The Development and Evaluation of a Cultural Competency Training Programme for Psychologists Working With Māori:

A Training Needs Analysis

A thesis

submitted in fulfilment

of the requirements for the degree

of

Doctor of Philosophy

at

The University of Waikato

by

WAIKAREMOANA WAITOKI

(Ngāti Hako, Ngāti Mahanga)

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

2012

Abstract

The purpose of this study was to develop and evaluate a cultural competency training programme for clinical psychology students to work with Māori consumers. A pilot programme (study 1) was developed from the international and national cultural competency and bicultural training literature. Following the pilot, it was identified that the programme could be made more robust by conducting a second study; the *training needs analysis* using the *critical incident technique.* Study two was conducted with 30 experienced clinical psychologists who had worked with Māori clients.

The training needs analysis sought to identify the awareness, knowledge and skills (AKS) that the experienced psychologists used in their practice with Māori. An unexpected finding from study two was that the psychologists used distinctly Māori-cultural practices, incorporating Māori tikanga and Māori knowledge with their clients even though they had little or no bicultural course content in their clinical training. The data from the pilot programme and the training needs analysis were used to refine the final workshop.

The workshop was delivered to two university sites over a two-day period using intern clinical psychologists. The programme evaluation had three components: (1) analysis of pre and post programme questionnaires; (2) analysis of the retrospective questionnaires; and (3) an analysis of a participant's case report on a Māori consumer.

The themes that evolved from this research are that the critical incident technique is a useful way of identifying bicultural training material that would otherwise go unnoticed. In relation to training evaluation, there is a real need to develop meaningful measures of bicultural competency acquisition for clinical students. The findings advance the proposition that a distinct Māori psychology exists that could potentially challenge the relevance of Western psychology for Māori.

A contextual theme underpinning bicultural training programmes is that training and practice occurs against the backdrop of Pākehā dominance in all

aspects of academia and society. Consequently, there is a need to find a balance between Māori and Western psychological knowledge. Future uses of this research will be in developing and evaluating bicultural training programmes, developing appropriate measures of cultural competency acquisition and assessing the potential for a distinct Māori psychology.

Ko Taku Mihi/Acknowledgments

E nga tini kua rere ki tua o te arai, e takahi ana i te marae o Hine-nui-te-po haere, haere, haere atu ra. Ki ngā kanohi ora, karanga mai, karanga mai.

I want my family and others to know that I have not forgotten the support they have given me. Ehara taku toa i te toa takatahi. He nui te aroha e pūmau tonu ana, e kapakapa ana mo koutou.

Main Cast: Ko Taku Whānau

Ko taku rau karamea – ko Alex. Previously appeared in 'the Masters Thesis', 'the PGDipPsych' and 'the Bachelor' degrees. *Me he pūtangitangi au, ka rere ake noa* – ka pūmau taku aroha mo ake.

Ko aku kōtiro ataahua – ko Joni, ko Wini. Also appeared as child-stars in the other degrees. Mau enei mahi mai te timatanga, kua tupu korua hei wahine purotu. Ko taku tama – ko Punua i tae mai koe i waenga i aku mahi hei hononga mo tātou, hei taonga moku.

Supporting Cast:

To my brothers and sisters – Neil, Stephen, Kevin, Korina, Davina, Alina, Nardine and my sister-in-law Donna, (and my nephews and nieces) you were there in spirit and in person and you remind me that life is about whānau, even if they are a handful sometimes, I love you all. Ko taku whānau tuarua – ko Mania, ko Mihi, he mihi kau noa ki a korua mo te tautoko mai i a mātou. To Alina, thank you for your time in the early days.

My friends: Juile, we started together when we were solo mothers living in Huntly and you are always in my thoughts. To Erana – those phone calls and mad emails. Ki aku hoa pūmau: ko Rose (and Brian) for the whare, kai, and the final hurdle at the end, ko Bridgette raua ko Hoani (me ngā tamariki ataahua) kia ora mo te tū hei pou tautoko mōku, kei reira korua i ngā wā katoa.

Ko Michelle (you and your global jaunts), thank you for begin there and reminding me how special friendships are and that they stand the test of time. To Lisa, who was climbing with me in the last few hills singing along

with Stan Walker. To Pip, you are an amazing woman. If I hadn't travelled to Otepoti to a marae in the middle of nowhere, I would not be calling you my friend. To Mel he mihi aroha ki a koe, just for being so full of life, laughter and kind words.   To Andrew, my new friend and karate-ka, thank you for your support and encouragement.

The Directors: Ko Nga Amorangi – The Academics

To Neville Robertson – humble and supportive, I know I dragged it out but you stayed with me to the end, thank you. Jane Ritchie – I am immensely proud to call you my supervisor, your quiet strength is inspirational. You were dad's lecturer in the 70s, mine in the 21st century. Ko Averil Herbert – he wahine manawa-nui, he wahine maia. Ko Catherine Love, always a role-model for me, always an inspiration to do better.

Linda Smith – thank you for taking time out of your busy life to sit with us as students and do your best to help us get through. To Paul Taylor – who just happened to read my ethics proposal and gave me hope and direction. To Ray Nairn, thank you for coming in at the eleventh hour. You are a kind and gentle man and I cherish my friendship with you.

The Producers: Ko Ngā Putea Tautoko

Ngā Pae o te Māramatanga, Tainui, Māori Education Trust, Hauraki Māori Trust Board, Ministry of Health, and Te Rau Matatini - Henry Rongomau Bennett Scholarship, nā ēnei roopu te pūtea tautoko.

Technical Support: Ko Ngā Hapai ō Ki Muri

This thesis would have no substance if not for the co-researchers, participants, the students, psychologists, and academic staff who provided me with access, support and encouragement. Ko ngā kaiwhakahaere o te tari o Mai ki Waikato: Joseph, Kirsten and Krista kia ora rawa atu. Thank you also to Jane Rangiwahia from Ngā Pae o te Māramatanga. Cultural Support and Advice: Mate Webb ka mau te wehi.

Stunts: Ko te Mahi Hākina

To all the karate-ka who love karate, *"Because it is better to sweat in training than to bleed in battle".* To Sempai Pete Barnard - osu, the spirit of perseverance. To the Mas Oyama Kyokushin Karate organisation, osu.

Musical Score: Stan Walker for 'the climb' and Amy Winehouse, moe mai ra e te wahine ki nga ringa or Hine-Raukatauri.

Disclaimer: Hei a wai te mana whakatika

No participants were harmed in the making of this thesis. All depictions are based on actual events. The researcher and probably the institution as well take full responsibility for the outcome of this research.

Mo taku māmā – moe mai ra. Mo taku papa

Mo taku mokopuna ko Mātangireira me ngā uri whakaheke.

Table of Contents

List of Tables

List of Figures

List of Appendices

Prologue

Positioning Statement

As I was growing up I wondered why people were treated differently from others. I didn't know at the time that it might have been to do with being Māori. Growing up in Putaruru and attending Oraka Heights and then the Catholic school of St Mary's, I noticed that some people were kind and others looked at me like there was something wrong with me. Whether it was the occasional school teacher, dairy owner, or policeman, the look was there, and I could not understand why.

When we moved to Hamilton it was the same. Not everyone was like that, but it happened enough through school, sports, and everyday life for me to think to was normal. As I got older I realised it was because I am Māori. The message was an explicit, inescapable fact.

My father wanted his children to be Europeans. We were not allowed to be Māori or to tell others we were Māori. When our maternal grandmother passed away, the six of us kids were taken to the front of the wharenui to pay our respects; we saw our mother cry, and then we were put back in the car to wait. We were only there for one day.

Thinking back, the way we were forced to not be Māori started my silent, but increasingly open dissent. You cannot go against a powerful father when physical punishment was the mechanism for obedience so without his knowing, I did the exact opposite.

My other memories of not being allowed to be Māori:

On school forms:

> Dad: "When you have to sign any forms at school that ask who you are, you are to write down that you are European". I didn't listen. For some reason, I knew it was wrong, I did not want to be Pākehā, I wanted to be Māori. I was proud to be Māori, My mother was Māori that was good enough for me.

On Māori language while I was in intermediate school, aged 10:

> "You are to drop the Māori class at school. Take French". I didn't drop the class. Dad asked how I was doing at French. I said "good".

On playing with the Māori neighbours:

> Dad: "Don't play with those kids next door". It was not easy because we went to school together, and they were cool. My sister and I got caught talking to the neighbours. We thought it would be ok because they sat on their side of the grass, and we sat on ours. Technically we were abiding by the rules. Dad didn't think so. He took us inside and tried to punish us with 'the belt'. I said "no". He still hit us, but it was the last time the belt was used.

On work, housing or walking into shops:

> It might be cultural paranoia, but I knew it was because I am Māori that I didn't get the nice house on the Pākehā side of town, or the job that the Pākehā girl also applied for, or that I am often followed or ignored in shops.

There were side-effects for me; I was suspended from intermediate and high school and eventually expelled. After a few years of drifting I had children. The real change came when they started kōhanga reo and I was exposed to a part of my identity that was previously suppressed. I studied Māori at night school, then Ātaarangi at Polytech, then to university, which was where I was bound all my life, as both my parents attended university.

When I began psychology and I learned that the voice of Māori sat in silence, I began to ask questions, as did others. The powerful Western culture and the Pākehā worldview of superiority over Māori was there in the way it taught me that psychology was better than other helping professions because it used science; a science that was objective, valid and above cultural constraints.

I was lulled into accepting that worldview as a way of helping Māori; I did not see that it was another form of cultural oppression, as the damage to my thinking had been done over many years. While I questioned and argued for

the inclusion of Māori content into what I learned, I was missing a vital element that made a real difference for Māori.

This research nearly became a standard clinical study with the typical, detached language common to other scientific studies. It was the way I was trained to speak, the voice of Pākehā knowing and authority. This style was all I knew.

But against that, my voice as Māori and what that means for me, my family and for other Māori had to come through.

I read Catherine Love's thesis written in the late 90s part way through my research and realised that I was wearing Western glasses to a greater degree than I realised. I thought I challenged the legitimacy of psychology in my work as a psychologist and a lecturer. I had challenged on one level, but I had missed the voice that said "look at your research, does it help Māori? What are you doing?" I was no different to the oppressor.

How embarrassed, but relieved am I now to be able to rid myself of the clinical voice; the clinical voice that showed a captured-mind. While I challenged Pākehā and Western values in psychology, I accepted those values as valid for Māori, and would have legitimated the use of mātauranga Māori for clinical training programmes because I thought I was doing the right thing for Māori.

I no longer agree that Western-psychology is valid for Māori as long as it has bicultural elements. It can be useful, but only if Māori have picked it apart using their methodologies and taken what is useful to them. My friend and psychologist Siautu Alefaiao said that she was told by some friends who are Samoan nurses, and healers in Samoa, *"…that the westerners go in and do some training with our people, and when they leave, our people take what they want from it, and discard the rest"*.

The missing element in my thinking was that psychology for Māori cannot be controlled by Pākehā and applied to Māori; it is for Māori to choose what we want and on our terms.

In conclusion, my father was a product of his time and I understood that. Somewhere he decided he had to let his family be who they wanted to be. Towards the end of his life he studied Māori language which was something he was very proud of. He was fiercely proud of his grandchildren who were raised in kōhanga and kura kaupapa Māori, and he also enjoyed te reo lessons delivered by his 4-year-old grandson. He changed his name from Richard to Rihari. It took him 40 years to figure out that all he needed to do was let us be Māori and we would do the rest.

Rebecca

I want to share with you a story about a woman that I worked with who wanted help from the local mental health service. Her cover name is Rebecca.

I was working as a clinical psychologist in a mental health service and part of my role was to do urgent assessments for inpatient clients. I received a request to assess a woman who specifically wanted to work with a female, Māori psychologist. At that time, I was the only such person in mental health in the region. I read her file and was appalled, fascinated, and apprehensive. The admission notes said that Rebecca had been picked up overnight by the Crisis Assessment Team (CAT and that she had barely slept for nearly two weeks. She had been taken to hospital in a state of extreme agitation, she was verbally abusive and she had hit a staff member. Rebecca was placed in a Limited Stimulus Area (LSA) where she settled within 10 minutes.

The attending psychiatrist noted that Rebecca was wearing a combination of colours which he deemed "inappropriate" and that she had symbols drawn in lipstick on her body. He described her as violent, paranoid, and delusional because she re-enacted her dreams as a means of exorcising them, and because she was convinced her gang-related neighbours were out to get her and a close relative. She was diagnosed with Bipolar Affective Disorder, possible Delusional Disorder and Post-Traumatic Stress Disorder (PTSD). I met with Rebecca a few weeks after her release from hospital.

Rebecca was a beautiful woman. She was cautious, suspicious, hopeful, and she was damaged. I wondered if the psychiatrist had read her earlier file as she had a history of hospitalisation. The diagnosis of PTSD suggested that

some attention was paid to her past experiences, but not enough. How could he understand a story about an abused Māori girl who grew to become an abused Māori woman? The psychiatrist said she was delusional and paranoid because of her choice of clothing, the symbols on her body, paranoid thinking and her attempts to exorcise her dreams.

Rebecca had chosen colours particular to Māori of red, black and white; the symbols were for her protection. In childhood Rebecca had experienced sexual abuse by a family friend; as a teenager she was sexually assaulted by her sister's boyfriend, and as an adult she experienced a horrific gang-rape. Of the rape, she only remembers the beginning, and then waking up in a mental health hospital days later with injuries to her body. Rebecca had also lost a child at 32 weeks gestation.

The trigger for Rebecca's admission to hospital was that she had spent several weeks travelling to various marae and getting very little sleep in response to political and public infighting within her prominent tribe. The media had used the opportunity to report negatively on her iwi which caused her significant distress. Other stressors were that gang-members had moved in with her friend next door; her cousin had brought a known sexual offender into her home; her relative was actually being sought by gang-members; and in her opinion, her brother had deserted the family by joining a religious group who denounced Māori cultural practices and values.

Rebecca knew that her behaviour signalled a need for help. She asked the CAT to admit her to hospital but they refused and told her "to wait until it got worse". When she did get worse and was admitted to hospital she was angry that they had ignored her requests for help. If she was experiencing a Bipolar episode, she would not have settled in less than 10 minutes without medication.

Rebecca epitomises the importance of cultural competency for Māori. Her life-story featured episodes of abuse from friends, family, and the mental health system. She should have been helped when she was first admitted to hospital. Why was she left to suffer on her own for so many years? My review of her case notes found repeated instances of institutional racism that

so often plague Māori; it had also prevented her from reaching her full potential.

Years later I prepared a powerpoint presentation about Rebecca for a training programme. My 10 year old daughter happened to read the details about the colours that Rebecca wore. She commented, "Those are the colours of Waikato Māori. Why is she doing that?" Why was that feature of Rebecca's distress obvious to my daughter, but not to anyone else in the mental health system? All those professionals, all that training...

Would a good cultural formulation framework have identified the impact of culture on Rebecca? Will training this generation of clinical psychologists in cultural competency prevent future abuses of other Rebecca's? Whenever I do cultural competency training I talk about Rebecca. Her story provides the perfect backdrop to considering why socio-political histories and issues are relevant; why knowledge about Māori family structures is important; and why knowing about marae, hapu, and iwi is important for many Māori.

When I tell students they need to know that religion is important in client's lives, they shake their heads knowingly, until I tell them about Rebecca. Her brother was the eldest male destined to take over from his father as an orator on the marae. His rejection of Māori culture for an intolerant religion was a significant blow to the family's standing in the community. When I tell them Rebecca's story, they can see why they need real understanding, not intellectual understanding.

Students or psychologists ask "what is the point of knowing about socio-political histories?" When that happens, I point to Rebecca's experiences. She reminds me that Māori have different ways of thinking and behaving and that if psychologists really understand the importance of difference they can potentially avert damage to clients. Psychology as a profession has to step outside its cultural tower and look at alternative Māori explanations and possibilities. My research goes towards helping to delineate those possibilities.

I return to Rebecca later.

Thesis Outline

This thesis relates to the education of clinical psychologists in Aotearoa-New Zealand who work with Māori. In **chapter one** I begin by outlining the position of Māori in psychology as consumers, the context for bicultural action including Te Tiriti o Waitangi/The Treaty of Waitangi, and breaches to Te Tiriti/The Treaty and their impact on Māori health. I use a metaphor of weaving a whariki, or mat to describe my thesis journey.

In **chapter two** I describe the genealogy or whakapapa of clinical psychology in North America and Aotearoa/New Zealand and highlight the events that led to the creation of clinical psychology training. I describe the scientist-practitioner paradigm underpinning clinical training and show that despite the lack of research in culturally diverse populations, Western psychology has maintained its dominant position.

In **chapter three** I show that despite the intended influence of biculturalism, psychology does not recognise its cultural origins because academic leaders, who represent the dominant values of society, set the rules about how psychological knowledge should be explored, explained and validated. I describe the influence of cultural safety theory, the Code of Ethics and the Health Practitioners Competency Assurance Act (2004). I construct a standing place for the views of minorities, persons of colour and indigenous peoples. The whariki incorporates the cultural competency literature from North America, Australia and the Pacific and provides hue and form to my thesis; it is another view, another challenging voice.

Chapter four is where I start to detail the education of psychologists in Aotearoa and provide an analysis of how clinical psychology has not been successful in its limited efforts to incorporate biculturalism because of cultural blindness. I highlight how clinical psychology contributes to the marginalisation of oppressed peoples through its historical ties to psychiatry, and through the global dominance of white, middle-class, values systems. I explore how training programmes in Aotearoa have fared in the past 30 years and show that psychology as an academic discipline has tended to ignore the legitimacy of a Māori worldview and in doing so, failed to prepare

students to work effectively with Māori. For the first time in my academic history I reflect on kaupapa Māori theory and principles and its challenge to hegemonic practice within academia. My own views on kaupapa Māori and what that means is broadened as I link psychology and kaupapa Māori principles. The reader will note that I am still coming to terms with the terminology, definitions and applications.

In **chapter five** I explore ways of identifying if a student is culturally competent. I want to move beyond accepting the standard response that a student will consult with an advisor if they have a Māori client. The literature provides compelling evidence that a cultural case formulation is a good measure of cultural competence.

In **chapters six** I outline the method used for the pilot programme, followed by the results. The students who participated in the pilot programme were trained and then evaluated. They also evaluated me as the trainer. Their stories have been woven into the thesis, but the shape started to warp. I moved over the warp and tried to weave a different design. The warp I skipped over began to pull the threads, creating tension. I also found what was missing. The voice of experience from psychologists who worked with Māori was painfully absent, so I set about finding ways of including them.

