

Decolonising mental health services one prejudice at a time: psychological, sociological, ecological, and cultural considerations

Jonathan Fay

Discipline of Psychotherapy, Faculty of Health and Environmental Sciences, Auckland University of Technology, Auckland, New Zealand

ABSTRACT

This paper describes a minority and marginalised psychiatric patient named 'Lucy' and offers an analysis of the multiple 'colonising' or 'power-over' relations that dominate her life. Lucy's colonisation and consequent struggle can be understood on multiple levels: psychologically, in the struggle between the discordant parts of her personal self; sociologically, in the struggle between a mainstream culture that dominates and rejects her and her almost equally insecure place in her own indigenous minority culture; and ecologically, in the planet-wide collision between the secular materialism that drives globalism and globalisation, and an indigenous holistic and psycho-spiritual orientation to nature and the cosmos. Mental health professionals can help our patients recognise and reclaim forms of wisdom and value that survive and flourish on the margins of the mainstream. Decolonisation strategies based on this understanding suggest a variety of practical ways in which Lucy and other marginalised persons might be empowered and assisted to return to health.

KEYWORDS

Colonisation; decolonisation; culture; psychiatry; psychotherapy

Introducing Lucy

Lucy is a 36-year-old single Māori (Māori' is the inclusive term identifying descendants of the original, indigenous New Zealanders of Polynesian origin, also known as tangata whenua or people of the land) woman with a six-month-old baby girl, father unknown. Lucy grew up in poverty and neglect, and was physically and sexually abused from a young age by older members of her immediate and extended family. As her two older children were removed from her care shortly after they were born, raising this child is probably Lucy's last chance to be a mother. Lucy has a 10-year history of contact with local mental health services, including a diagnosis of chronic schizophrenia with four brief inpatient hospitalisations for acute psychotic symptoms that include hallucinations, delusions, and significant danger to self and others. Lucy drinks alcohol and smokes cannabis daily; two of her last acute psychotic episodes appear to have been precipitated by her drug use.

Recently, Lucy was re-admitted to the inpatient unit amid concerns for her and her baby's safety. In conformity with their care and protection protocols, Child, Youth and

Family Services uplifted Lucy's baby against her wishes and placed her in temporary foster care. This resulted in Lucy's becoming agitated and emotionally distraught, dramatically increasing her psychotic symptoms. Lucy's insistence that her child had been stolen by faceless strangers who exercised devastating power and control over her life was interpreted as confirmation that she was 'paranoid' and unwell. There is no parallel indigenous experience in Aotearoa NZ that would bear comparison with Australia's 'stolen generation', yet witnessing Lucy's fears of losing her baby being cited as a reason she needed to be relieved of parenting responsibilities did call to mind child abduction and the violent elimination of indigenous difference.

In another life, in another world, Lucy might have been something special, a big woman, fine-featured, dark-skinned, with dark hair and dark eyes. In this world she is a ward of the State, overweight and dressed in ill-fitting, shabby clothing. She wears jandals year round, often preferring to go barefoot, her cast off footwear following in her wake. She perspires regularly and washes irregularly. She sleeps and eats badly. She has few material resources. She presents as naïve and unsophisticated, not quite all there. She left school early and is self-conscious about her lack of formal education. She is inarticulate and insecure in expressing herself until energised by anger. Although Te Reo Māori (indigenous Māori language) was spoken in her household as a child, Lucy never became fluent in her first language, nor was she ever given schooling in Te Reo or Tikanga Māori (cultural protocol). Much of her inheritance has been stolen or lost; she knows little of the traditions of her lineage.

