics that include disability studies, ecology, intergenerational trauma, listening/hearing, power disparities, the sense of home and belonging, and sound and music.

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