Chapter **seven** is where I examine the contribution that organisational psychology can make to clinical training. Here I find that the disciplines work independently, unlike the tuakana/teina (older/younger sibling) relationship that permeates Māori culture. I was surprised to see that clinical psychology did not use the insights and experiences that underpinned training programme development and evaluation within organisational psychology

In **chapter eight** I describe organisational psychologists' method of conducting a training needs analysis to identify what experts/tohunga say should be included in a training programme. I consult with experienced psychologists and asked them to describe the typical tasks they performed with Māori clients. Their responses showed that they practiced differently with Māori clients than with non-Māori. I had to know exactly what they did

because their responses were going to contribute significantly to the final training programme.

The psychologists told me the most amazing stories of how they worked with Māori. Some psychologists did the best they could as I knew that they had not had any previous culturally based training; others were inspirational. Their stories were spun to create a new thread that enabled a Māori worldview and a Western psychological worldview to sit together in a training programme. The experiences of those psychologists who worked with Māori also produced complex processes that created a warp in the thesis.

Western psychology has always woven its own mat, often from incomplete or stolen threads. When mistakes are made, rather than unpicking the mat and examining its mistake, psychology moves over it and weaves in a different way, or location. The tension I had created earlier kept pulling the thesis out of shape. Mātauranga Māori or Māori psychology was the thread that pulled as karakia, whakawhānaungatanga, te reo, mihimihi, and pōwhiri all demanded a place in training. Other ideas came forward: power sharing, accepting client challenges, and modifying Western psychological practice. I used them all in the final training programme. There were challenges along the way.

In **chapter nine** I search for the best way to evaluate a training programme. Once again, I borrowed from the organisational literature using an augmented model based on thoughts, feelings, behaviour, and intention. I needed to know that the participants had learned the material I taught and that they used it in their practice.

I describe how I ran the final programme and evaluated the students' learning. I used pre and post questionnaires, and a follow-up questionnaire that looked at what the trainees' believed about themselves prior to, and after training. I have one case study that a participant kindly provided despite asking for thirteen. I examine his ability to conceptualise cultural dynamics that may impact on Māori clients. Although he did not demonstrate the required competency, his attitude and manner in the

workshop showed me that with more training, he would not have allowed Rebecca to suffer as she did.

In **chapter ten** I conclude my thesis by discussing how my research supports previous arguments that psychology has an obligation to teach students to work with Māori. More importantly, the content of that teaching needs to reflect the core values of Māori knowledge and not simply be window dressing. Training clinical psychology students needs to be well constructed, and power sharing and respectful partnership mandatory for the discipline to be useful to Māori. Psychology training should show the strength of its design, as Māori do not deserve to be given the straggly bits of a mat that falls apart as soon as a client like Rebecca walks in the door.

CHAPTER 1: THE MĀORI EXPERIENCE

Māori and Psychology in Aotearoa/New Zealand

I do not advocate for the Natives under present circumstances a refined education or high mental culture: it would be inconsistent if we take account of the position they are likely to hold for many years to come in the social scale, and inappropriate if we remember that they are better calculated by nature to get their living by manual than by mental labour, (Henry Taylor, a school inspector in 1862, (Smith, 1999, p. 6).

Aotearoa-New Zealand's indigenous population

The question is often asked "why should Māori get special treatment?" Māori have been denied the right to equality in Aotearoa/New Zealand since Pākehā gained control of Aotearoa. Henry Taylor's comments reflect an attitude towards Māori that is still seen today. Why Māori should get special treatment is enshrined in Te Tiriti o Waitangi/The Treaty of Waitangi, and because the status of Māori as an *indigenous* group marks the need for special treatment.

The United Nations Declarations on the Rights of Indigenous Peoples was adopted by the General Assembly in 2007 following many years of heated debate. The debate reflected the long memory of indigenous peoples globally of being subjected to definitions imposed on them by colonising peoples and resistance to the notion that a scientific concept could be applied to all indigenous peoples. What was apparent, however, was the need for a working definition of indigenous. To that end, the UN and indigenous representatives[1] agreed on the definition proposed by Martinez Cobo, the

---

[1] The indigenous representatives are listed in the 1996 report of the Working Group (UN Doc. E/CN.4/Sub.2/1996/21). They stated: "We, the Indigenous Peoples present at the Indigenous eoples Preparatory Meeting on Saturday, 27 July 1996, at the World Council of Churches, have reached a consensus on the issue of defining Indigenous Peoples and have unanimously endorsed Sub-Commission resolution

Special Rapporteur in his 1986 report on discrimination against indigenous peoples:

> Indigenous peoples, communities and nations are those which, having a historical continuity with pre-invasion and post-colonial societies that developed on their territories, consider themselves distinct from other sectors of societies now prevailing in those territories or part of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system (Department of Economic and Social Affairs, 2004 pg. 4).

The core principles of the Declaration reflect values of self-determination, self-identification and the recognition that states have an obligation to alleviate the suffering imposed on indigenous peoples though colonisation. The same principles are evident in Te Tiriti/The Treaty.

New Zealand, under the Labour Government, along with Australia, Canada and the United States initially voted against the adoption of the Declaration. In 2010, Aotearoa/New Zealand, under the National Government, voted in favour of the Declaration although the Prime Minister publically stated that it "will have no practical effect" (Webpage newspaper, Young, 2010).

Te Tiriti o Waitangi/The Treaty of Waitangi

Perhaps the single most contentious document that unites and divides Aotearoa-New Zealand across government departments and educational institutions is Te Tiriti o Waitangi/The Treaty of Waitangi. Te Tiriti/The Treaty was signed by agents of the British Crown and a relatively small

---

1995/32. We categorically reject any attempts that Governments define Indigenous Peoples. We further endorse the Martinez Cobo report in regard to the concept of *indigenous*".

number of Māori chiefs who were not representative of Aotearoa-New Zealand Māori tribes and hapu (Orange, 1996).

Te Tiriti/The Treaty was an attempt by the English to settle mounting Māori grievances towards Pākehā and to prevent French, or other international interests gaining a foot-hold in Aotearoa-New Zealand. Two language versions of Te Tiriti/Te Treaty were written – Māori and English. Māori chiefs/rangatira at the time, signed a translated version of an imported English Treaty that used Māori terms that had different interpretations to the original document.

Te Tiriti/The Treaty represented a constitutional relationship between the Crown and Māori that outlined the duties and obligations of both parties. In delegating limited authority to the Crown (stewardship), the Treaty of Waitangi guaranteed Māori sovereignty (governance) or chieftainship over their lands, their settlements and all other property, self-determination, and equality with the British (M Durie, 2003; Orange, 1996).

Māori believed that they were to retain full and exclusive rights to their land, cultural expression and taonga, self-governance and self-determination. Māori also thought that they were allowing the Crown to govern Aotearoa-New Zealand as stewards, not as owners. The Crown on the other hand promptly set about acquiring vast tracts of land by stealth, deceit, and fraud which it then sold to Pākehā. Māori were left landless and poor and with that came low economic, social and health status compared to Pākehā.

Breaches to Te Tiriti o Waitangi/The Treaty of Waitangi

Within a few short years after signing Te Tiriti/The Treaty, it became apparent that Māori were significantly disadvantaged in relation to Pākehā. The reality was that Māori suffered land loss, cultural alienation, poverty, unemployment, and low levels of education. Indeed, it has been argued extensively that poor health, education and income levels are the result of breaches to Te Tiriti/The Treaty (Awatere, 1984; Lawson-Te Aho, 1984; Walker, 1990; Durie, 1994, Durie 1998, Durie, 2001).

Māori have a long history of protesting injustices towards them as indigenous people (McCan, 2001; Tau, 2008). Successive governments have attempted to redress injustices toward Māori, but these attempts were limited and had little effect (Hill & Bonisch-Brednich, 2007). A renaissance of Māori rights beginning in the 1970s gained considerable momentum and Pākehā became more aware of Māori grievances (Belich, 2001; Walker, 2004). Fantasies of racial harmony and of New Zealand having the best race relations in the world (King, 2003) were seriously challenged. There was a 'national myth' of 'ideal' reciprocal tolerance between Māori and Pākehā and a belief in enlightened official policy with regard to the Māori (Hill & Bonisch-Brednich, 2007).

Since 1840 Māori being meant marginalization of tāngata whenua/people of the land in their own land. With both Māori and Pākehā protesting human rights and Te Tiriti/Treaty breaches, the Crown had to do something to address the injustices. The position of Māori had to change for the benefit of Aotearoa/New Zealand society. Renaissance for Māori was not a passive exercise as Māori had to determine what they needed to live as Māori and to begin the process of reconciliation. Māori wanted compensation for state appropriation of their resources and suppression of Māori politically and culturally.

The Pākehā response to Māori protest was largely negative. The media portrayal undermined the legitimacy of Māori grievances and positioned Māori as activists, terrorists, lazy, wanting hand-outs, dole-bludgers, thieves, uneducated, and racist towards Pākehā (Phelan & Shearer, 2009). Walker, (2002) views the role of the modern media as "supporting the hierarchy of Pākehā domination and Māori subordination" (p. 218).

Māori and indigenous peoples worldwide are engaged in an uphill battle when the media is used to minimise and re-present their claims for self-determination as Māori activism. As Smith (2006) commented,

> Māori people are socially and economically disadvantaged in New
> Zealand and as a people are constantly vulnerable to the attitudes,

perceptions, judgments and moral panic of the Pākehā majority (p, 4).

The consequence of media depictions of 'other' as problematic and threatening perpetuates the marginalization of Māori and non-dominant ethnic and cultural groups and contributes to Pākehā apathy towards Māori grievances. The attitudes that underpin social constructions of Māori stress the need for cultural competency training and also underlie the reasons such programmes often do not work.

Māori and access to health services – the Tohunga Suppression Act

There are mixed views about the health status of Māori prior to Pākehā contact. Durie (1998) stated that Māori life was a struggle, health standards not exceptional and that Māori did not have superior health prior to Pākehā contact. On the other hand, Lange (1999) concluded in his thesis on infectious illness in the pre-treaty period, that Māori had good physique, tall stature, good teeth, and lived to a reasonable age, indicating a healthy people who lived in isolation from disease-causing micro-organisms.

This is not to say that Māori were without illness, as infectious diseases were present. However, Māori were very familiar with illness prevention and used efficient waste systems and cleaning routines (Lange, 2009). Equally important were the use of esoteric mechanisms such as tapu and noa to engage in sanitisation practices during childbirth, menstruation and death ceremonies (Durie, 1998; Lange, 1999).

Māori also had experts who fulfilled the role of religious counsellors, doctors, artists, psychologists, nurses, midwives, and educators. These experts were called tohunga and were critical to the well-being of their people. A close, reciprocal relationship developed where tohunga were ascribed with authority, but were also committed to meeting tribal expectations. Tohunga also had the advantage that they spoke Māori, shared a Māori worldview and underwent rigorous training over a period of several years, sometimes over a lifetime (Metge, 1976, cited in Dow, 2001, p. 41).

The tohunga was an expert in his/her craft which included for example, the arts, education, spirituality, healing, architecture, navigation, ornithology, and botany. Healing tohunga were considered more than the counterpart of Pākehā faith-healers and practitioners of folk healing. With the impact of introduced diseases Māori turned to their healers, who were mostly unable to deal with the rampant effects of influenza, whooping cough, dysentery, typhoid fever, measles, tuberculosis and venereal diseases. In many cases Māori had no choice as they were refused treatment by Pākehā doctors (Dow, 2001; Lange, 2009).

Notable Māori physicians (Dr Maui Pomare, Dr Peter Buck/Te Rangi Hiroa[2]) trained in Western medicine were deeply concerned that tohunga were using dangerous practices to cure widespread disease (e.g., dipping in cold water, prayers, herbal medicines) and that some tohunga were simply charlatans. There was also a concern that Māori were presenting to the doctor or hospital when it was too late, often after seeing a tohunga.

In 1903, Apirana Ngata took part in a general conference of the Horouta Māori Council where the first tohunga licensing system was written (Lange, 2009). The system was designed to distinguish the competent practitioners, known as herbal tohunga from those who caused harm. In spite of the system prepared by Māori, the Government passed The Tohunga Suppression Act,[3] 1907 ("Tohunga Suppression Act," 1907). There was no real attempt by the government to distinguish good practitioners from fake ones.

Pākehā 'practitioners' were not included in the Act (Voyce, 1989). For some, the Act was designed to protect Māori from 'quackery, or prevalent bastard tohungaism' (Ngata, 1907, cited in Dow, 1999, p. 51). In fact, Pākehā were

---

[2] There were also female, Maori nurses who worked to improve Maori health. There is very little mention of their contributions.

[3] The Act was sponsored by Maui Pomare, Apirana Ngata, and Te Rangi Hiroa (Durie, 1994).

opposed to Māori regulating their affairs and were concerned about the potential for Māori activism (Durie, 1994).

For Maori, the Act prevented tohunga from managing the effects of disease and addressing the number of Māori who were refused treatment by Pākehā doctors and nurses, particularly in rural communities. The Act eliminated Māori healing knowledge by imposing a Western-standard of medical knowledge, and relieved Māori of their lands (Durie, 1999a; Lange, 1999, 2009). It also served to criminalise tohunga who gathered Māori in large numbers thus providing the Government with an excuse to seize a Māori prophet of the time, Rua Kenana (Durie, 1994; Kiro, 2000; Lange, 1999; Voyce, 1989).

As a messiah, Kenana posed a serious threat to Pākehā as he promised that Pākehā would be purged from Aotearoa (Durie, 1994)[4]. Rua was arrested and charged with "using moral resistance against the police" (Durie, 1997, p. 35). Kenana's arrest is an example of Pākehā legal contradiction and double standards as his religious beliefs and dreams of freedom for an oppressed people were not that different from Christian prophets.

Despite the supposed good intentions of the legislation, the fact remained that Māori were either unwilling, or unable, to utilise Pākehā practitioners or medicine because they had been refused service, and that Māori found hospitals alienating and unintelligible (Turbott, cited in Lange, 2009, p. 330). When Māori were trained in the Pākehā system and registered as nurses there were discouraged from treating Māori because of a concern that they would not be objective (Durie, 1998).

The Act came directly after Māori attempted to manage their own affairs and destroyed much of the knowledge Māori had about healing, forced Māori healers underground, discredited competent practitioners and suppressed

---

[4] In 1800 there were 150,000 Maori. By 1901 Maori numbered 43,143 and Pakeha numbers at 772,719 (Pool, 1990, cited in Durie, 1994, p. 37).

Māori calls for equality (Durie, 1994; 1999). Perhaps it might have been more prudent to outlaw refusing to provide medical care to anyone in need.

The historical and contemporary relevance of the Tohunga Act relates to the socio-political motives that serve to maintain Pākehā dominance over Māori under the pretext of improved health for Māori. Coupled with 'better health' is the mistaken belief that Pākehā healing practices are superior to Māori. While there is no doubt that medicine has advanced exponentially since the 1900s, it appears that Māori worldviews and knowledge about healing were not considered as potential contributors to that knowledge base.

Barriers Māori currently face to accessing equitable health opportunities, and achieving self-determination mirror some of the issues faced last century. From a cultural competency perspective, training content should include an analysis of social and political power dynamics that influence the development of legislations that impact on the physical and mental health of Māori (Cooper, Rickard, & Waitoki, 2011).

Mental health

Māori mental health statistics show a disheartening trend when compared to non-Māori. Māori are more likely to experience barriers to treatment such as: delays; treatment often has little relevance (focus on symptoms rather than cause); and there is no comprehensive cultural assessment (Pitama, Robertson, Cram, Gillies, Huria, & Dallas-Katoa, 2007). There are also restrictive entry criteria; Māori have limited choice about psychological intervention or medication; Maori are more likely to have prior psychiatric inpatient treatment than non-Māori, Māori are more likely to experience misdiagnosis and multiple diagnoses; and Māori have the highest suicide rates (Durie, 1999b; Dyall, Bridgman, Bidois, Gurney, Hawira, Tangitu, & Huata, 1999; Ferguson, Collings, Blakely, & Allan, 2005; Ministry of Social Development, 2009).

Research conducted from 1990-2003 showed that Māori admission and readmission rates to hospital were higher than non-Māori for schizophrenia, affective psychoses and alcohol-related problems. Non-voluntary admissions

for Māori were double than those for non-Māori (Dyall et al., 1999; Gaines, Buckingham, Eagar, Burgess, & Green, 2003; Johnstone & Read, 2000).

Māori are also more likely to have court-ordered treatment, to be incarcerated, and to have concurrent mental health needs. Maori are also reported to have low levels of literacy, experience socio-economic issues that affect illness at all stages, increased substance abuse and higher rates of psychotic disorders (J. Baxter, 2008; J Baxter, Kingi, Tapsell, Durie, & McGee, 2006; Ihimaera, 2007; Mancall, Robertson, & Huriwai, 2000; Milne, 2001; Wharewera-Mika, 2007).

Herbert (2002) suggested that high rates of psychiatric admissions are common in minority populations and are less indicative of the level of psychopathology in the indigenous population, but more a reflection of the inability of mental health agencies to understand the social, educational, political and economic realities faced by many indigenous populations. Johnstone and Read (2000) found that some psychiatrists believed that Māori had a genetic predisposition to mental illness; a finding that points to the widespread assumption that Māori are to blame for their poor position in health statistics. Such an assumption shifts responsibility for addressing negative health statistics away from the dominant group and ignores wider socio-political influences on health.

Biculturalism

The status of Māori as tangata whenua and co-signers to Te Tiriti o Waitangi/The Treaty of Waitangi require that Māori needs must be jointly considered with non-Māori and form the basis for bicultural development (Durie, 1998; Herbert, 2002; Nairn, 2007). In 1980, The Ministry of Health established a Committee of Inquiry (Mason Committee) to identify admission and discharge procedures in certain psychiatric hospitals in relation to Māori. The enquiry was in response to the disproportionately high representation of Māori among committed and special patients and among prisoners. The inquiry identified that Māori were not receiving adequate care and treatment from a Māori or Western perspective (Ryan, 1996).

Of note were the findings that health professionals were rarely qualified in Māori matters, and that training for health professions was monocultural. The committee recommended that practitioners received training and support in bicultural matters, that bicultural services be developed and that the Māori health coordinator had the same status as any other head of service (Ryan, 1996).

Five years later a review found little had changed. The services still did not understand biculturalism and there were contradictions between the law, clinical concepts, and Māori lore. Despite the high number of staff who claimed commitment to the Treaty, services were unable or unwilling to demonstrate how that commitment was reflected in practice (Durie, 1989).

