

## Life in a Clinical Diploma Course

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**Ngati Raukawa, Ngati Toa, Ngati Maru, Ngati Tamatera  
Te Whare Wananga o Waikato**

This paper focuses on the author's experience of a Clinical Diploma programme. The author is a Maori woman who is in her second year of a three year post-graduate Clinical Diploma programme. The paper includes comment on the cultural focus of content, culture conflicts and areas where the programme might be improved for Maori students.

As indicated by the title and the abstract, this paper is necessarily personal. However for a Maori student, particularly in an insular programme such as the Diploma of Psychology (Clinical), where we are so few, what happens to one of us has implications for us all. Therefore where I illustrate my korero, it will be with specific anecdotal examples (with the permission of the Maori students concerned), as well as a number of experiences we have witnessed and shared.

I began the Diploma in March 1992 with mixed feelings. On the positive side, I had a vision that if I achieved the Diploma, I would be in a position to best serve the needs of the disproportionate number of Maori people who make up our client population (Durie, 1985). I had the support of friends and whanaunga, and had been awarded a bursary by Justice Department Psychological Services, for Maori students to undergo clinical psychology training.

The negative aspect of entering the programme related to the "mythology" which has developed among Maori people in the Psychology Department about the Diploma course: what happens when students attempt to incorporate a Maori way of working into the clinical methods taught in the curriculum; or how a lone Maori predecessor managed to survive the monocultural nature of the Diploma programme by adopting a "bite the bullet" strategy. The mythology acts to oppress Maori students even prior to entering the course.

The external facade presented by the programme is that efforts towards a bicultural perspective are sincere. The Psychology Department graduate handbook describes the course as being "committed to producing graduates who can function effectively in bicultural human services", and where "topics and experiences relevant to taha Maori and biculturalism will be covered in the training". A Maori person is present on the selection committee, an indicator to Maori applicants that the opinions and needs of Maori are taken into account.

The promise ends there. More than half-way through the three year course, (excluding student input), my year group has had two lectures with Maori content intended by the course co-ordinator (one lecture per year).

The most common ways in which cultural components in the Programme have been fulfilled, has been through the voluntary or involuntary contributions of Maori students. Voluntary contributions were often at times when it was necessary to take the role of "cultural watchdog" over course content and comments made in class; to challenge instances of misunderstanding, ignorance or prejudice implicit in staff members' or students' remarks, in an attempt to protect the well-being of those people's future Maori clients.

Involuntary contributions were made at times when, in the middle of a lecture, one of us would be asked direct questions about Maori, such as "What do Maori people do in this situation?" or "How do Maori people react when they're depressed?" The anomaly of such a question would be obvious if the situation were reversed. We would not consider asking lecturers, "How do Pakeha people react when they're depressed?" We recognise that Tauwiwi are diverse in characteristics, tastes, personal styles, and political orientation.

The intent of a lecturer who asks such questions may well be an effort to acknowledge that there are cultural differences in behaviour. In acknowledging this, and in view of the many Maori people receiving psychological or psychiatric treatment, a lecturer in a Clinical Diploma programme surely owes the subject a more serious consideration than a sudden impulsive curiosity in the classroom setting. Such questions indicate a failure on the lecturer's part to fulfil his or her own responsibilities in researching the areas discussed, and in recognising the importance of addressing for the Clinical trainees, the significance and implications for assessment and therapy these cultural differences hold.

One effect of asking a particular Maori student questions about all Maori, is that it places undue responsibility and pressure on the student asked. A student should not be obliged to be, and can not comfortably assume the role of being spokesperson for Maori. Further, when a Maori student pays her or his not inconsiderable tuition fees, there is no recognition that that student will be obligated to fulfil the role of cultural educator to her or his lecturer and peers.

The deliberate singling out of a Maori spokesperson by lecturers also has an unseen effect on other students who also identify as Maori but do not yet feel comfortable publicly discussing Maori issues or their own political stance, or who feel whakama about their lack of knowledge in these areas. By continuously asking one particular Maori student for opinions about tikanga Maori or Maori manifestations of symptomatology, a lecturer simultaneously publicly identifies these other Maori students present, as lacking in that knowledge.

There is an invisible *mamae* (pain) and *whakama* (shame) many young Maori feel at the loss and ignorance of their own *tikanga*, and the devastation of having, over generations, become alienated from their own *whanau*, *hapu* and *iwi*. The processes of colonisation and acculturation have to a greater or lesser extent affected all Maori. Jackson (1988), Gilgen (1991), Paterson (1992), and others have documented the damage which manifests itself in many Maori who find themselves in the lower ranges of the socio-economic and educational spectrum. What is less well understood is the high price paid in emotional and spiritual well-being of those Maori whose *whanau*, through the processes of cultural and socio-economic "adaptation" and "assimilation", have arrived at the point of *pakeha* "success".

It has been argued that perhaps the primary pre- and co-requisite for Maori to achieve academic success is extreme acculturation. While there are a number of *wahine* and *tane rongonui* who make a lie of that theory, in the case of some Maori Clinical Psychology students, the *mamae* is clearly present. Some students I know have coped by avoiding attention to their Maori heritage, or felt obliged to explain the recent historical circumstances by which they arrived at their self perceived cultural ignorance and alienation; yet others of us become rabidly political and work to bridge any gap between our *whanau/hapu/iwi* and ourselves, to learn *te reo rangatira* if we don't already speak it, and otherwise heal the wounds colonisation has wrought in our identity as Maori. Maynard Gilgen has spoken of the extra, unrecognised stress some Maori students undergo as they attempt to keep up with both their academic workload and their *whanau/hapu/iwi/community* commitments (Gilgen, 1991).