Lucy is not an easy client to work with. She has little reason to trust Pākehā (Pākehā designates all non-Māori born in Aotearoa New Zealand, and more specifically NZ descendants of British settlers). She has not been well served by Pākehā institutions or the mainstream, white NZ culture derivative of British settlement. She is sensitive to slight, quick to take offence, and mistrustful of others motives and intentions, particularly if they are persons in positions of authority. She has difficulty managing personal boundaries. She is impulsive and intrusive one moment, and oppositional or withdrawn the next. She retreats to a survival level of flight, fight, or freeze, yet none of these strategies offers her safety.¹ Lucy has been the object of considerable professional attention, the recipient of many public services and packages of care. She is neither invested in or grateful for her caregiver's assistance. Help has never helped her much. Staff have had to adjust to Lucy's chronic agitation and distress, her occasional outbursts of verbal hostility, her passivity and lack of initiative. They experience futility and express cynicism about her drug and alcohol fuelled repetitive crises. Faced with their own lack of effectiveness, staff feel guilty, withdraw and cut off, or become critical and disparaging of Lucy, imagining themselves different and better than her.

The impasse

It should come as no surprise that patients like Lucy are deemed incompetent to self-manage when they are in crisis, yet the forms of 'care' that they are encouraged to accept may also mean accepting a de-cultured and diminished form of citizenship. Patients' civil liberties may be withdrawn if deemed necessary in their own interest or for the safety of others. Mental health services may prioritise the needs of society in the interests of social control. The routine assumption that service providers know best has

an unintended negative consequence: mental health services has become a parental agency in which Lucy is forced to play the role of a child. The tight fit between Lucy as 'child' and her caregivers' as 'parent' works best when she is sick, but not so well when she is healthy. Lucy is frequently encouraged to grow up and become more independent, but only within parameters pre-ordained by the parental agency. When Lucy aspires to autonomy and self-determination, or simply to 'being Māori', she no longer fits the system and her spontaneity is often assumed to be pathological. An impasse is created when treatment compliance is prioritised ahead of therapeutic alliance or Lucy's independent efforts.

Understandably, the clinical team believe they know Lucy well and have her best interests at heart. They believe she needs to comply with treatment, accept temporary protective custody until her consciousness clears, refrain from substance abuse, take her medications as prescribed, and gain insight into her unwellness. She is encouraged to identify with an executive 'I' that can make good choices and set positive goals, develop a stronger ego and reclaim authority over her own life. Her stability and compliance will earn her the right to reunite with her child, initially under close supervision. She can then return to those few members of her kin who are still willing to have contact with her and gradually reintegrate back into the community.

Unfortunately, Lucy is unimpressed by her diagnosis of major mental illness and substance dependence. She views her drinking and smoking cannabis as an entirely normal and unremarkable activity unrelated to her psychiatric symptoms. Lucy reports feeling like a ghost much of the time. Cannabis helps her to feel more real and calms her upset and anger.

Mental health staff recognise that Lucy is living on the bottom rung of many ladders. She is under-resourced, poor, chronically subject to mental illness, emotional dysregulation, substance-dependence, physically unfit and unhealthy, uneducated and unsophisticated, and non-compliant with psychiatric treatment. What staff struggle to recognise is that Lucy's treatment regularly invokes several varieties of colonising power that confirm her minority and marginal status. Caring for Lucy requires the use of power and it requires critical judgments, some of which are bound to be wrong. This responsibility weighs heavily on staff and fuels their defensiveness and blindness to their exercise of power and prejudice. Some staff question Lucy's right to bear and rear children. Some blame her for her poverty and lack of formal education. Many have little comprehension of her culture or her insecure place in it.

So although mental health service workers sincerely aspire to assist Lucy to recover and lead a life of well-being, they are all too regularly positioned as her antagonists. More broadly, Lucy's entire whānau (extended family) are under attack, fighting for their lives and their way of life, locked in an ongoing power struggle with mainstream institutions, norms, and values. Seen through the lens of social psychiatry and community psychology, Lucy and her caregivers occasionally join forces to fight the symptoms of her illness, but are more often trapped in a stalemate that revolves around power, privilege, and cultural validity. While obviously dysfunctional and self-destructive, Lucy's behaviour and lifestyle can also be understood as an attempt to fly the flag of cultural self-determination and sovereignty. Efforts to treat these conditions 'objectively' without recognising their function as declarations of independence are unlikely to succeed. Within the public mental

health service, this ongoing struggle is a daily reality in which battle fatigue erodes empathy and optimism in patients and staff alike.