The review also found clear contradictions between clinical concepts and Māori health concepts. Māori concepts were considered 'soft' and 'unscientific' (Durie, 1989), consequently, Western constructs were applied to clients without consideration of alternative methods of healing. There appeared to be difficulties with understanding how Māori and Pākehā worldviews could operate in partnership.

In 1985, the Minister of Social Welfare commissioned a report *Puao-te-atatu* on the activities of the Department of Social Welfare in relation to the disproportionately high number of Māori in the welfare system. The review highlighted institutional racism in the Department and high levels of bureaucracy. The authors were in no doubt that change was essential. The report was significant as it highlighted the role of racism in the department and its adverse effects on Māori (Herbert, 2002).

As a result of these reports Māori health and welfare received a great deal of attention. Pākehā government officials, health and welfare workers suddenly had to consider the role that Māori culture played in determining best outcomes for Māori. Implicit in those outcomes was a need to recognise the role of Te Tiriti/The Treaty as a framework for health and welfare policy.

In 1985, the Waitangi Tribunal's assessment of the Crown's obligation to the Treaty of Waitangi heralded a new era of policy making and legal obligations

The Tribunal found that the Crown was obliged to protect Māori interests by providing for better standards of health for Māori. Justice Durie's (1989) analysis of Te Tiriti/The Treaty found that under Article 3, Māori were to be afforded the same rights as non-Māori, with the implication being that Māori health should be equal to that of Pākehā.

Summary

I have briefly described the historical context for Māori interactions with the government and organisations responsible for decisions related to Māori health and wellbeing. The defining features of that interaction are breaches to Te Tiriti/The Treaty contributing to inequitable status with Pākehā in health, economic, legal, social, education and political spheres. Māori have a long history of attempting to hold the Crown accountable for these breaches with limited success.

I now focus on the development of the scientist-practitioner framework underpinning clinical psychology in the United States and Aotearoa-New Zealand. I position this review to reflect the progression of bicultural inclusion in psychology. I focus on the influence of the scientist-practitioner model and monocultural research on clinical education and training.

CHAPTER 2: THE DEVELOPMENT OF PSYCHOLOGY

<u>Psychology in Aotearoa-New Zealand</u>

> If the definition of psychology includes the study of the nature, function, and phenomena of the human mind and human behaviour, then there were psychologists in New Zealand well before 1947, and even before 1840 (Durie, 1997, p. 32).

Western psychology was introduced into the New Zealand education system by the chair of Mental and Moral Philosophy at Otago University in 1871. The academic or philosophical orientation of psychology reflected, as did other schools, its British and European roots. The scientific focus for psychology and the subsequent move away from the influence of philosophy was established in 1907 at Victoria University, Wellington under the influence of Thomas Hunter (Shouksmith, 1990). Hunter also established a clinic, and the first laboratory in Aotearoa-New Zealand and Australasia (Evans, 2008).

Māori participation in psychology as the research subject

Psychology's first interaction with Māori began at a research level in the 1950s with Ernest Beaglehole. As a participant-observer Beaglehole was interested in the Māori character-structure, echoing a trend in psychology to uncover the relationship between culture and personality in indigenous communities (Stewart, 1997). Research on Māori shaped psychologists' views and government policies about Māori family life, child-rearing patterns, personality development and the ability of Māori to adapt to Pākehā society. Assimilation was a common theme,

> What needs to be done therefore is to provide the Māori with the means, the help, and the motivations so to change his [sic] character-structure as to fit this more nearly into the patterns of Pākehā civilisation (Beaglehole, 1946, cited in Stewart, 1997, p.85).

Jules Older, an American, was one of the first psychologists to draw attention to the needs of Māori within the context of the monocultural nature of psychology. Older's book, *The Pākehā Papers*, (Older, 1978) was timely, relevant and confrontational. The professional associations including the medical profession, on which he also focused, were not receptive to his ideas about ensuring Māori had equal status in psychology and medicine. However, it was not until 1993, that members of the New Zealand Psychological Society (NZPS) voted to incorporate bicultural directions in their constitutional rules (this rule is mentioned later).

From this point I describe the development of clinical psychology and how Western values of science, positivism and cultural superiority were infused into education and practice. The rationale is to show why bicultural and multicultural initiatives have been met with such resistance, and why clinical psychology's claim to be value and culture free is plainly misleading.

The Development of Clinical Psychology

The purpose of this section is to expose the social and political assumptions about the scientist-practitioner model that are not made explicit in psychology programmes. What is apparent is that clinical psychology has tenuous grounds for proclaiming its status as 'the'[5] most relevant helping profession, or the most applicable because of its scientific underpinnings (Hopeha, 2010).

As a student, I was taught that the model of choice was the scientist practitioner model. Over my years of training, practice and research I learned to critique clinical psychology for its relevance to Māori; since doing this research, I regard clinical psychology with some skepticism. Critics of clinical psychology argue that the scientific and predominantly positivist paradigm of clinical psychology is underpinned by paternalism, profession-envy, privilege and the subjugation of the masses (Pilgrim & Treacher, 1992).

---

[5] Linguist Professor Patu Hohepa, highlighted that the English language privileges the definite article 'the', whereas Māori (and other languages) prefer multiple pathways of explanation. (Hohepa, 2010)

Origins of clinical psychology

Wilhelm Maximilian Wundt (1831-1920) was a German medical doctor, psychologist, physiologist, philosopher, and professor. He would be considered a tohunga by Māori standards as he is known as the father of experimental psychology. In 1879, Wundt founded one of the first formal laboratories for psychological research at the University of Lepzig. Wundt is credited as the teacher of Lightner Witmer (who had the first psychology clinic), Edward Titchener (who had the first clinical laboratory), Granville Hall (child psychologist), Charles Judd, (educational psychologist), Munsterberg and Scott (contributed to organisational psychology), and Charles Spearman (Spearman's Rank Order Coefficient) (Ludy, 2005).

Wundt and his students explored the nature of religious beliefs, mental disorders and abnormal behaviour, and mapped damaged areas of the human brain. Wundt established psychology as a separate science and also founded the first psychological research journal in 1881. Clinical psychology was developed in America by Lightner Witmer in 1896 as a means of studying and teaching child psychology (Ludy, 2005). The term 'clinical' was derived from the clinics that were established to treat patients for a range of psychological conditions (McReynolds, 1987).

The scientist practitioner: The Boulder model

Prior to the end of World War II, the Federal Government of The United States predicted a shortage of psychologists able to work with returned servicemen and women resulting in a call to increase the number of clinical psychologists (Ludy, 2005). In 1949, academic leaders (N=75), mental health service staff agencies and allied professions gathered in Boulder Colorado, to discuss, debate and formalise the training of clinical, education, industrial and organisational psychologists (Evans & Fitzgerald, 2007; McFall, 2005; Raimy, 1950).

The conference produced what is now known as the Boulder model. The model proposed that students receive an equal balance of research and clinical practice in their training to ensure that they successfully integrated both areas in their work. The requirements for entry into the profession

were a doctorate, practicum work and a pre-doctoral internship. The Boulder model was adopted in virtually every programme in the United States (Evans & Fitzgerald, 2007; Stricker, 2005).

The scientist–practitioner model was based on two key ideas: clinical psychologists had to be responsible for the development of clinical psychology's scientific base, and practice had to be linked to that knowledge base (Hayes, Barlow, & Nelson-Grey, 1999). The principal aim of the model was to produce scientifically-minded clinicians who were more competent than clinicians without scientific training. As clinicians, they were scientists and practitioners who applied critical thought to practice and used hypothesis-testing to determine the source of and solution to client problems.

Clinical psychologists were expected to only use proven psychometric measurements and therapeutic interventions supported by the literature and to conduct research for the advancement of psychology (Raimy, 1950; Stricker, 2005). Proponents of the scientist-practitioner model prided themselves as having the same foundations as the scientific or positivist paradigm, with the same discipline, objectivity and systematic inquiry that occurs in a traditional laboratory. They also believed that this training was unique to psychologists, and that they were more useful than psychotherapists (Belar, Nelson, & Wasik, 2003). Rivalry amongst health professionals is common; however the basis for one being more legitimate than the other appears tenuous.

Jones, (1998) argued that the scientist-practitioner model is used as a way of proving the epistemic authority of psychologists and to ensure a privileged position in society,

> Psychologists, in common with other occupational groups, aspire to a privileged position in society. They do so on the basis of their claim that they are the originators of, and have privileged if not exclusive access to, a valuable body of authoritative and incontrovertible scientific knowledge that can be applied to further common societal goals (p. 24).

Despite the belief in the superiority of the scientist practitioner model, there was no consensus as to what constituted optimal training conditions. Raimy (1950) commented that "participants at the conference (Boulder) displayed considerable humility with respect to confidence in present techniques" (p. 80). The authors of the Boulder model recognised that universities would offer a diverse range of training programmes that were beneficial to the psychological community.

What was not anticipated however was "that there would be an almost universal emphasis on science and that practice would be neglected" (Raimy, 1950, p. 1). There was a concern that despite the stated intentions of the model, universities were not producing graduates who were competent in research and practice. It was evident that experience, supervision, course work, and practicum experience were not of established practical value and that practice often meant acting on intuition and hunches, and that professional judgment and research meant relying on discussions with colleagues (Belar et al., 2003; Christensen, 2000; Evans & Fitzgerald, 2007).

Evans and Fitzgerald (2007) noted the inability of programme staff to produce graduates who possessed competencies in both research and practice. A criticism of the model was that,

> Doctoral graduates were not producing original research, and that the practice of psychology was ingrained, and based on flimsy, non-empirical theories and principles, such as psychoanalysis and projective testing (p. 284).

Some argued that the Boulder model was: the least understood; the most distorted of all training approaches; ill-defined; and showed its academic bias by promoting a positivist position while ignoring the social determinants of health (Pilgrim & Treacher, 1992). Others believed that a focus on science alone might weaken practice (Stricker & Trierweiler, 2006) or that science and practice were incompatible and difficult to integrate (Albee, 1970; Hayes, 2005). Eysenck, (1949) (who is regarded as a forefather of psychology) argued that "social need should not influence scientific research and that research can and should occur without practice experience

as science should not be influenced by the idiographic, the mystical, or by intuitive and unrepeatable personal experiences" (p. 174).

The criticisms of the model are largely based on the difficulty with integrating science and practice. There is minimal mention in the clinical psychology literature about the flaws inherent in science, or the influence of personal experiences on practice (and science). Jones' (1998) argument is revealing when he said that the scientist-practitioner model constructs a particular reality that is discursively mediated

> The term scientist-practitioner model does not refer to a clearly articulated and coherent description, or representation, of the way in which psychology is practised, should be practised, or even could be practised. It is not a reflection of the way a particular aspect of the world has been discovered to be, but a reflection of a contingency-driven agreement about how a particular aspect of the world is to be spoken about. The model is disclosed in a discourse, a loosely connected, but not particularly consistent, collection of tropes, assertions, ideas, and stories, organised around a metaphor which likens "the psychologist" to an idealised, heroicised, but historically outmoded, picture of "the scientist" (p. 24).

The problem with the model from a bicultural or indigenous perspective is that the values, worldviews and beliefs of psychologists are not examined for their influences on science and practice. The scientist-practitioner would say that those things are irrelevant and have no impact on science, research and practice. Jones commented that scientist-practitioners held themselves out to be detached, objective empiricists "who should be accorded epistemic authority, because they are the mere vehicles through whom the voice of nature, or reality, speaks decisively, unambiguously, and undistorted by any question of personal interest or bias" (p. 25). With this in mind, psychologists may be given undue credit as impartial, trustworthy purveyors of truth.

Jones (1998) went on to say,

> That to draw attention to the possibility that those to whom nature supposedly speaks in this way could be hearing the echoes of their own voices, or that their personal circumstances or interests might

in any way bear on what is heard, is indignantly dismissed as underhand, ad hominem, and a breach of conventional civilities (p. 25).

From this point I describe the influence of personal experience on the scientist-practitioner and their supposed core function, their research outputs. Although research is considered a crucial part of the scientist-practitioner model, the reality is that the psychological literature contains limited reference to diverse cultural and ethnic groups. Without that research, how do psychologists know what to do with Māori? Herbert (2002) found that the *New Zealand Journal of Psychology* reflected international trends of minimal inclusion or acknowledgement of cross-cultural or indigenous topics; that 23% reported ethnicity, including statements such as 'predominantly Pākehā' or 'primarily white middle-class' (Herbert, 2002).

The lack of cultural diversity in research outputs was also noted in the United States where culture featured in only 5.4% of the clinical psychology literature published from 1980-1997 (Iwamasa, Sorocco, & Koonce, 2002). Despite the known dearth of guiding research, psychologists continue to use models of practice that have not been trialed with diverse groups. Furthermore, psychologists and researchers do very little to contribute to the research base on how to work with culturally diverse peoples. The ethics of working with a model that has changed very little in the past 60 years, and is known to be flawed, is questionable.

As I have outlined, while there are many criticisms of the Boulder model, those analyses did not include a critique of the relevance of psychology in general. Others, such as Love (2002) emphasised that Western psychology, on the whole, is incommensurable with the fundamental values underlying Māori psychology. Hare-Musten and Marecek (1997) also questioned mainstream assumptions that norms based on white, middle-class North Americans should apply universally to other populations. Despite the known limitations of the scientist-practitioner model, it, along with other Western models of psychology, was promoted to the world.

Challenges to clinical psychology

Clinical psychology and psychiatry

Research conducted by feminists, critical and community psychologists and bicultural or kaupapa Māori advocates, show that clinical psychology and its White, dominant group members ignore the relevance of social and political histories. For example, critics have argued that clinical psychology's association with science, psychiatry and the medical model that dominated the Veterans Administration Hospitals of the 1940s, was the primary reason clinical psychology grew in power (Pilgrim & Treacher, 1992; Prilleltensky, 1997). Pilgrim and Treacher (1992) claimed that psychiatry was used to calm the masses and make them well enough to continue working, though not quite well enough to question the power imbalance between the wealthy and the poor.

Clinical psychology neatly constructed itself as a superior profession through its alliance with psychiatry and science, and its presumption that other disciplines should conform to their standards (Jones, 1998; Pilgrim & Treacher, 1992). Through its links to psychiatry, clinical psychology is seen as perpetuating an individualist, medical/organic understanding of human suffering that takes only secondary account of the role of structural relations and the sociopolitical context in shaping people's experience (Albee, 2000; Hare-Mustin, 1997; Love, 1999).

Albee (2000) argued that "by aligning itself with the conservative view of causation, clinical psychology has joined the forces that perpetuate social injustice" (p, 2). Clinical psychology's reliance on positivism results in a narrowly defined reductionist approach that is decontextualised, positioning the individual as the source of their problems that are separate from political, cultural and social influences (Hare-Mustin, 1997).

Moghaddam and Studer (1997) stated that psychology should be viewed as the science of normative behaviour rather than the 'science of observable behaviour'. In their view, individual or group constructs identifies and uses complex normative systems as guides to behaviour. Those complex systems are guided by rules and norms which in turn become so well established and

accepted that they go unremarked, becoming in effect invisible to in-group members.

The practices ingrained in psychology appear fluid, normal and unseen, while any challenges to those norms are viewed with mistrust. Clinical psychology is seen as promoting a self-serving political role that perpetuates certain theories, maintains its epistemological dominance, and ensures financial gain by invoking the 'scientific' and commercially viable notions of realism and truth (Barnes, 2004; Ussher, 2003).

Psychology and globalisation

The importation of Western psychology into Aotearoa-New Zealand reflects a trend of increasing globalisation for the benefits of a select few.   In Aotearoa/New Zealand, clinical psychology is largely criticised for reflecting the dominant views of white, middle-class, male 'fathers' of psychology (Lawson-Te Aho, 1993) and for having a history of hegemonic discourse with other forms of knowledge (Hare-Mustin, 1997). Clinical psychology is also seen as disregarding social and political influences on human behaviour, and mirroring colonising practices by applying Western scientific theories onto diverse ethnic groups (Lawson Te Aho, 2002).

Love (1999) believed that psychology developed out of the role of the community healer, or the older, wiser family member and that the concept of the traditional healer has moved away from it roots towards a commercial profession. Love (1999) also argued that developmental psychology is correlated with the manifestations of a capitalist economy including urbanisation, industrialisation, increased mobility of individuals and families, and an associated breakdown of relatively permanent communities and traditional support systems.

The breakdown and invalidation of traditional healing structures is made easier when people are disenfranchised. Earlier I highlighted how the Tohunga Suppression Act and Te Tiriti/Treaty breaches accelerated the breakdown of Māori healing systems and enhanced Pākehā systems of healing. Globalisation is another form of colonisation where communities are coerced or beguiled into relinquishing their autonomy and are expected

to conform to the demands of the dominant group. In this case, the main producer of Western psychology, the United States forms the dominant group.

Moghaddam and Studer (1997) commented that North America maintains its dominant and unchallenged position because it is a major producer and exporter of psychological knowledge. Within psychology, Whites constitute the dominant group and minority voices are largely unheard. They added that Whites expressed the norms of their own culture as if they were universal laws of human nature. In their view, it followed that other cultural groups were expected to adapt their behaviour to what the dominant group perceives to be the facts of human life.

They proposed that White, middle-class males have enjoyed a monopoly as both the researchers and subjects of psychology and constitute the core of psychology's *first world* producers of psychological knowledge. *Second world* producers are Britain and Canada, while Cuba and Bangladesh are classed as *third world* producers.

Third world social scientists are seen as totally reliant on their Western counterparts and become passive recipients of research agenda, methods and ideas from the social science powers. They are also seen as tied up in certain circumstances where they find no way out but to depend on metropolitan knowledge, theory, books, journals, funding and resources for attaining success in their academic arena. Furthermore, their dependence on Western knowledge leads to the neglect of their people's unique cultural knowledge (Dueck, Sing-Kiat, & Cutiongco, 2007; Kais, 2010). As a result of that neglect, the views of first-world producers are maintained as there are few challengers.

Alatas (2002) argued that third world countries, as developing societies, are prevented from producing independent and autonomous social science knowledge because of the intense bombardment of Western knowledge. The consequence is that scholars in developing societies uncritically assimilate Western knowledge. Alatas (1972) called this phenomena "the captive mind" I explore this issue further in the next chapter.

In Aotearoa-New Zealand, there has been a shift from a dependence on Western, or colonising countries towards the production of indigenous knowledge that reflects free thinking and critical scholarship. Nikora, Levy, Masters, & Waitoki (2004) proposed a fourth-world producer that encompasses "indigenous communities positioned within colonial first, second or third world nations…the original inhabitants of the lands in which they dwell" (p. 2). While fourth-world researchers share some struggles with marginalised and oppressed peoples, their experiences cannot be described in the same way.