Wherever on the continuum Maori students lie, no matter how we are perceived by *pakeha* staff and fellow students in the programme, Maori students are Maori because our *whakapapa* makes it so. I find it necessary to make this point when I recall first-hand experiences of a Clinical staff member making judgement on the "Maoriness" of another Maori student, or another psychology lecturer in the department asking a student "how much Maori have you got in you?" Such comments and questions speak volumes about the misconceptions held by our *taiwi* teaching staff, about what is needed to "qualify" us as Maori.

I'll turn now from the apparently innocent remarks, attitudes and occurrences which detrimentally affect Maori Clinical students in our academic setting, to the

content and issues of our practical training. This has been unashamedly and uncompromisingly monocultural. An example of the attitude of our primary first year lecturer was the following: "Some people say that to work successfully with Maori clients you have to work with the whole whanau, but that's a load of garbage". Our arguments for a culturally adapted mode of clinical assessment and treatment were responded to by this lecturer with suggestions that if we didn't like the way things were taught in the Clinical Diploma programme, we should "go and join a Maori counselling course".

Despite such comments, and in response to the lack of input regarding non-tauwi cultural styles, the other Maori student in the class and I on one occasion role played a clinical interview with a Maori clinician and client for the class. We employed the interview format we had been taught, but introduced the following obvious differences: we kissed or hongi'd, shook hands and the "clinician" carried out whakawhanaungatanga with the "client" and her imaginary whanau members. Having established whakapapa connections, we were told by the lecturer that the clinician should disqualify herself from further contact with the case. We explained that in many cases, a link between a Maori client and clinician would go far in increasing trust and rapport. The lecturer concerned said "Interesting...". He subsequently informed me that if the model we had demonstrated was used in practice, we would fail the course. On remonstrating, I was told "This is a pakeha programme. We have a set way of doing things".

This was yet another confirmation of the mythology. We knew that a student in a senior year group had been reprimanded by Clinical staff for "wasting time" during an initial interview, by first carrying out whakawhanaungatanga with a client. Whilst viewed in isolation in terms of a fifty minute interview, the time the process of whakawhanaungatanga may take could indeed be viewed (by a pakeha clinician) as excessive. However, in comparison with the possible alternative of a stultifyingly slow establishment of rapport and trust (or with complete failure in this regard), surely even in tauwi terms, whakawhanaungatanga is time well spent.

From the mock clinical interviews we conducted in our first year class, to the experimental component in our second - the years of "placements", the mismatch between my clinical training and the way my puku tells me to behave has increased. We are taught that if a client should tangi, don't awhi, pass tissues! It feels cold, negligent. To act in a professional manner, we must "control" the aroha. Working "under the auspices" of an agency, we are compelled to confine our offer of tautoko to set appointment times.

These rules of professional behaviour undoubtedly sound reasonable to many practitioners. However there is a lack of recognition that many Maori people have a different expectation of the professional manner of a Maori practitioner from that of a pakeha practitioner in the same position. The discrepancy is hard to define. It may consist of a set of subtle behaviours such as differences in tone of voice, a glance, a smile, the way a phrase is expressed, comfort and familiarity with a cultural style. The establishment of trust and rapport with a Maori client are based on such subtleties. And the growth of these elements is dependent upon active caring, interest, follow-up: on "walking the talk".

The Maori trainees' placement supervisors have commented on that "indefinable something" which occurs when we interview our Maori clients. They call it "a connection", "a bond". Catherine Benland might call it the "S-factor - taha wairua". (Benland, 1988). One of our trainees has recounted that while she was observing her placement supervisor conducting an interview, the Maori clients replied to her. Regardless of whether such experiences are gratifying, mystifying, or embarrassing to us as trainees, we are well aware that in response to the greater trust and openness our Maori clients show us, we in turn have a greater responsibility not to betray that trust, and the expectations which underlie it. For those trainees who fully acknowledge the role that colonisation has played in

rendering them incapable of delivering their services in the culturally appropriate manner expected (if indeed that is possible), this discrepancy causes great anxiety.

A Maori trainee currently working as an intern in a public institution, relayed to me her feelings of inadequacy and fear upon being approached by Maori mental health workers there. They expressed relief that finally there was a Maori psychologist to whom they could refer their many Maori clients. The trainee, feeling that she could not fulfill their expectations, yet too whakama to tell them, avoided further such requests, and they are no longer forthcoming. She says she feels ashamed, and that the experience has increased the pressure in an already difficult year. She intends to develop her knowledge of tikanga Maori, but says "...I can't devote time to learning what I need to do to get the job done properly".

Glover (1992) has noted that working in a monocultural way with clients not belonging to that culture, is contrary to the Psychologists' Code of Ethics. Psychologists throughout Aotearoa (eg. Awatere, 1981; Durie, 1984, 1985; Abbott & Durie, 1987; Jones, 1993) have for years been publishing their recognition that things must change.

It's an outrage that in 1993, learning sensitive and appropriate ways to work with our Maori clients should still be an extracurricular activity to a Clinical Diploma course; one which those students with conscience and good-will are forced to pursue over and above their tauwiwi Clinical training. It's inconsistent that within the same course we are distributed such worthy articles as Abbott and Durie's (1987) "Whiter shade of pale: Taha Maori and Professional Psychology Training", while simultaneously being prohibited from attempting to develop our own clinical methodology and style. It's interesting that of six Maori students enrolled in the Diploma of Psychology (Clinical), only three (thus far) are progressing according to the prescribed route.

While this situation exists in a Clinical Diploma course, Psychology continues to act to oppress both Maori clients and those of us who hope to work with them. The cultural and professional arrogance referred to by James Ritchie in the recent NZPS Bulletin (Ritchie, 1993), are alive and well, and it is Maori who suffer.

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