On reflection, it is obvious that mental health patients' attitudes and behaviours are not driven by mental illness alone. Arguably, they are equally driven by social and cultural alienation. In addition to medical treatment and care, Lucy and patients like her need social and cultural engagement, enlightenment, and empowerment. How might mental health systems and mental health staff be assisted to respond to this need? How might they creatively and constructively engage this 'shadow',² learning to recognise unacknowledged aspects of power and prejudice, and appreciating their interactive and systemic consequences?

A broad-spectrum view of colonisation

To colonise means to establish a new colony and make a new home, which sounds innocent enough, but colonising also involves seeking dominance and competing for limited resources on territory that is usually someone else's home. In human affairs, this hostile takeover is often pre-meditated and quite intentional. Cultural domination is achieved with the help of an ideology of superiority that justifies the foreign presence and enforces submission to it. Following the definition of racism as 'power plus prejudice',³ this paper suggests a parallel formula for colonisation. Colonisation equals power and privilege plus prejudice. Wherever prejudice can be projected with enough power and sustained with enough privilege, colonising dynamics result.

Historically, the word colonisation refers to European colonial ambitions to annex new territories occupied by indigenous peoples. Here it is worth distinguishing between two distinctly different modes of domination: colonialism that dominates for the purpose of exploitation, and settler colonialism that dominates for the purpose of establishing a new home. The dynamics of settler colonialism typically include the initial military subjugation of an indigenous majority followed by the steady transfer of land and other resources to an ever-growing colonising minority who become over time the dominant majority. While the overt intention to subjugate and displace indigenous culture in this manner is no longer morally acceptable, mainstream 'Eurocentric' ideologies of superiority that accompany the exercise of superior power continue to flourish unabated. The dynamics of colonisation that result from the intersection of power, privilege and prejudice continue to hold sway at structural and systemic levels. The majority of New Zealanders, like their white Australian, Canadian and American counterparts, remain regrettably ignorant of the discriminatory treatment that favoured their non-indigenous forbearers and continues to favour them. Unaccustomed to thinking of themselves as having benefitted from indigenous people or as beholden to them in any respect, they make no connection between their own relative affluence and the scandal of indigenous poverty. They have neither learned nor been taught colonial history: about government and settler violence, broken treaties, land grabs, and the imposition of a harsh colonial administration that still exists and persists today.⁴ They may be profoundly unaware that the colonial history of the past still persists today in less overt and obvious guises.⁵

The paradigm of broad-spectrum colonisation and decolonisation proposed here is modelled on actual colonial history. It extends ideas of cultural difference and disparity to include all the cultural containers that hold personal identity and group identifications.

The dynamics of cultural elitism and marginalisation that create majority and minority disparities impact all the cultural contexts that we carry inside us and carry forward in time via the multiple identities ascribed to us and taken up by us, including cultural, sub-cultural and species differences. The related disciplines of psychology, sociology, and ecology span different size scales that include microsocial, mesosocial, and macrosocial levels of social engagement. They offer different perspectives on human relationships at different points along what I have described elsewhere as the 'cultural continuum'.⁶ This cultural continuum extends from the smallest to the biggest examples of human relatedness. The cultural continuum includes: (1) the microcultural, intrapsychic world of individuals and parts of individuals; (2) the minicultural, face-to-face world of close, enduring personal relationships, such as are found in family life; (3) the sub-cultural, wider interpersonal world of groups, organisations, and communities extending beyond direct, face to face engagement; (4) cultures at large, each of which have their own distinct identity that binds their members, who may not be otherwise known to each other, together; (5) the macroculture of impersonal, complex large scale relationships between peoples, cultures, nations and nature, globally, and worldwide.

Within each of these different levels of social organisation and cultural contexts are sets of unbalanced power relations, historically accumulated and reinforced and refined over time. These structural and systemic arrangements favour the majority over the minority and favour a managerial elite over everyone else, including the majority. On all the fundamental personal and social characteristics by which we define ourselves and each other we can picture a spectrum that runs from the managerial elite to the majority to the minority to marginalised social, economic, and political positions. These identity markers include our ethnicity, the place we call home, our gender, class, age, sexuality, and sexual preference, our various abilities and disabilities, and our species status as members of this present generation and historical epoch. This cultural continuum contains not only a diverse range of unbalanced power relations but an equally diverse yet also stable and predictable variety of prejudicial attitudes. Ideologies of superiority attach to the exercise of elite power and privilege, while ideologies of inferiority are attached to non-elite minority status, particularly to those who have been marginalised.⁷ It is these power relationships, and the fixed ideas and rigid illusions of superiority and inferiority that attach to them that create the dynamics of colonisation as that term is used here.