Nikora et al (2004) described indigenous psychology globally is characterised by a reaction against the dominance of the American psychological knowledge 'production machine', and the search by indigenous peoples for a voice in their own futures (p. 2). The struggle to be heard in academia is often a reaction to what is written, or not written about indigenous peoples. As Smith (1999) commented in relation to academic writing about Māori, "much of what I have read has said that we (Māori) do not exist, that if we do exist, it is in terms which I cannot recognise, that we are no good and that what we think is not valid" (p. 35).

In the psychological literature, culture, diversity and indigenous perspectives are consistently overlooked despite the lack of research to aid practice and teaching (Iwamasa, 1996; Love & Waitoki, 2007). Herbert and Morrison (2007) pointed out that although Western psychology positions indigenous knowledge and skills as an entirely separate and independent system of knowledge, they believe that Western and indigenous knowledge can contribute to a universal knowledge domain.

Summary

Clinical psychology relies on science, research and practice for its status and identity despite the monocultural underpinnings of the scientist-practitioner paradigm. Those values encourage psychologists to apply the results of research to their clients with minimal consideration of the potential to cause harm.

It appears that clinical psychology training is inconsistency about the efficacy of education and training, while at the same time, Western theories are viewed as value-free and universally applicable to all peoples. The internal debate about the validity of the scientist-practitioner model does little to convey trust in University psychology departments. On the outside looking in, it would appear that clinical psychology's grip is maintained not so much by the validity of its theories and worldviews, but by the White, dominant group in society whose privileged position enables them to determine the parameters of valid knowledge.

The relevance of this chapter to this research is to highlight the history and socio-political underpinnings of psychology that will form part of the cultural competency training programme. With this knowledge, students will have a basis from which to question the relevance of the scientist-practitioner model for Māori clients.

In the next chapter I describe the legislative and ethical rationale for including a Māori perspective into psychology education and practice.

CHAPTER 3: CULTURAL COMPETENCY

The Development of Cultural Safety and Cultural Competency

In this section I describe the history of kawa whakaruruhau/cultural safety in Aotearoa-New Zealand and the cultural competency literature from the United States. I also include the legal and ethical imperatives that underpin cultural competence in psychology in Aotearoa-New Zealand, followed by a description of the definitions, strengths and limitations of cultural competency. These models formed the framework and the ethical and legislative rationale for using specific competencies in the training programme.

Kawa whakaruruhau/Cultural safety in Aotearoa-New Zealand

In the late 1980s, Nurse Irihapeti Ramsden developed a model of culturally safe nursing practice that sought to address the way Māori patients were treated by non-Māori nurses. Ramsden (2002) found that Māori were treated according to the nurse's specific cultural upbringing: for example, not disposing of blood-products appropriately, handling tapu areas of the client's body, not allowing Māori to practice their rituals related to health or death, or by not treating Māori at all. The focus of the cultural safety model was to train non-Māori nurses to work effectively and safely with Māori patients while considering culture at all times.

Ramsden rejected the nursing motto of the time, 'nursing regardless of creed' as it allowed non-Māori nurses to disregard the impact of ethnicity and culture on nursing practice. Ramsden (1996) reworded the motto to read 'nursing regardful of creed', stating that Māori had been passive consumers with little input into funding, policy and delivery of health services, which in her view contravened Te Tiriti o Waitangi/The Treaty of Waitangi.

Irihapeti expected that education providers and practitioners meet their Te Tiriti/Treaty obligations to be responsive to Māori needs by implementing health policies and directives that address the poor status of Māori health

compared to non-Māori and developing appropriate definitions of health and treatment. She argued that education and service providers should also be aware of how their ethnic-cultural heritage affects health outcomes for Māori and that there is recognition of the impact of cultural diversity on variables such as health-seeking behaviour and access to health resources. Irihipati developed a definition for safe nursing practice as,

> The effective nursing or midwifery practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual beliefs; and disability (Nursing Council of New Zealand, 2005, p. 7).

In 1990, the Nursing Council amended its accreditation standards to incorporate cultural safety into its curriculum assessment processes (Nursing Council of New Zealand, 2005). There was, however, vitriolic opposition to the inclusion of Māori culture into the nursing curriculum (Ramsden, 2002). Irihapeti characterised the criticism as, "the idea of the comfortable and treating nurse image being influenced by Māori who were demanding unreasonable and unrelated input into nursing education was all too much for some people" (Ramsden, 1997). The reaction from across social and academic quarters highlight the influence of racism on the health status of Māori, as course work was amended and Māori cultural values treated contemptuously by the media (Ramsden, 2002).

Cultural safety was unique in Aotearoa-New Zealand as it gave clients the ability to determine whether they received culturally safe care and it underpinned the development of a separate nursing course for Māori students. The use of the cultural safety model is relevant for psychology as it challenges psychologists to recognise and acknowledge the existence of cultural bias and cultural-boundness implicit in aspects of Western psychological theory, training and practice. Psychology had very little in place that emulated the principles of cultural safety.

The process towards achieving cultural safety involves:

(1) Cultural awareness: understanding that differences exist; sensitization to the emotional, social, economic and political context in which people exist.

(2) Cultural sensitivity: awareness of the legitimacy of difference, and beginning the process of self-exploration (focused on the impact of life experience and how this might impact on others).

(3) Cultural safety: an outcome of education that enables safe service to be defined by those who receive the service (Nursing Council of New Zealand, 2005, p. 8).

Keri Lawson-Te Aho (2002) undertook a study of Māori psychology staff to identify whether cultural safety principles were embedded in the teaching and practice of psychology in Aotearoa/New Zealand. The report raised a number of critical questions and issues for psychologists teaching, training and/or practicing in Aotearoa/New Zealand. Some of the issues Keri posed are reproduced below:

> A question fundamental to cultural safety in psychology teaching and practice is "How 'safe' are our practices as psychologists in cultural terms?"
> Cultural safety has an inherent requirement that psychologists reflect on their roles as holders of power
> Cultural safety is about self-reflection and more importantly, what the consumer experiences
> Consumers of psychological training and services are the ultimate judges of cultural safety.

I address these issues later in the chapter. While the debate about cultural safety in teaching and practice raged in the public and academic arena, most psychologists continued blissfully unaware that their Tiriti/Treaty obligations were not being fulfilled.

The Code of Ethics

The *Code of Ethics for Psychologists Working in Aotearoa/NZ* (New Zealand Psychological Society, 2002) (NZPsS) was modeled on a Canadian code (Seymour, 2007). The code aimed to be an aspirational document that encouraged ethical decision-making rather than prescribing rules of conduct (Seymour, 2007). The National Standing Committee on Bicultural Issue (NSCBI) members commented on the individualised character of the Canadian code and recommended that the new code give more recognition to collectives (Nairn, 2007).

Nairn (2007) reflected that NSCBI's recommendation was not easily interpreted because "the dominant culture in both psychology and society is structured around the autonomous individual" (p. 28). He added that "English lacked an adequate, accessible vocabulary with which to capture that insight [*of collective identities*] in the principles, values and practice implications" (p. 28).

As a result of the lobbying by NSCBI, the revised code included 'Peoples' in Principle 1 and has specific reference to Te Tiriti/The Treaty,

> In giving effect to the Principles and Values of this Code of Ethics, there shall be regard for New Zealand's cultural diversity and in particular for the provisions of, and the spirit and intent of, The Tiriti o Waitangi (p. 1).

The Code is structured around four principles: (1) Respect for the dignity of persons and peoples; (2) Responsible caring; (3) Integrity of relationships; and (4) Social justice and responsibility to society (NZPsS, 2002). These principles together with explicit references to the provisions, spirit and intent of the Treaty of Waitangi/Te Tiriti o Waitangi, makes the code unique in its responsiveness to the indigenous Māori population as Treaty partners.

The revised Code was formally adopted by the New Zealand Psychologists Board (NZPB), NZPsS and The College of Clinical Psychologists (CCP) in 2002. The Code is also directly referenced in the New Zealand Psychologist's Board (NZPB) *Core and Cultural Competencies* criteria. Internationally, the Code is

unique in its attention to peoples (ethnic groups, collectives), as well as persons (individuals).

There is opposition to the language version used in the code's text. Campbell (2005) pointed out that although the Code states that "Te Tiriti o Waitangi is given priority as the text that was offered and signed by the majority of the Māori signatories (p. 4)", the term Treaty of Waitangi is marginally used throughout the Code. She also argued "that the meaning of the terms *due regard*, *spirit* and *intent* can produce radically different principles for practice" (p. 85). The practice of privileging the English text over the Māori text in the Code heightens the narrow understanding of the history of Te Tiriti/The Treaty and has implications for the way the Code is interpreted and used.

Māori and Pākehā psychologists also lobbied the New Zealand Psychological Society (The Society) to consider their Tiriti/Treaty obligations to Māori as psychologists and consumers. The Society amended its constitutional rules to show its commitment to Te Tiriti/The Treaty. Rule 3 (now known as the Bicultural Commitment Rule) proposed that,

> In giving effect to the objects for which the Society is established, the Society shall encourage policies and practices that reflect New Zealand's cultural diversity and shall, in particular, have due regard to the provisions of, and to the spirit and intent of, the Treaty of Waitangi (NZ Psychological Society, 1993).

As a constitutional document, the Society's Rules signified a major shift in thinking about biculturalism. However, subsequent evaluations of the Society's bicultural performance found that Rule 3 had not been fully operationalised as the National Standing Committee on Bicultural Issue (The NSCBI) was the primary source of bicultural activity (Duirs, 2005). The Code offers an imperative to ensure the inclusion of Māori in psychology but it was not enough. Perhaps a piece of legislation was necessary.

The Health Practitioners Competency Assurance Act 2003 (HPCA)

The HPCA Act 2003 replaced the Psychologists Act (1981). The HPCA Act sets out the conditions for the registration and discipline of health

professionals with the intention of providing protection for the public. In the drafting stage of the Act, numerous submissions were made to the Ministry of Health expressing concern at the lack of reference to the Te Tiriti/The Treaty, lack of bicultural direction, limited cultural consideration and the lack of provision for Māori representations in the various structures to be established by the (then) Bill (Love, 2002, p. 17).

The exclusion of Te Tiriti/The Treaty from the Act reinforced the belief that the Ministry, despite its stated goals of improving Māori health, was not ready to consider the needs of Māori within the context of Te Tiriti/The Treaty framework. The Act may imply that the competency of health professionals is 'assured', but the reality is that Māori were once again reminded that "the state is essentially Pākehā and it works to reproduce the interests of Pākehā" (G. Smith, 2000a, p. 185).

At present, psychologists and students are required to have knowledge of the Code of Ethics as part of a minimum standard for competence and cultural competence (NZPBb, 2006, p. 4) and to gain knowledge and experience when working in an area outside their area of expertise (New Zealand Psychological Society, 2002). 'Outside their area of expertise' relates to dealing with clients from different cultural backgrounds (in addition to other knowledge and skill areas such as family, neuropsychology).

Although there is no mention of Māori in the HPCA Act, section 118(i) enabled the Psychologist's Board to mandate cultural competency in the education and practice of health professionals by "setting standards of clinical and cultural competence, and ethical conduct to be observed by health practitioners of the profession" (HPCAA, 2003, p. 87). The positioning of clinical and cultural as dichotomous forms of practice is an ongoing source of tension between Māori and Western health professionals. The assumption is that clinical practice is not cultural practice and vice versa. I come back to this point in more detail in study two where I attempt to blend the two practices together.

Under the HPCA Act, each health profession is able to define the competencies that best suit the parameters of its training and practice. Some

of the registration boards were proactive in developing cultural competency standards[6]. The Psychologist's Board's response to the Te Tiriti/The Treaty obligations was to develop the *Cultural Competencies Framework* (New Zealand Psychologists Board, 2006a) which is intended to underpin the *Standards and Procedures* (*for the Accreditation of Psychology Training Programmes and Educational Institutions)*, and the *Core Competencies* document[7] (New Zealand Psychologists Board, 2006b).

The documents fulfill some of the functions of the Act: to set standards of registration, accredit tertiary institutions and to protect the public. The cultural and core competencies are also offered as guidelines for ongoing professional development by requiring cultural competence in relation to Māori and diverse cultures and the requirement to demonstrate a working knowledge of the Treaty as the basis of culturally competent practice.

Love and Waitoki (2007, p. 268) proposed that the implications of these guidelines and policy documents for psychology are that cultural competency should be included in the teaching and practice of students and psychologists in the following way:

> (1) That educational institutions offering courses of study leading to registration in the psychologist's scope of practice must contain appropriate curriculum content and experience to ensure that students achieve the specified minimum cultural competencies.

> (2) That persons seeking registration in the psychologists scope of practice must be able to demonstrate cultural competence within that scope and to maintain and develop that competence over time

---

[6] See the Occupational Therapists, Medical Council and Physiotherapists cultural competency documents available on their websites).

[7] This document provides the basis for determining the assessment of initial qualifications for registration; the standards in competency reviews; and for the accreditation of tertiary educational institutions (NZPBc, p.1 2006).

(3) That persons seeking registration in either the Clinical or Educational scopes of practice must be able to demonstrate cultural competence for the psychologist's scope and additional cultural competence specifically related to the particular scope they are seeking (such as Clinical and Educational scopes)

(4) That psychologists undergoing a competency review may be required to demonstrate cultural competence if this is identified as a deficit area of practice

These statements suggest that the Board's documents together with the Code of Ethics provide sufficient imperatives to include Māori perspectives in psychology. I have already highlighted that despite the existence of policies and incentives to include bicultural content there has been minimal change. At this stage, there is limited evidence to suggest that academic institutions are doing anything different in their teaching and practice in relation to Māori (Love & Waitoki, 2007).

Despite clinical psychology's reliance on North American and British literature, there was a wholesale blindness to the diversity literature from that part of the world that has been developing for over 30 years. I now highlight that literature and its influence on the development of my research.

As a clinical student and then clinical lecturer whose mind was captured by North American psychology, I reviewed the literature on African-American, Hispanic, and American-Asian cultural competencies with the view that it could be applied to Māori. Although that literature base paid scant reference to the experiences of the indigenous peoples of the world, I failed to fully understand the implications of what I was doing. I explain further on what happened with that idea.

History of Cultural Competency in the United States

The development of multicultural competencies in North America travelled on currents in much the same way as Aotearoa-New Zealand, with authors writing about the limitations of psychological paradigms and techniques, and how ethnicity and culture were minimised in teaching, research and practice

(S. Sue, 2003; Suzuki, McRae, & Short, 2001). The primary shift in thinking occurred in response to the Civil Rights Act (1964), the removal of segregated education (Brown vs Board of Education, 1954*)*; affirmative action policies; and the establishment of a minority research office within the National Institute of Mental Health (NIMH) in 1971 (American Psychological Association, 2003; Ponterotto & Mallinckrodt, 2007). The background and rationale to the establishment of cultural competencies reflected the changing social landscape and the pressing need for social justice policies and programmes for minority groups (APA, 2003).

The multicultural competency literature in the United States for the last 30 years is largely based on the work undertaken by the Education and Training Committee of the American Psychological Association's (APA) Division of Counseling Psychology – Division 17. The APA (APA) recognised that psychology had been traditionally defined by and based on Western, eurocentric and biological perspectives and assumptions, and had failed to consider the impact of racial and cultural influences and the effect of that bias on clients and the public interest (APA, 2003).

The psychological profession was a significant opponent to the development of multicultural competency training and practice. Sue et al (1998) commented that,

> . . the call for infusing multicultural competency criteria into standards of practice has been vocal, loud, and compelling. Yet, as a whole, the profession has not always been a willing participant in the recognition, endorsement, or infusion of multiculturalism into our standards of practice, code of ethics, and training programs. At best, the mental health professions can be characterized as unenlightened and reluctant to consider the racial/cultural issues in counseling and psychotherapy; and, at worst, they have been downright hostile, antagonistic, and guilty of cultural oppression (Sue et al., 1998, p. xi).

The counseling division (of which Sue was a member), in conjunction with other committees, produced a range of cultural competency guidelines that

formed the basis for the development of multicultural counseling psychology courses. The most relevant guidelines[8] were the:

- *Cross-Cultural Counselling Competencies* (D. Sue, Bernier, Durran, Feinberg, Pederson, Smith, & Vasquez-Nuttal, 1982);
- *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (APA 1990);
- *Multicultural Counseling Competencies and Standards: A Call to the Profession* (D. W. Sue, Arredondo, & McDavis, 1992) which included dimensions of identity and the concept of multiple, and collective identities occurring in multiple contexts;
- *Operationalisation of the Multicultural Counseling Competencies and the Guidelines on Multicultural Education, Training Research, Practice and Organizational Change for Psychologists* (American Psychological Association, 1993, 2003).

The last two guidelines were adopted by the APA in 2003. The latter guidelines were focused on the role organisations had in maintaining racist practices and on the role of psychologists of both racial/ethnic minority and non-minority status in education, training, research, practice and organisations, as well as students, researchers and clients. In the guidelines, psychologists are encouraged to consider the importance of multicultural dimensions on personal identity and the interactions of multiple other identities within and between individuals.

Multiculturalism relates to "the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religions/spiritual orientation, and other cultural dimensions" (APA, 2003, p. 380). The APA uses the term multicultural competency whereas in Aotearoa/New Zealand, the term cultural competency is used. A problem with the word competency is that it suggests that if one were to undertake

---

[8] The term guidelines refer to pronouncements, statements or declarations that suggest or recommend specific professional behaviour, endeavours, or conduct for psychologists (cited in APA 2003, p. 378).

some form of cultural training or learning, then one may consider oneself 'competent' (this point is described in more detail later). While we live in a multicultural society, our responsibility under Te Tiriti/The Treaty is to protect the bicultural relationship with Māori and non-Māori.

Love and Waitoki (2007) argued that Te Tiriti/The Treaty was signed by Māori as the indigenous people and Pākehā as Crown representatives; an act that formalized a bicultural relationship. We believe that all non-Māori who came to Aotearoa-New Zealand under the conditions of the Crown, as citizens or sojourners in Aotearoa/New Zealand, are Tiriti/Treaty partners to Māori.

These responsibilities and obligations are an ongoing source of tension for some who consider they are exempt from Māori and Pākehā history because they came post Tiriti/Treaty, or they consider that Aotearoa-New Zealand is a multicultural country and that Māori should not be afforded any privileges above other ethnic groups. This positioning is contrary to the spirit and intent of Te Tirit/The Treaty where Māori have rights and privileges due to their unique status as indigenous peoples. Helms considered that focusing on multicultural characteristics obscured issues associated with ethnicity, such as racism and oppression (Helms, 1997).