Along the cultural continuum, power imbalances and 'power-over' relations exist in each of the following pairs: I over me, ego syntonic over ego dystonic, left brain over right brain, parents over children, men over women, rich over poor, white over yellow or brown or black, settler over indigenous, Pākehā over Māori, straight over gay, well over sick, abled over disabled, formally over informally educated, English over non-English language speakers, technologically savvy over technologically unskilled, urban over rural, global over local, private over public, science over art, objective over subjective, the economy over the biosphere, secular materialism over spiritual holism, the present generation over future generations, and the human species over all other life forms.

In the paradigm proposed here, the history of European conquest and colonisation defines a particular cultural 'fault line' that includes racial, ethnic, linguistic, and technological power disparities and prejudices. Gender and class represent other important 'fault lines'. As bell hooks notes 'Sexuality has always provided gendered metaphors for colonisation.'⁸ Males and females relate and communicate across a gender difference

that is also a divide. Women are subjugated worldwide by sexist assumptions of male superiority enforced by male power and privilege. Parallel to this, the rich have routinely colonised the poor. As well as suffering economic disadvantage and deprivation, the poor suffer inferiorisation from assumptions of class and caste inferiority. Persecution and intolerance mark the relationship between straights and gays. Majoritarian assumptions widen the gap between abled and disabled persons. Other culture clashes and power imbalance accompany differences in formal education, language fluency, and technological sophistication, each of which is routinely mistaken for intelligence itself.

Each human person is a complex composite, the sum total of multiple identities. Our conscious and unconscious experience and functioning is nourished by multiple lineages, formed, informed, and deformed by culture. Intrapsychic positionalities include multiple iterations of I's and me's, we's and us's. Parts of self may include persecutors, rescuers, victims, or bystanders; or divide into parent, adults, and child. Interpersonal positionalities include core roles and lifelong role relationships. Sociological positionalities assign power and status based on the marker variables described above. Ecologically, our present generation, human species membership describes a singularity that links our otherwise diverse habitats. Our self-centred modern lifestyle is increasingly answerable to the consideration of long-term individual and collective human impacts. Naïvely unreflective assumptions of human species superiority inevitably contribute to a careless destruction of the biosphere on whom all life depends.

A broad-spectrum view of decolonisation

If anyone can be a coloniser in relationships of unequal power where they are the dominant party, then conversely, anyone can become a decoloniser by sharing power, equalising privilege, and challenging the assumptions of superiority and inferiority that sustain unbalanced power and privilege. It is always possible to uphold the dignity of marginalised persons and peoples and seek to reclaim the wisdom and value of marginalised positions. Decolonisation, then, refers to various forms of consciousness raising and to the accompanying strategies that seek to address the violence and trauma produced by inequitable and inhumane social practices.⁹ Supporting the logic of these decolonising strategies is the broad-spectrum model of 'power-over' relations described above, which identifies varieties of psychological, sociological, and ecological power imbalances, all of which need rebalancing in the interests of human survival, sanity, safety, health, and well-being.

Decolonisation empowers and encourages those who have been subjugated to free their minds and reclaim their lives.¹⁰ Decolonisation also encourages members of dominant groups to challenge the inequitable distribution of power and privilege by critically examining their prejudices and sharing their power. Decolonisation strategies are most likely to succeed when developed as partnerships in which prejudices can surface, be addressed, and replaced with mutual understanding. Those in the more powerful (elite or majority) position can actively support those in the less powerful (minority or marginalised) position by supporting and amplifying minority and marginalised voices, helping to retain and reclaim the wisdom of minority and marginalised individuals and groups. Without the rich diversity provided by a plurality of 'me's' and 'we's', 'I' remains impoverished. Without the naïve and nourishing wisdom of the child to ground us, the abstractions

of 'adulthood' may appear as educated foolishness. Monoculturalism is a set of blinkers or blinders that protects and preserves the status quo by making the reality of diversity and pluralism invisible. Diversity can threaten our sense of unity but also extend our range and increase our resilience. The restrictions imposed by monocultural vision are particularly detrimental in times of change, when maximum flexibility and adaptability are needed.

The decolonisation of mental health services challenges the dynamics of disempowerment and inferiorisation that contribute to suffering and ill health in Aotearoa New Zealand and around the world. A broad continuum of health from micro to macro size scales connects individual health to community health to global health. The validation of minority and marginalised consciousness contributes to individual and collective well-being and species survival and is vital to good health and good healthcare. Decolonisation strategies validate indigenous wisdom and the need for indigenous voices to be heard, but also applies these principles to many other instances of systemic power difference and disparity. At every location along the cultural continuum, seeking out the wisdom that belongs to the less powerful member of the 'power-over' pairs listed earlier can produce unexpected insights. Retaining and reclaiming the wisdom from the margin enriches the majority as well as helping to restore health and develop positive identity for the minority and marginalised individuals and groups who have suffered inferiorisation.

Different 'fault lines' organise different types of elite/majority/minority/marginal dynamics, each with its own potential for oppression or liberation. Lucy's identity as Māori in a Pākehā mainstream environment implies a colonising dynamic that is organised around majority cultural validity and minority cultural invalidation. The stigma of mental illness or chemical dependency brings its own type of personal and social invalidation of the sick minority by the healthy majority. The direct and indirect impacts of being female, poor, or lacking formal education and life skills may require other, specific forms of attention. Some practical indications for Lucy's treatment emerge from a consideration of three particular fault lines or 'power-over' pairs, organised in order of ascending size scales: 'I over me', 'parents over children', and Pākehā over Māori.

Decolonising relations between 'I' and 'me'

Clients value different parts of themselves very differently. Certain parts of self appear feared or hated, devalued, or rejected. These disowned self-parts are often associated with negative childhood experiences, key early experiences of abuse and trauma, neglect, deprivation and loss, or with needs or wants that evoked or provoked parental censure or rejection. As self-acceptance is an effective catalyst for positive personal change, psychotherapy and counselling practitioners have developed methods and techniques that encourage clients to re-own and integrate disowned parts of themselves.

Decolonising interventions aim at reducing power disparities between the overt, official, and legitimate version of the self and other versions of self that include covert, illegitimate, or marginalised self-parts. By reducing prejudicial and disparaging attitudes towards 'me', the wisdom of the 'inferior' member of the I/me pair can be recovered in the recognition of a pluralistic self. We are all the ages we have ever been. 'Me' is two months old, two years old, two decades old. Potentially, we could access and operate from all these different 'me's' The ideal 'I'dentity would be an integrating adult¹¹ that

selects from the entire diversity and range of possible 'me's', putting into play the most situation-appropriate, present-centred version of myself. Of course what we observe in real life is a state of compromise rather than an ideal 'I'.

320 In psychopathology, much of the richness and diversity of self is lost. Relations between 'I' and the 'me' are fraught and compromises expensive. In states of mania or meglomania, the return of the repressed emerges with pathological spontaneity, setting free a variety of non-dominant provisional and unfinished versions of self. In states of depression, the central 'I' pillar of identity is present but experienced as empty, tired, and depleted. In a depressive state of colonial melancholy, we wander lost and exhausted among endlessly recursive 'still just me's' and 'me again's'. In Lucy's psychotic moments, only minority selves remain present and accounted for, the integrating 'I' is missing in action. This is actually a subversive refusal to submit to the colonial power of the 'I'. The tragic irony is that this subversion also abdicates and abandons executive function. I is not only the colonial overlord over the rest of the 'me' selves, but the sovereign self in relation to others and the world. Having lost hope of any forthright self-determination and self-sovereignty, in states of psychosis we abandon our central organising 'I' identity while retaining subversive fragments of ourselves that tend to seek self-expression in heavily coded symbolic communications.