Defining multicultural competence

The first three of the six APA guidelines apply to individual psychologists from two main perspectives: (a) knowledge of self with a cultural heritage and varying social identities; and (b) knowledge of other cultures (APA, 2003, p. 378). The remaining three guidelines address the application of multiculturalism in education, training, research, practice, and organisations.

The core principles of the guidelines are that:

1. Ethical conduct is enhanced by knowledge of differences in beliefs and practices that emerge from socialisation through racial and ethnic group affiliation and membership and how those beliefs and practices will necessarily affect the education, training research and practice of psychology

2. Understanding and recognising the interface between individuals' socialisation experiences based on ethnic and racial heritage can enhance the quality of education, training and practice, and research in the field of psychology

3. Recognition of the intersection between racial and ethnic identity with other dimensions of identity enhances the understanding and treatment of all people

4. Knowledge of historically derived approaches that have viewed cultural difference as deficits and have not valued certain social identities helps psychologists to understand the underrepresentation of ethnic minorities in the profession and affirms and values the role of ethnicity and race in developing personal identity

5. Psychologists are able to promote racial equity and social justice - aided by their awareness of their impact on others and the influence of their personal and professional roles in society (i.e., power and privilege)

6. Psychologists know about the roles of organisations as potential barriers to the development of multicultural initiatives in education, training and practice (APA, 2003, p. 382).

Multicultural competency or cultural competency has been defined as the sum of a counselor's awareness, attitudes, beliefs, knowledge and skills to engage in a course of actions or to set in motion conditions that maximise the optimal development of the client and client systems (Reynolds, 2001; Stuart, 2004). Multicultural competency is not a unique set of skills, but rather a specific type of philosophical orientation from where psychologists can recognise, respect and respond to the relevant socio-political dynamics of ethnicity and principles of cultural socialisation (Sue, 2006).

The focus on a philosophical orientation is a challenge to clinical psychology to consider whether the scientist-practitioner model with its monocultural orientation can adjust its education and training standards. The underpinning philosophy of the APA and the Psychologist's Board documents reflects a growing awareness of the historical and socio-political influences

on psychological wellbeing, and of the monocultural nature of education and practice. A requirement of cultural competency is the need to move beyond cultural sensitivity and awareness, and to encourage psychologists, trainees and educators to consider a range of personal and structural questions that they should address at intellectual, emotional and behavioural levels.

Cultural competence approaches encourage the examination of personal and professional assumptions, identities, values and beliefs and how these are reflected in practice (American Psychological Association, 2003; Downing-Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000; Sue, 2006; Sue, 2008; Suzuki et al., 2001). The emphasis is on considering one's culture and that of the client at all times thereby providing a mechanism for identifying issues that might otherwise go unnoticed, for example, the effects of oppression, discrimination, poverty and privilege.

Sue (1998) argued that counselling and psychotherapy may act as instruments of cultural oppression by defining the lifestyles of clients from non-culture defining groups as deviant and abnormal and by imposing culture-bound solutions on them. Sue found that psychologists were uncomfortable with sharing responsibility for determining the outcome of an intervention and that some psychologists were guilty of being arrogant and contemptuous. These psychologists did not accept or respect clients, were insensitive to client's needs, were unable to relate to clients' life experiences, and had little insight into their own biases.

The APA guidelines were used to develop the Psychologist's Board's definition of cultural competency, together with the Nursing Council's cultural safety framework and Te Tiriti/The Treaty principles. The definition developed by the bicultural committee of the Psychologist's Board, of which I was the co-chair, underpins this research,

> Cultural competence is defined as having the awareness, knowledge, and skill, necessary to perform a myriad of psychological tasks that recognises the diverse worldviews and practices of oneself and of clients from different ethnic/cultural backgrounds. Competence is focused on the understanding of self as a culture bearer; the historical, social and political influences on health, in

> particular psychological health and wellbeing whether pertaining to individuals, peoples, organizations or communities; and the development of relationships that engender trust and respect. Cultural competence includes an informed appreciation of the cultural basis of psychological theories, models and practices and a commitment to modify practice accordingly (New Zealand Psychologists Board, 2006a).

The definition explicitly states that psychologists consider their clients' ethnic and cultural characteristics taking into account the socio-political influences on their own worldviews and behaviour and those of the client. Psychologists are also encouraged to consider the influence of those worldviews on the development of psychological theory, research, education and practice. With such a broad definition, there is plenty of space to consider how the multiple avenues by which psychology can incorporate cultural variations in all areas of education and practice.

Criticisms of cultural competency

In this section I describe three criticisms of cultural competency: a lack of a precise definition; the belief that psychologists should not be advocates for social justice; and the distinction between clinical and cultural. While there are many criticisms, these ones seemed to resonate with me more than others.

Cultural competency definitions have been widely criticised for not being precise or consistently defined, contributing to a lack of confidence in the construct. It has also been argued that it obscures issues that arise because of race or ethnicity and that multiculturalism is another form of colonial oppression (Helms, 1997; Patterson, 2004; Weinrach & Thomas, 2004b). McDonald and Chaney (2003) expressed their concern that multiculturalism is conditional and is an extension of colonial oppression, which for Native Americans means genocide, land alienation, disease, poverty and lack of citizenship in their country.

As the indigenous peoples from the country in which cultural competencies were developed, McDonald and Chaney's views are a warning that minority groups stand to lose themselves in multicultural societies. Love and Waitoki

(2007) cautioned that multiculturalism posed a risk to the bicultural relationship founded under Te Tiriti/The Treaty and was actually a way for Pākehā to avoid their responsibilities.

Sue (2003) argued that cultural competency is difficult to conceptualise and measure because it is contextually based rather than technique specific and that it is possible to be expert in one dimension and ineffective in another. Sue, (2006) added that outcome studies needed to examine the context in which therapy occurs rather than limiting the focus to psychological techniques alone and that research on cultural competency is limited by funding and limited access to competent researchers.

Sue (2006) believed that research on the definition of cultural competency is also limited because of the criteria for efficacy studies. He argued that research was limiteed by the reliance on hypothesis testing as opposed to discovery-based forms of knowledge. Moreover, research needed to be ethnic-specific rather than testing only whether Western models can be applied to ethnically diverse peoples. Sue's (2006) concern highlights the positivist position which maintains a view that knowledge can only be validated using Western scientific principles. When troublesome guidelines are proposed that recommend alternatives to Western psychologies they are reconstructed as abstract and unrealistic (Weinrach & Thomas, 2004b).

Opponents of cultural competency also argue that the term and the APA guidelines, are useful at a symbolic level or moral level, and that it is neither possible nor desirable to develop cultural competencies for every cultural and ethnic group (Patterson, 2004; Siegel, 2002; Weinrach & Thomas, 2004a). By recreating principles of interaction and behaviour as intangible, and symbolic, the message to psychologists is that cultural competency is not as important as actual 'clinical work'.

Cultural competency attempts to address the myriad concerns of diverse groups of people. For that reason, having a definition that suits some groups and not others is more in keeping with recognising the existence of multiple realities. While critics argue that there should be one definition of cultural

competency, the reality is that this is unlikely to happen as long as there are diverse groups of peoples.

Perhaps the most limiting factor of cultural competency definitions is the failure to incorporate consumer input. As noted previously, the cultural safety model requires that consumers are the final arbitrators of culturally competent practice. With this in mind, it is unhelpful to argue about definitions in the face of overwhelming evidence for the need to respond to diversity. Indeed, Weinrach and Thomas (2004b) thought it necessary to comment that APA competencies guidelines are flawed because they did not distinguish between *multicultural* and *diversity*.

Others have resorted to attacking the theories underpinning human behaviour based on ethnicity and culture. Roysicar (2005) described psychology's resistance to the validity of multicultural assessment and measurement as being due to a rejection of the theory that clients come with values-based assumptions, world-views, cultural socialisation, racism experiences, acculturation versus enculturation conflicts, culture-bound mental health issues and help-seeking attitudes.

The debate over whether there should be a precise definition of cultural competence muddies the water and detracts from the importance of recognising cultural influences on psychological wellbeing. Some of the arguments against cultural competency appear to reflect personal biases, a lack of critical thinking about historical, social and political influences on behaviour and a tendency to 'victim blame' minority groups.

There is also a prevailing view that therapy is not about techniques, skills and knowledge, but it is more about the quality of the relationship (Patterson, 2004, Weinrach & Thomas, 2004a). Patterson (2004) argued that cultural competency guidelines are unnecessary as competence is inherent in the personal qualities of the mental health practitioner and that there was more to learn by highlighting the similarities between groups rather than the differences. Patterson essentially advocated for the universalist's perspective based on Carl Roger's model of 'client-centered' therapy (2004, p. 70). However, the contrasts between psychologists and clients can be so

great that there is very little similarity to note beyond very basic demographics.

The values approach promotes that all that is needed to work with multicultural groups is for psychologists to exhibit genuineness, empathetic understanding, communication of empathy and respect, and structure (that therapy is not ad-hoc and random) in each session. While many psychologists are genuine, caring and empathetic professionals, non-dominant group clients who are forced to attend therapy are likely to be hypersensitive and mistrusting. Furthermore, empathetic and respectful behaviours are culturally determined. Therapists who believe that sensitivity and acceptance of diversity enables them to transcend the impact of cultural difference are actually mirroring prevailing societal attitudes and ignore the role of therapists as social change agents.

Psychologists as social change agents

Perhaps the second most useful cultural competency activity for psychologists next to client assessment and interventions is to advocate for social change. Sue (2001) undertook a review of the cultural competency literature over a 30 year period and found that psychology failed to adequately address issues of racism, bias, and discrimination as major contributors of mental illness amongst persons of colour (p. 801).

The sources of treatment disparities between minority and majority group members are based on historic and contemporary inequities and involve many players at several different levels, including health systems, bureaucratic processes, healthcare professionals and clients.

As far back as 1952, social justice advocacy was not considered the work of psychologists (Eysenck, 1952). In later years, Weinrach and Thomas (2004) condemned the role of psychologists as agents for social change describing the cultural competency guidelines as a complete failure and "a case study in creative, relentless and zealous social action" (p. 87). Further, they proposed that social issues were dealt with in the office, where relevant and as they arose, but that anything outside the relationship was the job of politicians.

Critical psychologists advocate for the elimination of oppression by transforming oppressive institutions and altering the basic premises of unjust systems. Prilleltensky and Fox (1997) proposed that psychology's traditional practices and norms hindered the goals of social justice and that psychology is not a neutral endeavour conducted by scientists and practitioners detached from social and political circumstances. They also commented that mainstream psychologists shied away from the moral, social and political implications of differing political interests and social dynamics.

Certain aspects of cultural competence can be applied on a daily basis such as advocating for clients and disadvantaged groups, and challenging the hegemony of the Western-dominated knowledge base of psychology as it is applied in academic institutions and service organisations. Sue (2001) argued that psychologists needed to concentrate some of their efforts on addressing systematic institutional discrimination, to effect changes in clients who are the victims of failed systems, in the same way as systems theory works on addressing an individual's problems in the family.

Prilleltensky and Fox (1997) reasoned that if psychologists consider that a focus on diversity is only symbolic, they are contributing to and maintaining, the oppressive structures that subjugate the most disadvantaged social and ethnic groups. Sue (1998) noted that the Western model's emphasis on an 'in-the-office' remedial and verbal mode of intervention ignored the importance of 'out-of-office' strategies addressing the systemic causes of discrimination and ill health (p. 801). Sue (1998) suggested that the every-day, unchallenged, real-life values and beliefs that psychologists hold are barriers to advancing the inclusion of culture into psychological practice.

The view that psychologists should not be social change agents overlooks the growing potential that exists within the discipline to advocate for disenfranchised individuals or groups outside of the office. Delpit (1995) noted, "To act as if power does not exist is to ensure that the power status quo remains the same" (p. 39). It could be argued that those who reap the tangible benefits of privilege have little apparent reason to question what has always been assumed to be true.

A particular feature of cultural competency training is that psychologists are required to pay attention to culturally determined influences on clients' behaviour. In doing so, psychologists are exposed to the possibility that they have benefited from or have perpetuated oppression and discrimination in minority groups (see also the literature on white privilege by McIntosh, 1988).

Some of the benefits relate to being able to name, categorise, distinguish and validate healing processes as clinical or cultural. Clinical practices (from the dominant group) are trustworthy, scientific, and empirically validated. Cultural practices (usually from non-dominant groups) are native, indigenous and ethnic. The demarcation of healing practices into clinical and cultural perpetuates the belief that one system of practice is valid while the other is not.

Cultural-clinical distinctions

Since the 1980s authors have argued that cross-cultural skills should be placed on a parity with other specialized therapeutic skills and that competence in cross-cultural counseling overlaps with competence in counseling in general (LaFromboise, 1991). A concern about cultural competency guidelines relate to the positioning of non-dominant group healing processes as separate from what could be considered psychological practice.

The cultural-clinical distinction privileges the non-dominant group by enabling them to determine what is cultural and what is not. The clinical-cultural distinction is maintained when cultural competencies are relegated to the appendix, a separate section in clinical training and accreditation policies, or promoted as an addition to clinical competencies.

For example, Evans (2008) stated that students should possess foundational skills such as (a) the ability to develop rapport; (b) the ability to use actuarial measurement and clinical judgment; (c) sufficient knowledge of mechanisms of change to develop interventions; and (d) knowledge of research methods and common threats to validity. Evans suggested that "to these four quintessential clinical abilities, we would need to add cultural competencies"

(2008, p. 7). Establishing rapport, knowledge of change mechanisms, clinical judgment and knowledge of research requires cultural knowledge and skill. Adding cultural competency as a fifth competency negates its actual presence in everyday practice.

Evans (2008) provided a good example of how Māori researchers interweave clinical and cultural practices. In his paper, Evans commented on how his friend and colleague, Averil Herbert, conducted herself during the data gathering phase of her research where she taught parenting skills to Māori mothers:

> Yet as I watched her teach simple weaving skills to these disadvantaged young Māori mothers, it struck me quite forcefully that she also had a role that was completely compatible with Māori traditions—that of respected grandmother and teacher, not Herbert, university senior lecturer, registered clinical psychologist, holder of two Master's degrees, doctoral candidate (p. 10).

Evan's reflected that credibility comes not only from the letters after one's name (i.e, PhD) but through commitment, and more,

> Commitment alone is never enough, however, you have to have something valuable to offer—Herbert could teach weaving *and* a sophisticated perspective on the nature of parenting, drawn from many years of international research as well as generations of Māori whānau tradition (Evans, 2008, p. 10).

Averil embodied how cultural competency and clinical competency should be viewed as simultaneous practice with each informing the other. One could argue that it is a skill derived from cultural traditions to be able to use sophisticated methods (such as weaving and intergenerational knowledge) rather than a whiteboard, or handouts to teach parenting skills to Māori mothers.

The monocultural practices within psychology maintain the belief that while diversity and culture may be incorporated into some parts of psychology, it cannot be a viable competitor to established psychological knowledge and practice. When non-Western knowledge systems are implemented, the dominant group is less than gracious about recognising its real value. Siegel

(2002) described non-Western science as an ethnic science that produces valid knowledge which at times is more useful than Western science. However, he also believed that Western science was ultimately more beneficial to society. While Siegel's view is reminiscent of cultural encapsulation (a term I describe later) he acknowledged that non-Western cultures practice science.

Clinical psychology training promotes the clinical-cultural distinction when students are taught to conduct a clinical interview using detached, impersonal engagement processes. The clinical interview makes sense within the culture of clinical psychology but is devoid of other forms of social engagement processes such as hongi (sharing breath by pressing noses together), kissing on the cheek, touching, or self-disclosure. The Western values of detachment imbued in the clinical interview is seen as safe as compared to Māori practices of touching and sharing one's breath.

An understanding of the criticisms of cultural competency allows for a deeper analysis of the psychology that should be taught to clinical students. Whether the term multicultural, diversity, or bicultural is used, psychology ignores the relevance of culture for research and practice despite recognising that behaviour and cognition is reinforced by cultural factors (Roysicar, 2005). Clinical psychology cannot continue to avoid cultural issues in training and practice and expect to be seen as providing competent psychological services. With this in mind, it is helpful to consider what is meant by competence, as it would appear that a precise definition is also up for debate.

Defining competence

There is considerable discussion about what is meant by competence. Shippman et al, (2000) described the history of the term competence as arising from a range of contexts including legal, clinical psychology, vocational, educational, and industrial psychology. Competence has been variously defined and involves the possession and successful or adequate demonstration of knowledge, skills, abilities and attitudes necessary to

perform a myriad of tasks (Shippman et al., 2000; Spruill, Rozensky, Stigall, Vasquez, Bingham, & De Vaney Olvey, 2004).

Competence also "refers to the professional's overall suitability for the profession, reflecting his or her knowledge, skills, and attitudes and their integration" (Rubin, Bebeau, Leigh, Lichtenberg, Nelson, Sanford, Smith, & Kaslow, 2007, p. 453).

Sue, Zane, Nagayama, and Berger (2008) argued that competence is a relative skill or quality, depending on one's cultural expertise or orientation. The premise here is that competence differs according to the client's racial or ethnic group, and that cultural skills cannot be easily imported from one cultural group to another. For example, what is considered competent practice with Asian communities might be considered incompetent practice with Somali communities.

Competency is a developmental, incremental, context dependent and evolving process beginning with the novice, and leading to the advanced and expert stages (Rubin et al., 2007). The staged approach to learning is integral to clinical psychology training when Western psychology is taught. However, cultural content is more likely to be taught in an add-on programme or a series of one-off seminars.

Non-Western definitions of cultural competence positions learning as circular rather than linear, and is a process rather than an endpoint (Kingi-'Ulu'ave, Faleafa, & Brown, 2007; G. Smith, 2003). Others consider that competence is not characterised by completeness of knowledge, but by the attitude of recognising one's limited knowledge and embracing the prospect of learning (Garvey, 2007).

A prevalent feature of the competency literature is to describe Western psychological knowledge and skill in detail while consigning cultural knowledge and skill to the add-on position. The effect of this positioning is to maintain the view that Western psychological competence is more important than cultural competence, and that discussion about culture only occurs when the non-dominant culture is present.

Cultural and clinical competence should be infused to the extent that psychologists have more than adequate levels of competence to work with a wide variety of culturally diverse clients, their families and their communities (Suaalii-Sauni & Samu, 2005; Sue, 2008). Splitting competent practice into clinical and cultural competence once again makes the Western cultural underpinnings of clinical psychology invisible, normal and taken for granted.

Summary

The existence of so many differing definitions of cultural competence contributes to the criticism that cultural competency is unworkable as it has not been properly defined. I have argued that due to the diversity of the population, there should be many ways of describing cultural competence, as what might be competence in one culture could be considered incompetence in another. Competence cannot be assumed to transfer safely to other cultural group as cultural mores, values and beliefs are specific and unique to each cultural group (Castro, 1998).

Cultural safety and cultural competency are about the relationship between the psychologist and the client. Both perspectives assert that the cultural features and experiences of the client and psychologist should be considered at all times and that it is incumbent on the psychologist to demonstrate his or her ability (competence) to work with cultural factors. Cultural safety offers an indigenous perspective to the cultural competency literature through the requirement that clients determine whether they receive competent practice. This feature is also missing in the competency literature.

In the next chapter I describe psychology's response to ethical imperatives to incorporate biculturalism into the curriculum. The outcomes are varied and highlight progress in some areas, and stagnation in others due to the struggle to share power with Māori and non-dominant groups in society. These issues also form part of cultural competency training.

CHAPTER 4: PSYCHOLOGY'S VALUES, EDUCATION AND TRAINING

Challenging the Legitimacy of Psychology's Dominance

In the past 30 years, academic institutions have been challenged to examine the impact of their practices on Māori health needs. Universities and health providers are constantly exposed as incapable, and often unwilling to change their dominant position and afford Māori equal status with Pākehā under Te Tiriti/The Treaty (Love, 1999; Love & Waitoki, 2007; Macfarlane, 2008; McCreanor, 1993; Milne, 2005; Nairn, 1997; Nikora, 1995). Social justice requires that psychological practices and behaviours, whether individual or collective, are tika (correct, just) and morally right (Nairn, 2007) to ensure that Māori and Pākehā worldviews are equally valued in psychology.

Increased attention to cultural issues, both at the individual level and within the context of the constitution of psychological theory and practice is essential to the survival of the profession (Belar, 2003). Nikora (1993) positioned cultural factors as relevant focus points for challenging the dominant status of Pākehā in psychology arguing that paying attention to cultural justice ensures that power is shared evenly across those involved in psychology,

> Within the psychological profession cultural justice is about ensuring that all facets of the profession and discipline are conceptualised, structured, delivered and practised in a fashion that maintains a balance of justice and rightness for all groups involved. Due to the diversity of cultural backgrounds that individuals spring from, and the continually changing nature and patterns of cultural meanings and behaviours, cultural justice cannot be about finger pointing, but it can serve as foundation from which ethical standards of practice and discipline spring from (p. v).

Despite the use of language such as justice and rightness to compel or inspire dominant group members to attend to the issue of inequality, there appears to be little apparent change since Nikora's paper. The omission of culture (other than White culture) from psychology has partially stemmed from the belief that culture is not a legitimate area of study, that politics or social dynamics have a limited role in health and that problems reside within the individual, and are therefore the individual's responsibility (APA, 2003; Love, 1999; Pilgrim & Treacher, 1999). The other side to the exclusion of non-White culture in psychology is also a reflection of the values of the dominant group with Western societies (Smith, 1999).

Constructing psychological norms

Social construction theory offers a platform to consider the way that psychology privileges certain types of knowledge. Social construction is premised on the view that our experiences shape and come to represent what we believe to be reality and what we regard as truth. These representations are dependent on a social consensus which is provided by the dominant group (Hare-Mustin, 1997). The language that the dominant group uses to describe society, family, and knowledge excludes the language of those who are oppressed.

Jones (1998) commented that psychological knowledge is shaped and constrained by social forces and bears the marks of the culture from which it has arisen (p. 26). Hare-Mustin & Marecek (1997) argued that psychology reflects and reinforces the dominant cultural themes, ideologies and preoccupations of our day. Those themes are constructed in a way that results in a language that is used to diagnose, treat and evaluate clients. The application of those words construct a worldview or set of experiences and behaviours about health that assumes that only psychologists are able to understand or treat those experiences.

The dominant group's ability to define societal culture affects how majority and minority group members view themselves. Tyler (cited in Black & Huygens, 2007, p.50) asserted that culture-defining groups tend to be ethnocentric and have the least interest in justifying their world views.

Conversely, non-culture defining groups need to be constantly aware of their position in society and to provide justification for their way of seeing the world.

These arguments raise a valid concern about the role psychology has in recognising and responding to society's influences on the manifestation and explanations of psychological health and their treatment. Psychologists could be blamed for creating what they studied, as mental illness may exist not in the mind of the patient, but in the mind of the psychologist (Harris, 1997).

Psychology exerts its dominance by defining others according to its definitions about what constitutes normal or abnormal behaviour. Parker (1994) proffered the notion of the *psy-complex:*

> The psy-complex is a network of theories and practices that comprise academic, professional and popular psychology, and it covers the different ways in which people in modern Western culture are categorised, observed and regulated by psychology...The psy-complex is part of a particular 'regime of truth' which makes our talk and experience about the self, personality, and attitudes make sense (p. 240).

The parallels between psychological theories and social and political agendas are unexamined in psychology training to the extent that psychology maintains cultural blindness and impedes psychologist's self-understanding. Smith (1999) commented that social science fields of inquiry are dependent on the way society is viewed, and the body of knowledge which legitimates that viewpoint. Despite claiming to be "scientific" and value-free, psychology as a social science is permeated by societal influences.

The cultural-blindness and unwillingness of academics and, consequentially, students, to critically analyse power dynamics and the monocultural origins of their discipline, derive from the influence of society, personal choice, family and peers. Gergen, Gulerce, Lock, & Misra (1996) proposed that rather than privileging the psychologist as the scrutiniser of culture, that psychology be placed under scrutiny to determine the degree and effects of psychological science as a cultural manifestation.

Historical blindness

The historical and contemporary influences on practice and education in psychology is not understood or critically examined and is presented to students and consumers as legitimate, respectable and valid. Prilleltensky and Fox (1997) argued that mainstream psychology does not scrutinise the social, moral and political implications of its research, theory and practice and fails to recognise how its inherent values of individualism and disregard for inequality maintains oppressive structures.

Western cultural traditions of individualism and consumerism have had an impact on the development of psychology. When culture is invisible, the language of the dominant group may contain outright lies, contradictions, or omissions. Harris' (1997) discussion on *'Repoliticising the history of psychology'* commented that social and personal influences on psychology are omitted from textbooks and history books to buttress the view that psychology is value-free.

Harris' review of the history of behaviourism revealed that 'Little Albert' was not conditioned to fear rabbits and similar objects as easily as Watson and Rayner claimed (Harris, 1997). Little Albert was viewed as an "origin myth" of psychology to ensure that behaviourism had a long and illustrious past. Excluded from the story are factors such as financial interest, salesmanship and manipulation of evidence to create an image that behaviourism was a legitimate theory. As a clinical student I believed that Little Albert's story, although unfortunate, made a significant contribution to psychological theory and practice.

The economic influences of society on psychology are apparent in the example above. Parker (1994) maintained that professional psychologists make their truths come true and police discursive practices that propose alternative views on human experience and knowledge forms. The act of policing enables psychologists to position themselves as qualified experts.

Feminist psychologists, critical psychologist, cross-cultural psychologists, gay and lesbian psychologists, and indigenous psychologists worldwide have

highlighted the role that psychology plays in maintaining the worldview of a select few.   These critical perspectives are rarely included in clinical education. Hook (2007) argued that culture and education are interwoven as the education system is primarily linked to mainstream culture; a culture that has enforced on Māori conformity with Pākehā socio-economic interests and values. The cultural encapsulation that permeates those interests and values are reflected in psychology education and training.

Cultural encapsulation

Cultural encapsulation occurs when individuals or groups are perceived as outside the rules that define fairness and, while outside, they are expendable and undeserving of equal status with the dominant group (Pedersen, 1999, p. 11). The exclusion and control of indigenous perspectives is a by-product of cultural encapsulation and ensures that power remains with the dominant group.

The features of *cultural encapsulation* include: the definition of reality within a set of cultural assumptions that becomes more important than the real world; and the development of beliefs that are unsubstantiated, or although capable of disproof, are protected without regard to rationality (Wrenn, 1962).

Cultural encapsulation also includes insensitivity to cultural variations among individuals and an assumption that one's views are real and legitimate (Pederson, 1999; Wrenn, 1962). Also, in the absence of competing viewpoints, there is no recognised responsibility to accommodate the behaviours of others, except from a self-referential perspective (Pedersen, 1999; Wrenn, 1962).

The multiple layers of marginalization that result from cultural encapsulation is mirrored are academia and passed on in the education and practice of psychologists.   Moghaddam & Studer (1997) offered the view that 'mainstream psychology and cross-cultural psychology consistently neglected ideology, power disparities, intergroup relations and other issues related to justice" (p. 186).

Academic institutions are overwhelmingly staffed and managed by members of the dominant cultural group and as such, their values, norms and assumptions are explicit and implicit in maintaining a monocultural perspective on training, practice and research.

The attitudes and values of society that shape the content of psychological training and practice reflect the belief that biculturalism or Māori helping practices are irrelevant to Western psychological education and practice. When Māori worldviews are included in psychology, they are expected to be palatable to Western audiences.

I now deal with how biculturalism is incorporated into clinical training. I present several studies that show resistance and support for biculturalism from both Pākehā and Māori researchers.

Biculturalism in Training and Practice

Programme reviews

There are certain seminal papers written by Māori and non-Māori that record the progress of Māori involvement in psychology education and practice. Abbott and Durie's study (1987) involved a review of clinical, educational and community psychology training programmes in New Zealand. They found that no Māori academic staff were employed in the departments; of the nine programmes, none had produced a Māori graduate within the previous two years; the academic staff had made limited efforts to incorporate a Māori dimension into course work; and trainers had failed to provide bicultural content in training. Abbott and Durie (1987) stated that compared with other health disciplines, applied psychology disciplines were the most monocultural in terms of Māori representation (p. 67).

In 1991, Sawery (1991) interviewed 169 psychologists and asked them to talk about their bicultural experiences and attitudes about Māori. Seventy percent of respondents felt that they had inadequate knowledge of taha Māori, but less than half felt that there should be more bicultural content included in training courses, and most agreed that kaumatua and Māori consultants should oversee their work with Māori. Sawrey noted that the

psychological institutions of universities and professional organisations were monocultural and likely to alienate Māori.

In Sawrey's study, interviewees noted their lack of training and knowledge but did not consider training courses as a place where they could learn to work with Māori. Several years later, the pattern of limited bicultural content across training programmes was still evident. Nathan's (1999) replication of Abbott and Durie's study found that two of the universities had made significant improvements by incorporating customary Māori practices (tikanga) into the curriculum. The remaining programmes showed no improvement.

Perhaps the most comprehensive review of clinical psychology programmes in Aotearoa-New Zealand was undertaken by Heather Barnett (2004). Her thesis [9] focused on,

> The dominant discourse of clinical psychology, and the epistemological and theoretical approaches taken in most clinical psychology training programmes that continue to marginalise gender and analyses of power, and the interrelationship between structural relations and sociopolitical context, and psychological health (p. 3).

Barnett's thesis was primarily about gender issues, but she also probed the attitudes, practices and values of staff and students on the positioning of kaupapa Māori and the Treaty of Waitangi/Te Tiriti o Waitangi. Barnett interviewed clinical programme staff and students at six universities about the ways clinical psychology training programmes included education related to the Te Tiriti/Treaty, endorsed bicultural protocols, and incorporated Māori systems of knowledge. Of the six programmes, two showed pro-active Te Tiriti/Treaty initiatives, and four programmes showed none.

---

[9] I have spent some time describing Heather Barnetts' thesis as it is the most relevant research done to date on clinical psychology programmes. I did not come upon this thesis until well after my data was collected.

Students in the non-proactive programmes talked about a lack of endorsement of Te Tiriti/Treaty and bicultural practices from clinical staff and the wider psychology department. Students attributed their learning about The Treaty/Te Tiriti, tikanga Māori and bicultural perspectives to Māori students, other coursework and exposure to community services. The training delivery methods and content were described as: 'ad-hoc, low-key, and informal; showed superficial commitment; no depth whatsoever; were informally organised get-togethers by students; one or two lectures; or consisted of Māori guest lecturers. The explanation given by non-proactive staff was to blame past programme staff, and a lack of funding available to support Te Tiriti/Treaty initiatives.

Barnett reported that Pākehā staff at the proactive Universities described the tensions around teaching biculturalism and teaching people how to be clinical psychologists as currently defined. These results are not surprising as the definition of clinical psychologist within the scientist-practitioner framework provides no space to meaningfully incorporate bicultural competencies.

Staff commented that while they received some support for their proactive initiatives, they found "some very staunch, unchanged attitudes in the profession" (Barnett, 2004, p. 197). Similar attitudes were also present in some of the students.

Students as bicultural educators

Barnett (2004) also asked students to describe their experiences in clinical training. Her findings were consistent with previous research that found that Māori students are often used as educators. Māori students worked extra hard because they were relied on to do 'all the Māori things in terms of protocol and so forth' (Barnett, 2004, p.194). Although the practice is unethical, Pākehā academics who do not know or who are uncomfortable with bicultural practice often use Māori students and staff as educators so that the illusion of good bicultural standing is maintained.

Māori students are often compelled to correct misconceptions, or educate their peers because they are concerned for future Māori clients (Paterson,

1993) and are also left with little option but to 'conform to survive', 'stick it out', 'become a cultural watch dog', and to be 'conformist or protestor' (Paewai, 1997; Taitimu & Gavala, 2007). Some of the staff in Barnett's thesis acknowledged the cost and consequences for Māori students of being positioned as cultural educators but it seemed that there was no real understanding of the burden that position placed on Māori students.

Despite the findings and recommendations by Māori that Māori consumers and students require alternative psychological services (Merrit, 2003), the reality is that psychology departments do not have the research, staff (Levy, 2007), course material, or the inclination to make that happen (Waldegrave, 1997, Barnett, 2004; Love & Waitoki, 2007). Some of the burdens relate to policing acceptable knowledge that Māori student educators can pass on, and privileging Western knowledge over Māori knowledge.

Policing occurs when students are only allowed to educate others about approved topics. For example, they would be silenced (Gavala & Taitimu, 2007) if they raised the issue of racism, or the marginalization of Māori worldviews in clinical psychology. Brady (1992) found that once inside the clinical programme, Māori are "forced to consider human dysfunction in terms which do not reflect Māori beliefs or value systems" (p. 59).

Barnett (2004) described how students noticed the barriers to incorporating anything cultural into the programme, and that when bicultural issues were discussed (at the student's behest) those issues "disappeared into the background pretty quickly especially when staff were trying to get across some really Pākehā concept like cognitive behaviour therapy" (p. 192). Additionally, bicultural issues were most often discussed in the context of ethics, where Pākehā were the psychologists and Māori the clients.

'Kas,' a student participant in Barnett's (2004) study, noted that the lack of attention to issues of diversity (e.g., Māori, gender, poverty, sole-parenting) in her programme made her feel 'ashamed' (p. 182). The students descriptions mirror the findings of other research where Māori and non-Māori students felt inadequate, unprepared, and unfit to work competently with Māori (Ihimaera & Tassell, 2004; Merrit, 2003). These findings

highlight the fact that students are often more ethically minded than programme staff.

Using 'othering' language

As I argued earlier, clinical psychology typically uses language that maintains its dominant position and remains unexamined. Barnett (2004) found that programme staff maintained their dominant position by using 'othering' language in their coursework and training material that described ethnic groups but not Pākehā. She noted that some students genuinely sought to practice and develop their knowledge and skills while others demonstrated only a rhetorical verbal knowledge of the bicultural material and failed to show any critical analysis.

For example, despite knowing about diversity issues, and Te Tiriti/The Treaty, some students still used language that placed anyone different from them in the 'other' category using terms such as, 'they, them, a Māori, Samoans' (p. 185). Students quickly defaulted to discussing issues using language which reflected dominant culture assumptions and stereotypes (p. 182). The danger with using dominant cultural assumptions about diversity issues is that blame is apportioned to the "other" person and any attempt at critical thinking is lost.

The attitudes of academic staff are critical factors in determining whether Māori content is included training and in what manner. Waldegrave (1996) used discourse analysis methodology to identify the attitudes of psychology academics at two universities in relation to biculturalism. Discourse analysis examines written and spoken text for hidden meanings, studying the specific ways that the material predisposes readers to a particular interpretation. The analysis seeks to identify hidden ideological and political meanings of text and identifies how particular discourses clarify or obscure oppressive relationships in society (Nathan, 1997).

The academics in Waldegrave's (1996) study also used *othering* language and asserted their cultural dominance by reinterpreting Māori concerns as unjustified and the fault of Māori. They constructed Māori as drug-takers, unemployed, immigrants (and therefore not entitled to lay claim to an

indigenous position) or as victims of the economic and developmental failure of Māori as an ethnic group. Waldegrave's analysis revealed that the academics' views reflected a belief that knowledge is accumulated, is devoid of personal and political interests, and is value-free.

Waldegrave also found that despite an official intention to develop biculturalism, the personal values of the academics hindered that goal because they asserted monocultural control over their bicultural journey. The academics were unaware of, or denied racism in psychology and blamed Māori for their lack of involvement. They commented that Māori were not studying psychology because there was a more immediate need to train in law or Māori studies.

The academics felt that biculturalism had not advanced because Māori did not guide them when needed (i.e., Māori were often required to work for non-Māori, such as arranging pōwhiri, or conducting waiata practice). They also felt that power acquired through professional training was legitimate and showed minimal concern for power sharing. These views allowed the academics to resist change without having to consider how they maintained the inequality within the academy (Waldegrave, 1996).

Bicultural inclusion

Other research shows that active efforts had been made to increase taha Māori/Māori dimension in clinical training at Waikato and Canterbury Universities. In the mid 1990s to early 2000, Waikato provided exposure to Māori protocols (i.e., pōwhiri, waiata, karakia) and a commitment to include bicultural material in teaching (Herbert, 2002). Course content included Te Tiriti o Waitangi/The Treaty of Waitangi, knowledge of Māori cultural values, Māori identity, whānau structures and roles, and whakapapa (Herbert, 2001a; Herbert, Evans, & Phipps, 2001).

Tikanga processes were included more recently in the training programme at Canterbury University (Skogstad, Skogstad, & Britt, 2005)[10]. Students are encouraged to attend a Māori language course and are required to attend a series of seminars over their three-year training period with the aim of encouraging interest in tikanga Māori (Māori protocols). The seminars incorporated the history of colonisation, Treaty of Waitangi/Tiriti o Waitangi, awareness of disparities, features of Māori identity and aspects of tikanga Māori (Māori processes and protocols).