330 Lucy is suffering from a lack of 'I' identity. She experiences identity theft in acute paranoid states and an ongoing sense of identity loss and diffusion. Time and effort are wasted struggling with Lucy over her lack of proactive executive agency. Accepting her as she is and attending closely to her unintegrated 'me' experiences is more likely to help her develop 'I' referenced self-identity. Appreciative enquiry finds meaning and value in a broad range of unusual human responses to extraordinary life circumstances, including decoding the personal significance of hallucinations and delusions.¹² Alienation from the human world tends to generate alternative non-human attachments. Inquiring widely about whatever Lucy feels connected to will eventually find a link between these attachments and specific parts of self that are living in hiding.

340 In moments when Lucy is re-living her past, she may appear terrified or lost, but clients most readily de-escalate from states of terror and fear when their reality is empathically received. We can offer Lucy gentle companionship and empathy for the suffering child who was forced to endure trauma, deprivation, and loss. When Lucy describes performances she considers shameful, we can imagine their positive aspects, assert the basic goodness of childhood needs and motives, and locate the original contexts in which these needs and motives can be understood as healthy and appropriate strivings. Lucy serves more than one master and suffers warring and competing inner voices, some of which appear to her to originate from outside herself. Parental authorities from her past and medical authorities in her present are disharmonious, out of alignment. Her voices often arise as pre-emptive strikes against herself following an impulse to oppose authority or fight back. Facilitating dialogue between these voices can challenge unhappy compromises and negative self-talk.

350 In general, we may defer to Lucy and seek to please her, but Lucy can be wilful as well as psychotic or traumatised. She sometimes escalates her demands, declining to settle for empathy or understanding, committed to being 'bad' rather than 'mad' or 'sad' so to speak. At such moments, it may be helpful to meet her will with our own, friendly and respectful but firm as well. Later, we might wish to congratulate her on taking a stand and ask her how she managed it.

Decolonising relations between parents and children

365 Effective counselling and therapy requires an open, balanced perspective on the daily tensions and contradictions of family life. Parenting is an impossibly difficult and demanding job. Parents inevitably offer their children a mixture of good and bad authority. Parental guidance and discipline is useful in many ways. Children's self-mastery depends on learning to hold back from seeking immediate gratification and the generous spirit vital to happiness depends in part on recognising and honouring the needs of others. But parents may not practice what they preach. Parental love and loyalty may be misguided or altogether absent. Clients with a history of abuse and neglect were often scapegoated as children, negatively and unfairly projected onto, forced to sacrifice themselves to others' selfishness. These clients need partisan and proactive solidarity; professional neutrality or objectivity will be experienced as tacit support for the status quo. Working from an alongside, experience-near, pro-client position, counselling and psychotherapy can still maintain balance and remain alert to collateral information and the contribution of other family members' perspectives.

370 Lucy grew up in an unsafe world, becoming accustomed to violence and trauma as a child. Dissociating and letting her mind wander may have originated as a trauma survival strategy, now no longer under her conscious control. Her current psychiatric symptoms provide some clues to accessing and working with her early life trauma. Lucy becomes distressed when she sees a child walking to school alone, particularly if they look neglected or poor. Believing she knows exactly how they feel, Lucy wants to engage and help them. Having suffered police accusations of harassing these children, she holds herself back from this impulse. Her distress and identification with these children is very poignant. Affording Lucy the opportunity to express her feelings about these children may prove transformative. Hearing her own story, she may become receptive to the suggestion that she too has an inner child that feels neglected and needy and walks alone. More fully in emotional contact with herself, Lucy can maintain her aspiration to help these children while feeling relieved of the pressure to act impulsively on their behalf.