Students are also shown how to develop relationships with Māori clients and given practice opportunities to utilise the skill and knowledge gained to develop culturally and clinically safe practice (e.g., doing assessments using a Māori worldview and health model).

The description of proactive and non-active bicultural initiatives above show that over a 25 year period, some institutions have incorporated substantial changes, while others show continued entrenchment of monocultural practices. It is not surprising that discussions about Māori should occur in a cultural vacuum. A real discussion could only happen if programme staff had experienced aspects of Māori culture across a range of situations.

Summary

The attitudes held by the participants in Waldegrave's and Barnett's studies are deeply concerning because they occur in the majority of Universities. The participants did not recognise or mention the contribution of oppressive structures to Māori (or Samoan) disadvantage choosing instead to blame Māori for their situation and the lack of change. Their views reinforce the presence of institutional racism that reflects values of individualism, self-advancement, and hegemony. In terms of learning acquisition, students are affected by their learning environment and are cautious about what they think they can do and say.

---

[10] The Canterbury programme instigated the first scholarship programme for Māori clinical students in 2009.

On the basis of the literature reviewed thus far, it seems as though training programmes are unwillinging to meaningfully incorporate cultural competencies into the curriculum. Bicultural content is typically added to clinical training although there have been full-year courses taught at various institutions, some of which have not been reported in the literature (i.e., Herbert, 2002).

While a few clinical programmes offer a limited range of bicultural content to students, the majority have very little bicultural training, no Māori staff, and no Māori-focused research. Given these limitations, there does not appear to be evidence to support accreditation requirements for training programmes or cultural competency requirements for students seeking registration.

I now deal with the issue of Māori resistance to including bicultural content in psychology courses.

Indoctrination and appropriation

I have criticised psychology for excluding Māori perspectives; however it is true to say that many Māori do not want psychology or Western knowledge forms to impinge any further into their lives and practices (Love, 2002; Milne, 2005; L. Smith, 1992, 1999a). This attitude shows a mistrust of psychology and a belief in Māori self-determination – Māori should be empowered to develop their own psychology that has equal status with mainstream psychology.

Catherine Love at the inaugural Māori graduates of psychology symposium held at Waikato University in 2002 asked:

> How many of the concerns about the fundamental mismatch in the assumptions on which psychology is based, and the assumptions prevailing in te ao Māori, will be addressed by providing Māori content in psychology curricula as an addition to the mainstream psychology that dominates? And how much will these fundamental and philosophical concerns be resolved through increasing cultural sensitivities, or adding cultural competencies, or providing cultural supervision, or developing Māori units in our institutions? (Love, 2002, p. 15)

Catherine added that "the imposition of a body of Western cultural practice, known as professional psychology, no matter how polite, sensitive or competent the imposition, is ultimately destructive and genocidal in its effect on indigenous peoples" (p. 15). The process of cultural appropriation also risks divorcing indigenous approaches to psychology from the cultural frameworks within which they attain their rationality (Love, 2006).

Love (2006) proposed two mechanisms of colonisation that operate in psychology: exclusion and appropriation. The exclusion of indigenous narratives from mainstream psychological discourse, theory, and practice means that indigenous knowledge is devalued and discarded by Western and indigenous scholars. The appropriation and distortion of indigenous culture, philosophy and models has been described as 'theft' of intellectual property. Appropriation is part of the face of ongoing colonisation and the diminution of indigenous knowledge is seen by some as the latest wave in Western exploitation of indigenous peoples (Love, 2006).

As a consequence of colonisation, Māori are more likely to resent and mistrust Pākehā intentions. In many instances, aspects of indigenous philosophies, orientations and practices have been appropriated, redefined and inserted into Western frameworks to the detriment of Māori (Lawson-Te Aho, 1993; Love & Waitoki, 2007b; Milne, 2005). Mahuika (2008) also highlighted Māori experiences of disempowerment and misunderstanding at the hands of researchers,

> Māori, like other indigenous peoples have had first hand experiences of disempowerment through researchers who have taken Māori knowledge and claimed it as their own, presuming to set themselves up as authorities on our culture yet discussing our lives and experiences in ways that are alien to our understanding (p. 2).

For Māori, when language, culture and knowledge of the colonised are used in an un-reflexive way it serves to affirm the group of people who already occupy the position of power (Bertanees & Thornley, 2004). While there is a need for bicultural initiatives and cultural competency training in psychology, what is not needed is a wholesale misuse and lack of understanding of Māori culture and its relevance to psychology.

Marsha Linehan, a professor of psychology provides an example of appropriation. Linehan developed a comprehensive therapeutic programme for borderline personality disorder called Dialectical Behaviour Therapy (DBT) (Linehan, 1993). DBT contains elements that may be viewed as appropriated from Buddhist principles of meditation. The DBT programme is 'exported' as a therapeutic framework and comes with financial and professional benefits for the producers and trainers[11].

The religious and cultural context from which DBT is derived receives minimum acknowledgement and does not form part of the training module. When considering Buddhist philosophy and Dialectical Behaviour Therapy a question arises, does every trainer/psychologist who implements DBT understand the principles of Buddhism? What would a Buddhist monk say about having part of their religious practices taken out of context? Perhaps the answer depends on which monk you asked, as views about appropriation and who benefits vary. Some may say that it might be useful to teach clients about Buddhism as a whole philosophy rather than just teaching elements.

The use of elements of Māori culture within psychological confines without considering the cultural context of Māori experience may constitute another form of oppression, and risks alienating Māori students from their people. Levy (2002) identified a concern that psychology departments did not know what they were doing when tikanga Māori (protocols and processes) were added ad-hoc:

> The danger is if we start putting bits of Māori content into psychology then we have supposedly culturally competent psychologists practicing the limited monocultural psychology which is already there, for example with karakia [Māori spiritual invocations] at the beginning and end of sessions. That is more dangerous than being obviously not competent to work with Māori (participant, in Levy, 2002, p. 44).

---

[11] The technique is also on the 'probably efficacious' list of therapeutic techniques, which may or may not be due to the Eastern origins (Chambless & Hollon, 1998).

The process of adding-on tikanga for the sake of appearing culturally competent highlights the lack of understanding of Māori knowledge and its purpose. Lawson Te-Aho, (1994) commented that cultural development strategies in psychology assume that 'cultural tailoring' inside the unchallenged and unchanged context of Western psychology can produce safe psychological practice and safe outcomes for Māori.

In light of the goals of biculturalism, it is not surprising that Māori are concerned about what is happening with their knowledge forms and expressions and wish to avoid further erosion of their values, culture and their people. The difficulty that Māori are faced with is the need to include Māori content into psychology, while preserving the essence of Māori culture, and preserving the cultural integrity of Māori students. That is, preserving the standing of Māori academics in the eyes of their tribal elders.

The captive mind: Māori psychologists

I now expand on an earlier comment about Alatas' description of the captive mind in third world countries. Alatas argued that the captive mind, as a syndrome, characterises the features of indoctrination, cultural encapsulation and brain-washing:

> A **captive mind** is the product of higher institutions of learning, either at home or abroad, whose way of thinking is dominated by Western thought in an imitative and uncritical manner. A **captive mind** is uncreative and incapable of raising original problems.

> It is incapable of devising an analytical method independent of current stereotypes. It is incapable of separating the particular from the universal in science and thereby properly adapting the universally valid corpus of scientific knowledge to the particular local situation.

> It is fragmented in outlook. It is alienated from the major issues of society. It is alienated from its own national tradition, if it exists, in the field of its intellectual pursuit. It is unconscious of its own captivity and the conditioning factors making it what it is.

> It is not amenable to an adequate quantitative analysis but it can be studied by empirical observation. It is a result of the Western

> dominance over the rest of the world (Alatas, 2004, cited in Kais, 2010, p. 339).

The problem with the captive mind is that the person lacks originality and is uncritical at all levels of scholarly activity including problem setting, conceptualisation, analysis, generalisation, explanation and interpretation (Alatas, 1996). Concerns about the appropriation of Māori knowledge also relates to appropriating the minds of Māori students.

Māori concern about what is taught in mainstream institutions is a reaction to the potential for Māori students to develop internalised racism towards their people. Indigenous and non-Western peoples are wary of their own people being 'indoctrinated' into Western psychological frameworks and becoming 'infected' with Euro-American thinking (Essandoh, 1998; Milne, 2005). Moe Milne (2005) found that there was a perception amongst her participants that those who had gone through mainstream Western psychology training must unlearn a lot of what they had been taught in order to operate safely and effectively with Māori.

Moe's (2005) research is often cited among Māori psychologists as she offered a unique perspective into the views of Māori about Māori. According to her participants, Māori who entered into mainstream training institutions were trained to think as Pākehā: "Māori become brainwashed in training" (p. 15). A particularly stinging quote is the belief that, "Ako Pākehā atu, ka puta Pākehā mai - Given Pākehā teaching, it will be Pākehā (thinking) that emerges" (anonymous participant, Milne, 2005, p, 15).

The implication here is that Pākehā thinking is destructive not only to the person, but also to advancing Māori aspirations. There is also a concern that Māori who think as Pākehā adopt deficit theories about the position of Māori in society. Māori academics (who most likely consider themselves as not brainwashed) believe that deficit theories about Māori result in marginalisation, cultural inferiority, and immobilising oppression (Bishop, 1999; Mahuika, 2008).

The dilemma is that although education can be an emancipatory tool, it can be difficult to overcome socialisation and to avoid being captured by the

values of the institution. Stanley (2002) voiced his disdain for Pākehā institutions, warning that Māori, as academics, needed to be careful not to lose sight of who they are. He made no attempt to sanitise his comment, "if you lay down with dogs, you get fleas" (p. 85).

There are also emotional reactions to indoctrination, or the captive mind. Comez-Diaz (2005) in her journey to becoming a multicultural therapist, experienced internalised racism, and described herself as going through a period of being a *"conceited clinician, favouring scientific tools over indigenous ones"* (p. 976). She used the term "*professional socialisation*' to describe how she had come to despise folk healing and had forgotten who she was and where she was from (Puerto Rico).

Māori-centered psychology

Māori knowledge may become distorted by the academic training orientation providing situations where the tools of the oppressor are seen as being used against Māori aspirations (Stanley, 1993). Cultural appropriation of knowledge is so endemic that some indigenous peoples have cautioned cultural competency trainers to avoid developing indigenous material that would be 'captured' and appropriated for the benefit of non-indigenous academics or institutions (Garvey, 2007). Tribal leaders and elders may be suspicious of attempts to incorporate Western methodologies into their healing processes due to concerns about safety for their people and of losing their cultural practices (Rangihau, 1975).

Indigenous peoples who have a shared country and cultural practices but with distinct identities are often overlooked in favour of a view which homogenizes. Overlooking the existence of distinctive groupings among similar peoples ensures that the task of appropriation and colonisation is simplified. Darren Garvey (2006) described the way that Aboriginal Australians were regarded as a single group, rather than as unique tribes possessing distinct languages and cultural expressions, saying that,

> I suspect that the profession more broadly has regarded Indigenous people in certain ways. I think that something that has been mentioned has been that this observation of a group or an individual Indigenous person may have been used then to inform or stop any

> additional consideration of other Indigenous people. So the homogenisation of Indigenous people occurred early on, I'd say. So what one learns from one person may have been extrapolated to other original inhabitants of Australia. I think that's generally how that pattern went (Garvey, 2006 p. 77).

Gone, a native psychologist (cited in Trickett, 2009, p. 410) attempted to incorporate indigenous cultural knowledge of self, wellness, healing and spirituality into culturally appropriate interventions but was met with resistance by his people. Gone was seen as an outsider attempting to inflict assimilationist assumptions on Native Americans. He was asked by an elder, "How does it feel to be an Apple Indian? (red outside, white inside)". The history of mistrust, and perhaps an increased confidence in indigenous healing practices, meant that Gone's intentions were unacceptable to his people.

Achieving the balance between Western psychology and indigenous healing processes is difficult when the processes of validation and verification operating in both systems are in opposition with each other. A framework is needed that manages the strengths and limitations of each system, and also allows for cross-fertilisation of useful ideas and practices. I propose a way around this dilemma in a later section.

Māori as psychologists

The first real attempt to ask Māori clinical psychologists what they did with Māori and non-Māori clients was undertaken in 1997 (Paewai, 1997). Paewai developed a model based on a cultural safety framework to assess the practices of Māori psychologists to identify key areas where cultural safety was essential in their work. Paewai's study is unique as she did not presume that a Western framework would dominate psychologists' practice, thereby providing an opportunity for a description of Māori processes to emerge. The model incorporated four domains of practice: *preparation* (the way the organisation or psychologists prepare to work with Māori; *skills* (essential skills necessary to work with Māori); *practices* (essential procedures necessary to work with Māori) and *outcomes* (the results of incorporating cultural safety).

An interesting feature of Paewai's (1997) study was that Māori psychologists stated they did not need to use cultural safety practices with Pākehā clients as they believed Pākehā values attitudes and beliefs underpinned psychological practice. The implication was that Pākehā are already safe, whereas Māori are not.

One psychologist commented that "...psychology is all about Pākehā cultural safety – how their attitudes and values and beliefs impact on behaviour and this why our practice (clinical psychology) is unsafe for Māori" (Paewai, 1997, p. 84). Since Paewai's study, other Māori psychologists have presented research showing their unique contributions to advancing psychology for Māori.

Modifying or adapting evidence-based treatments has been studied as a viable alternative to Western psychological treatments. Cultural adaptation refers to the systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values (Bernal, Jimenez-Chafey, & Rodriquez, 2009).

Research conducted by Māori psychologists show that Māori clients are being treated with either culturally adapted psychological practices or indigenous Māori practices and processes. Both forms of practice use distinctly Māori processes, however in the culturally-adapted approach, Western psychology is the main assessment and treatment modality. These studies advance the possibility of identifying a set of practices and philosophies that are uniquely Māori, and could be used in clinical education and practice.

The studies show that culturally-adapted practices are used to engage with clients by using *mihimihi* (greetings), self-disclosure, karakia, Māori language and personal contact (Bennett, 2009; Manna, 2002). Personal disclosure is used in the process of *whakawhānaungatanga* (establishing family connections) where open discussion about family and geographical links occur (Bennett, 2009; Robertson, Collier, Sellman, Adamson, Todd, Deering, Heal, & Huriwai, 2001). Goldsbury (2003) also found that clients thought it was important to be asked about their ethnic identity and that psychologists

should be able to demonstrate knowledge of tikanga processes and Māori values.

Culturally-adapted practices also include showing respect for clients and their unique ethnic and cultural identity and values by sharing power, being culturally responsive, instructing and guiding clients and by using Māori healing methods. For example, "encouraging the use of tohunga" and "not using conventional methods of teaching" (Paewai, 1997, p. 52).

Psychometric tools incorporating Māori worldviews are also included in the range of psychological practice with Māori. Palmer (2004) developed a tool to measure Māori wellbeing, *Homai te Waiora* which is based on concepts drawn from models of Māori wellbeing including *Te Whare Tapa Wha* (Durie, 1994) and *Te Wheke* (Pere, 1994).

There are also healing techniques that have existed in Māori culture for thousands of years. Durie's Te Paiheretia (2003) model explores the wider set of relationships that impinge on mental health and seeks balance across four fields of experience – *spiritual, mental, physical,* and *social.* Te Paiheretia highlights the role that Māori processes have as therapeutic interventions for Māori to develop a secure cultural identity, develop balanced relationships and reciprocity with the wider environment.

Cherrington (2003) offered a Māori-focused intervention based on pūrakau/story-telling. The principles contained within the pūrakau method are wānanga (discussion and debate) (power-sharing) and re-telling the story. Consumers decide which method they use to retell the story which typically includes the use waiata, haka, poetry, drama, sculpting, painting, drawing, storytelling, and/or writing.

Cherrington explained, "traditionally, pūrakau have been handed down from generation to generation to provide advice and insights to the thoughts, actions, and feelings of our ancestors" (p. 118). Walker (1975) wrote that Māori stories have contemporary value as they provide guidance for appropriate social and individual behaviour.

Durie (1994) provided a model of Māori health that helped shape the way Māori clients are assessed that has become embedded in public health policy (Pitama et al., 2007). Durie's Te Whare Tapa Wha Model consists of four dimensions underpinning Māori beliefs and values about health and wellbeing: ko te taha whānau (the family dimension), ko te taha wairua (the spiritual dimension), ko te taha tinana (the physical dimension), ko te taha hinengāro (and the psychological dimension). Health professionals use the four dimensions as guiding points to gain a better understanding of the causal and protective factors for Māori health and to develop interventions to help their clients. Durie's model is one of the few models taught in clinical training.

Pitama et al. (2007) modified Durie's model by adding two extra dimensions: taiao (physical environment), and iwi katoa (societal context). Their new "Meihana Model" (based on Te Whare Tapa Wha) consists of six dimensions that allow for the fusion of clinical and cultural competencies while directly assessing Māori values and beliefs. The taio dimension assesses the physical impact of the environment on the client and their access to the service (i.e., poor housing, drugs and alcohol); and the iwi katoa dimension identifies the societal structures that impact on the organisations' ability to work alongside the client/whānau.

The model recognises the importance of social justice and advocacy by proposing that that assessment and intervention is more than the interaction between the clinician and the client, but is part of a combination of multiple relationships that occur within a larger system. The Meihana model provides some much needed structure and guidance to Te Whare Tapa Wha and is helpful in outlining specific Māori beliefs and values and their potential impact on Māori clients.

Some common themes across Māori-centered interventions are that Māori experiences are normalised, the interventions belong to Māori; they provide validity for Māori philosophical beliefs and they promote Māori identity. Using indigenous models and culturally-adapted models does not preclude the use of Western-only models as all three systems can work in partnership.

Durie (2003) stated that as Māori live in two worlds there was no reason why a mainstream service cannot include Māori cultural values.

The use of Māori processes as healing methods in psychology is in its infancy and its real potential may not be apparent because of the structured context in which Western therapy is conducted. There is an issue about training and practice with Māori psychologists that has not been commented on in the literature, which is that Māori psychologists (and some non-Māori) graduate from training and implement Māori processes in their practice that they did not acquire at University.

The observation that psychologists use Māori cultural processes is revealing, as I have already established that bicultural practices are largely excluded in clinical training. Furthermore, had Māori psychologists used those processes, they would not have passed the training programme (Paterson, 1993; Brady, 1993). The scientist-practitioner model does not endorse using non-empirically validated models with clients, and yet these psychologists used processes they knew worked with Māori.