385 Children may be considered 'inferior' as the less powerful member of the parent/child pair, yet often bring an impressive level of basic goodness and undefended authenticity to their relationships. The wisdom of the child resides in their naïveté, a reality orientation which foregrounds 'is' in preference to 'should'. Until they learn otherwise, children assume that what is must also be ok, naively and immediately embodying the mindfulness so arduously cultivated by adults. The wise child is preserved in 'inferior' psychological functions as well: feeling vs. thought, perception vs. judgment, introversion vs. extroversion and intuition vs. sensation.¹³

390 Based on a combination of life stress and the conditions of their own upbringing, parents often fail to recognise and meet their children's legitimate needs. When stressed, Lucy loses sight of significant differences between herself and her baby. Temporarily unable to empathise and attune to her baby's need, her poor self-care becomes neglect of her baby. Putting temporary caregivers in her place is last choice. What would benefit Lucy and her baby is education and support to practice parenting in the company of more experienced maternal caregivers. Ideally, Lucy's parenting skills could be improved with help from the members of her own whānau.

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Therapy with Lucy requires tolerating her grief, opening to her experience of lapsing and languishing, empathising with her struggle. Therapeutic companionship offers her relief from profound aloneness. The opposite and complement to being receptive is a gentle and persistent challenge to Lucy's belief that it is too late to get well. As the inner child is reclaimed in psychotherapy, psychological resilience is strengthened. Validating Lucy, particularly when she invalidates herself, offers her a basis for positive aspiration. This requires distinguishing her symptoms from her person and holding staunchly to an understanding of what Lucy might be like with her symptoms in remission. Because Lucy is an 'invalid', she is too often assumed to be invalid. Patronising Lucy with solicitude and symbolic tokens of respect, telling her that she has 'choices' to make, yet failing to consult her about major decisions, sends an inconsistent, double message. Too often, serious discussions about Lucy's future are conducted out of her earshot,

Decolonising relations between Pākehā and Māori

Te Ao Māori or the Māori world orients Māori people to a holistic, interdependent universe or cosmos in which relationship is fundamental. Relationship precedes separate identities. Whakapapa or genealogy connects all things and brings them into unique patterns of relationships. The human social world is part of and encompassed by the natural world, which in turn is part of the cosmic, eternal world. Core values that organise Māori relationships within this larger world include manaakitanga, the enhancement of others' dignity and social standing by means of generosity and hospitality, whanaungatanga, or family cohesion and loyalty, kaitiakitanga or care and guardianship, particularly over the natural environment, kotahitanga or unified purpose and consensus-seeking, rangatiratanga or sovereignty and self-determination, and above all wairua, spiritual connection and relatedness, mauri, the ubiquitous presence of spiritual and life-force energy, and aroha or compassionate love.

Māori values and worldview have many similarities and parallels with other indigenous worldviews worldwide. The family rather than the individual is the basic social unit, a social unit that is intimately linked to ancestral land. People are born from the land and land is a part of the self. Māori self-introductions begin with specific ancestral landmarks such as a mountain or a river, continue with human ancestors, and end with the smaller personal self. The indigenous conception of a consensual, communal, nature-based selfhood, so radically different from the European mindset, was the source of many misunderstandings and difficulties from the very beginning of contact.

In 1840, the signing of Te Tiriti o Waitangi (the Treaty of Waitangi) established British kāwanatanga or governorship over the land, while the chiefs retained their rangatiratanga or sovereignty. Under te Tiriti/the Treaty, undisturbed possession and rights over all taonga or treasured resources, material and cultural, land, language, and resource rights were guaranteed. Māori were also granted full rights as British citizens. Yet despite their rhetoric of peaceful cooperation, the British believed it both inevitable and desirable that they would eventually pacify and resettle the natives, appropriating the best land for themselves through military force if necessary, but preferably through the power of purchase and the exercise of British law. There was no local equivalent to Australian and US government practices of forcibly removing indigenous children from their families, however, cultural assimilation was actively employed as an essential policy in the toolkit of

NZ colonial administration. 100 years of Native Schooling helped to 'civilise' the indigenous population, inducting them into European norms and values while simultaneously eroding the intimacy of land, language, and custom in kinship-based communities.

455 Fast-forwarding through two centuries of colonial history and nation building, Pākehā mainstream dominance and Māori marginalisation remains the current reality in Aotearoa New Zealand. The dominant Pākehā group is automatically and unconsciously regarded as good and right and normal, and the corresponding non-dominant Māori group is equally automatically and unconsciously regarded as bad or wrong or problematic. Collective injustice and individual deprivation go hand in hand, operating inter-generationally as
460 cause and effect. Accordingly, Māori are vastly over-represented in all statistics of ill health, including mental health. Nonetheless, mainstream mental health services are still largely geared to Pākehā cultural norms and values. With a 50% Māori census, however, Lucy's hometown is making a concerted effort to develop Māori oriented and pro-Māori services. Iwi tribal services parallel mainstream services. A kuia and kaumātua
465 (female and male Māori elder) have been appointed to liaise with Māori patients and facilitate cultural input and understanding. The new psychiatrist is Māori, the first Māori psychiatrist on the service. Translations of diagnostic labels and treatment plans into Te Reo Māori have begun. Other Māori staff include nurses, social workers, and mental health specialists, small but significant steps on the path to becoming bi-cultural.

470 Colonised and marginalised cultural groups face the loss of ancient traditions central to their identity, undermined by global cultural homogenisation and hyper-dependent consumerism. These same marginalised cultural groups are also disproportionately affected by contaminated local environments and local unemployment created by the outsourcing of jobs in the relentless search for cheap labour. So while one urgent health question concerns the rights of future generation to inherit a healthy and uncontaminated natural
475 environment, another concerns the right of traditional cultures to attain adequate standards of living without being forced to adopt Western models of development that undermine their core values. Lucy and her extended family remain continuously at risk from a mainstream, modern, money-based consumer culture that is all pervasive and extremely
480 seductive in its sales pitch for the good life, yet fundamentally oblivious to Māori needs and aspirations. With most adult men and women now both working in fixed hours paid employment, traditional networks of family-based intergenerational care and responsibility have been largely replaced by a social safety net of public services. Yet these social
485 services are now themselves under attack from a dominant economic ideology that disintegrates social responsibility and devolves social services to a user-pays business model that punishes the poor and those without stable employment.

Lucy's whānau is stretched. Family members struggle to care for themselves and have neither the resources, nor the time, nor the skills to care for Lucy. Lucy is mostly dependent on an overworked, underpaid staff whose day treatment programmes and periodic home visits are a lifeline
490 that have successfully managed many crises and averted several hospitalisations, yet cannot produce the substantial permanent changes needed to ensure her good health. Current social welfare systems invest in expensive and punitive monitoring systems whose hidden cost-containment agenda disallows rather than facilitates service. A decolonised health service would prioritise active partnership with extended family systems. Family consultants skilled in health promotion
495 would assist with the systematic re-building of extended family support networks and would provide family carers with a wage as well as ongoing education and support.

Conclusion

The approach proposed here seeks to bring together and unify psychological, sociological, and ecological perspectives on healthcare assessment and treatment. Ideologically, it is oriented to 'educare',¹⁴ incorporating education and consciousness raising as well as psychiatric and psychological approaches to mental health issues and general problems of living. It seeks to 'think globally but act locally', to be pragmatic and grounded, and to respond creatively when people become stuck in their lives. It assumes the need for adequate resources to ensure basic care as well as skilful intervention. Psychiatric and nursing expertise take their place as part of a larger, more integrated, patient-centred partnership. This partnership consists of collaborative group-to-group efforts, a loose-knit and unruly 'family' of health professionals working closely with patients like Lucy and her extended family. These two groups need to come into relationship and stay in relationship. This is in the interest of doing what works, what is effective and gets results. This paper will have accomplished its task if it has opened a vista, a doorway through which a better world of health and healthcare might be glimpsed.

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Notes on contributor

Dr Jonathan Fay is a Senior Lecturer at Auckland University of Technology and Head of Clinical Services in the School of Public Health and Psychosocial Studies. He originally trained as a clinical psychologist at Duke University in Durham, NC and was for several years a psychiatric unit chief at Elmcrest Hospital in Portland, CT. He has practised psychotherapy for 37 years in the United States and Aotearoa New Zealand. He is a Registered Psychologist, a Member of the New Zealand Association of Psychotherapists (NZAP), and a recipient of NZAP's Distinguished Service Award. He is an Associate Editor and the Reviews Editor of *Psychotherapy and Politics International*.

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