The answer perhaps is related to what constitutes empirically validated protocols and whether Pākehā or Western science's monopoly on legitimating those protocols is workable in Aotearoa-New Zealand. Additionally, there is a real need to identify whether Māori processes are effective and if they can be taught in training. Any research that seeks to bring Māori processes into a Western context needs to consider issues of appropriation and the potential for abuse to occur.

Kaupapa Māori theory offers a platform to ensure that Māori aspirations are protected and enhanced. An overview of kaupapa Māori theory and practice is warranted in this study despite not explicitly using this literature in the research design or implementation. The main reason was that my earlier thinking about Māori and psychology was more in line with the cultural adaptation process described earlier. In actual fact, I was suffering from the 'captive mind' syndrome.

I became more aware of the goals of emancipation for Māori and sharing knowledge when I set about analysing the results of study two. With this is mind, I present the kaupapa Māori theory framework to manage the tensions that occur between the discourse of biculturalism or kaupapa Māori and Western dominance in psychology. I also present kaupapa Māori theory as a remedy for those who, like me, had a captured mind.

Indigenous knowledge: Kaupapa Māori

The term 'Kaupapa Māori' originated in the Kōhanga Reo and Kura Kaupapa Māori education movement of the 1980s as part of a series of Māori-led initiatives aimed at strengthening Māori language, affirming cultural identity, and encouraging community involvement (Bishop, 1999; Eketone, 2008; Mahuika, 2008; G. Smith, 2003). The term has developed considerably in the past 30 years by incorporating "the philosophy and practice of being and acting Māori" (Smith, 1992, p. 1).

Kaupapa Māori is seen as the operationalisation of self determination/tino rangatiratanga (Smith, 1999), and is described as being "committed to a critical analysis of the existing unequal power relations within our society" (Bishop, 1999, p. 2).

Kaupapa Māori theory challenges mainstream assumptions (i.e., those prevalent in academic institutions) as a source of knowledge production and cultural capital (Henry & Pene, 2001) and "addresses the prevailing ideologies of cultural superiority which pervade our social, economic and political institutions" (Bishop, cited in Smith, 1999, p, 184).

Kaupapa Māori theory, through its alignment with critical theory, has elements of conscientisation, resistance and praxis (Smith, 1997, cited in Pihama, 2001, p. 81). For Māori, resistance enables transformation, which in turn allows for self-determination. Kaupapa Māori theory also provides a lens through which colonising processes and practices can be identified and challenged.

Paulo Friere, (1972) proposed that the oppressed must "first free ourselves before we can free others". Implicit within this statement is a call to action;

"through praxis, oppressed people can acquire a critical awareness of their own condition, and, with their allies, struggle for liberation (p. 36). The freeing of our minds relates to indigenous peoples imagining themselves free from oppression and free from the grip of hegemony (Smith, 2003).

The 'grip of hegemony' occurs when indigenous and colonised peoples come to take on dominant group thinking and ideas as though they were "common-sense, even though those ideas may be contributing to their own oppression" (G. Smith, 2003, p. 3). Smith (2003) proposed a solution to hegemonic thinking,

> The counter strategy to hegemony is that indigenous people need to critically `conscientize' themselves about their needs, aspirations and preferences. This calls for a `freeing-up' of the indigenous imagination and thinking given that one of the important elements of colonization is the diminishment of the indigenous ability to actually imagine freedom or a utopian vision free of the oppressor. Thus a critical element in the `revolution' has to be the struggle for our minds (p. 3).

Kaupapa Māori theory is underpinned by the desire to live in ways that are determined by Māori, ways which are fundamentally different to dominant Western ideals. Kaupapa Māori assumes the taken for granted social, political, historical, intellectual and cultural legitimacy of Māori people (Bishop, 1999) and their aims and aspirations. Once the mind is set free, Māori are able to consider for themselves what they need to transform and participate in te ao Pākehā and te ao Māori (the Pākehā and Māori world). Smith (2003), contended that,

> ...the real revolution for Māori began with a shift in mind-set of large numbers of Māori people, a shift away from waiting for things to be done to them, to doing things for themselves; a shift away from an emphasis on reactive politics to an emphasis on being more proactive" (p. 2).

Smith (2003) defines kaupapa Māori as incorporating six key elements, or metaphors:

1. The principle of self-determination or relative autonomy.

2. The principle of validating and legitimating cultural aspirations and identity

3. The principle of incorporating culturally preferred pedagogy

4. The principle of mediating socio-economic and home difficulties

5. The principle of incorporating cultural structures which emphasise the collective rather than the individual

6. The principle of a shared and collective vision/philosophy.

Kaupapa Māori as a theoretical framework has evolved from a base of being Māori, asserting recognition, affirmation and validation of cultural world views as Māori, and enables a culturally-defined theoretical space for Māori to explain their experiences (Pihama, 2001). The description of kaupapa Māori so far highlights that Māori simply wish to live their lives as Māori and to participate in society as equals. Implicit within this desire or aspiration, is that Māori live according to who they know themselves to be, or wish to be, and that Pākehā do not stand in opposition. Mahuika (2008) positions kaupapa Māori as a frame from which Māori aspirations for self-determination are made possible,

> Kaupapa Māori theory provides a platform from which Māori are striving to articulate their own reality and experience, their own personal truth as an alternative to the homogenization and silence that is required of them within mainstream New Zealand society. Inherent in this approach is an understanding that Māori have fundamentally different ways of seeing and thinking about the world and simply wish to be able to live in accordance with that specific and unique identity (Mahuika, 2008).

The ways that Māori address these principles varies across institutions and professions including education, health, science, law, and psychology. Theory building from a Māori perspective provides a serious challenge to the dominant Western view by positioning people, genealogy, history and culture as valid theory-testing methodologies. Furthermore, a Māori perspective incorporates aspirations of escaping from oppressive systems. Pihama viewed kaupapa Māori theory as,

aligned with critical theory as it exposes underlying assumptions that serve to conceal the power relations that exist within society; and the ways in which dominant groups construct concepts of 'common sense' and 'facts' to provide ad hoc justification for the maintenance of inequalities, and the continued oppression of Māori people (cited in Smith, 1999, p, 185-6).

As I have highlighted so far, Western psychology reinforces oppressive structures in society by positioning itself as the legitimate holder of power and knowledge about normative behaviour. Barnes (2000) describes kaupapa Māori as a challenge to accepted norms and assumptions about knowledge and the way it is constructed, and as a continuation of a search for understanding within Māori worldviews. Her premise is that Māori knowledge should be considered ordinary and taken for granted. Instead it is defined, discussed and explained in ways that serves as a reminder of the power of colonisation.

Kaupapa Māori offers an alternative to Western scientific explanations. The elements that define kaupapa Māori are grounded within Māori metaphysical, philosophical, and social, language and cultural worldviews (Pihama, 2001). These worldviews are self-legitimated through centuries of tried and tested usage, and by comparison, should withstand the relatively recent Western mono-lens.

Kaupapa Māori theories and goals challenge the status quo within mainstream institutions by critically analysing "orthodox", "established' and "taken-for-granted" theories and philosophies, not by following Western rules, but by using its own.

Kaupapa Māori theory provides for intervention and transformation at two levels: institution and mode (Smith, 2000). The institutional level relates to economics, power, ideology and constructed notions of autonomy. Mode relates to pedagogy, curriculum and evaluation (Smith, 2000). Implicit within institutions are notions of politics and power. Smith (1997, cited in Smith, 2000, p. 273) asserted the necessity to challenge and change unequal power within institutions and modes, adding that,

> Kaupapa Māori strategies challenge the right of Pākehā to dominate and exclude Māori preferred interests in education, and asserts the validity of Māori knowledge, language, custom and practice and its right to continue to flourish in the land of its origin, as the tangata whenua (indigenous) culture (p. 273).

Others are not so convinced of the value of kaupapa Māori theory, arguing that it serves to replicate unjust power hierarchies by replacing the rich and powerful former masters, with an academic elite and that alternative approaches by Māori reflect resistance to critical theory (Rata, 2006). Marie and Haig (2006) criticised kaupapa Māori "adherents" as drawing on key tenets of bicultural "ideology" and claiming kaupapa Māori research "doctrine" as having parity with standard accounts of scientific methodology on the grounds that it represents a separate, yet equal worldview (p. 4).

Marie and Haig argue that kaupapa Māori researchers have exploited the political environment by insisting that the ideology of biculturalism affords their "doctrine" special privilege and protection. Marie and Haig (2006) are inconsistent in supporting biculturalism as an ideology, while rejecting biculturalism that theorises and proposes transformation, liberation, and alternative views of science and knowledge.

By labelling kaupapa Māori theory as a doctrine, the implication is that it is unscientific; a view that is a reminder of the monocultural positioning of biculturalism as "window-dressing" which is safe (i.e., not challenging), is controlled (used when required, and subject to non-Māori rules about validity), and is silent (unheard and unseen, except when pōwhiri is required).

In 1975, John Rangihau, who also chaired the *Puao-te-Ata-Tu* (Department of Social Welfare, 1985) committee commented on how Pākehā expectations about how Māori ought to behave,

> You see, when Pākehā say we are all one people, they seem to mean that you're brown and a unique feature of the indigenous scene. But they want you to act as a European provided you can still retain the ability to poke out your tongue, gesticulate and do your Māori

> dances...I can't go along with this because I can't feel like I can be Pākehā (Rangihau, 1975, p. 189).

Constructive criticism of kaupapa Māori recognises a Māori worldview, understands the rationale for kaupapa Māori theorising and does not presume ownership of words such as valid, scientific and empirical. Eketone (2008) raised the issue of whether or not centring kaupapa Māori within Western theoretical frameworks is regressive or progressive to the advancement of Māori peoples. He proposed that kaupapa Māori is underpinned by two differing and at times competing perspectives – critical theory (which seeks to challenge and transform), and social constructionism (where knowledge is validated through a social construction of the world).

Eketone (2008) suggested that an alternative to kaupapa Māori theory is to contextualise it within a Native Theory framework as it fits with a community perspective of a Māori worldview. A community worldview takes into account iwi and hapu perspectives, is self-critical, and does not rely on Māori being oppressed, or locked in a perpetual challenge against unjust power dynamics (Eketone, 2008).

Nepe (cited in Smith, 1999) argued that "kaupapa Māori is derived from very different epistemological foundations and metaphysical foundations and it is these which give kaupapa Māori its distinctiveness from Western philosophies" (p. 187). As such, whānau and community input and confirmation are moved beyond the role of 'cultural advisor', and terms such as 'social validity' and 'face validity' are left behind as being insufficient.

The whānau framework is brought to the centre in kaupapa Māori theory and research (Smith, 1999). This view accepts that knowledge is contained within these communities to the extent that Māori knowledge depends on iwi, hapū and whānau knowledge for its coherence and legitimacy. The debates about whether kaupapa Māori excludes or positions one view over another obscures the foundation of kaupapa Māori theory – that is the philosophy of being and acting Māori, on Māori terms.

The dilemma for Māori is to find ways of validating Māori knowledge while balancing the need to preserve their uniqueness and mana. The relevance of

kaupapa Māori to this thesis is that it provides guidance to ensure that Māori aspirations are recognised as integral components of cultural competency training. Before I move into describing the data gathering process, I shall deal with the belief that kaupapa Māori is anti-Pākehā.

Is kaupapa Māori anti-Pākehā?

There is an assumption in some circles that kaupapa Māori advocates reject Pākehā theories, methods and practices. This is antithetical to kaupapa Māori principles of advancing Māori aspirations. In the 1800s, Māori used Pākehā farming and agricultural techniques to advance their economic position within the framework of Māori iwi, hapu and whānau (Bishop & Glynn, 1999).

Kaupapa Māori principles do not advocate the rejection or exclusion of Pākehā culture or a 'one or the other choice'. Māori want the option of being able to critique, evaluate and choose pathways that meet their aspirations. Stewart (2007) notes that kaupapa Māori is not defined by its methodology but by its political stance; a stance that also includes stated biases, goals and assumptions. Such openness is necessary as Māori need to be clear about what is required to be free of oppressive institutions and practices.

While Māori are in a relationship with Pākehā they must continue to align with Pākehā and to position themselves strategically in a partial attempt to "contain the unevenness and unpredictability, under stress, of people engaged in emancipatory struggles" (Smith, 1999, p. 186).

Due regard must be given to the many Pākehā who believe in Māori self-determination by engaging in emancipatory struggles with and for Māori (Black & Huygens, 2007; Hammerton, 1998; McCreanor, 1993; Nairn, 2007)[12]. As noted previously, a good deal of the participation by Māori in psychology (mainly clinical and community) is directly linked to the support

---

[12] I have only named a few Pākehā to illustrate. Many are already included in the other parts of this thesis.

(research outputs, staff appointments, student support programmes, scholarships, training opportunities) provided by Pākehā.

A range of programmes exist that have produced Māori psychologists, lecturers, and researchers who contribute to the ongoing development of Māori in psychology. Levy (2007) proposed that Māori needed to consolidate their resources (i.e., the right people in the right places) to achieve a point of irreversible change. Underpinning the purpose of consolidation is the goal for Māori of attaining autonomy, equality and the ability to participate as Māori in Māori and Pākehā worlds. The value of kaupapa Māori theory is that it allows multiple worldviews to be included in theorising and practice. For Māori to do that, they need to claim as much space as possible to develop their own psychology and to have control over the relevance of psychology for them.

Summary

In the past 30 years, there have been repeated calls for psychology programmes to include Māori-focused education in the curriculum and in research outputs. Research conducted by the small number of Māori psychologists, researchers, academics and students on education and practice outcomes show that while change has occurred, it has been slow and the pathway difficult.

As Barnett and others found, Māori experience racism and cultural blindness, and tend to be the default educators for Pākehā on Pākehā terms, or are viewed with distrust by Māori communities as being brainwashed, and contributors to genocidal practices (Cargo, 2008; Love & Waitoki, 2007a). The double-edged sword for Māori is that a way forward must be found where two worldviews can operate while maintaining the integrity of both cultures.

The literature that I reviewed so far has positioned clinical psychology as an antagonist to Māori aspirations in psychology. However, I know from my own experiences as a clinical psychologist that psychology has alleviated some difficult mental health issues for Māori clients. In regards to kaupapa Māori theory, it is not helpful to reject theories and practices that work for the sake

of calling something a Māori framework. With this in mind, I have attempted to theorise how Western models can advance Māori aspirations.

My primary concern with Western psychology is that it does not allow alternative views to have a voice, or equal standing in the academy. By blending two worldviews I hope to sort out which parts are usable and which parts should be discarded, or left for another time. There is also evidence that Māori have the potential to develop their own psychology (Levy, 2007; Moeke-Pickering, 2010). The research done by Māori has shown that this is a real possibility (I return to this later).

At this point I turn to describe the literature on whether training programmes produced competent psychologists. There is some overlap in content with the previous section on training content in Aotearoa-New Zealand.

CHAPTER 5: CULTURAL COMPETENCY EDUCATION: DOES IT WORK?

Training pedagogy

Cultural competency programme reviews conducted over the past 40 years focused on a range of aspects of multicultural education including programme design and evaluation methods. Topics included the amount of cultural competency in the curriculum (i.e., add-on or infused, workshop, single-lecture) whether the course was compulsory or elective and how competency is taught and evaluated.

Longitudinal research conducted from 1980-90 sought to identify whether academic institutions prepared clinical psychologists to work with ethnic minorities (Bernal & Castro, 1994; Quintana & Bernal, 1995). Although the reviewers found a substantial increase in the number of universities offering cultural diversity content in their courses (1980 = 57; 1990 = 138) there was evidence to show that clinical programmes did not require students to enrol in those courses.

In relation to preparing students for practice, a substantial proportion (74%) of the programmes reviewed over 15 years lacked the structural basics of minority training and did not require even one minority course for completion of the doctorate (Bernal & Castro, 1994; Maton, Kohout, Wicherski, Leary, & Vinokurov, 2006). Ten years later, Castro's (1998) review of clinical courses found widespread expression of endorsement of the importance of cultural competency, but programmes still had underdeveloped infrastructures (coursework, minority faculty recruitment and retention, community links) for promoting cultural competence in training. They commented that "most programs nationally would fare no higher than being culturally sensitive" (p. 139).

Since those earlier reviews there has been a substantial increase in the inclusion of multicultural courses and research opportunities in psychology

training programmes due primarily to accreditation requirements (Ducker, 2001). Courses were designed to develop students' awareness of their own racial and cultural heritage, biases, and assumptions in addition to building knowledge about other racial and cultural groups, and the skills to work across cultures (Edmondson, 1999). However, compliance with accreditation standards alone seemed to be the driving force underpinning multicultural education with little attention paid to outcomes or validity.

Fouad (2006) commented that although her institution received a favourable accreditation report based on its diversity plan, the counselling psychology programme in which she taught did not have a diversity plan. There is a real possibility that institutions nationally and internationally are being accredited for something that does not exist, and that their programmes do not actually produce competent psychologists. Unless there is accurate reporting and honesty, there is no real way of knowing beyond anecdotal evidence.

The most common approach to multicultural training is the single-course format. Although single courses are cheaper to run and require fewer departmental resources, they are seen as the least effective and viewed as an 'add on' rather than integral to cultural competency (D'Andrea, Daniels, & Heck, 1991; Glover & Robertson, 1997; Ponterotto, 1997). As I comment later, the add-on approach has some benefits but it depends on how it is taught and whether the content is meaningful.

Ridley, Espelage, and Rubinstein, (1997) highlighted how multicultural education is typically taught: (a) *traditional strategies,* defined as didactic lectures, reading and research assignments, impersonal class discussions of topics; (b) *exposure strategies,* defined as activities that permit direct contact and interaction with persons from diverse backgrounds by having guest speakers, visits to different communities, or participation in diverse cultural activities; and (c) *participatory strategies,* defined as role plays and counselling simulations, experiential exercises, self-exploration, candid class discussions of reactions to course assignments/activities, and processing of resulting emotions (p. 122).

Ridley et al., (1997) also proposed that cultural competency training is more likely to be effective when it is infused in other parts of the psychology department. The term *infusion approach* is used in psychology training to describe how cultural variables are incorporated into a single course and also throughout other courses in a department and within the faculty (Ridley et al., 1997).

Aotearoa-New Zealand

As far back as the 1970s there were concerns about the effects of offering services to consumers by untrained psychologists (Abbott & Durie, 1987; Lawson-Te Aho, 1993; Paewai, 1997). To date, efforts to teach bicultural course material in clinical psychology have not been hugely successful: neither have these methods been evaluated in any meaningful way. Evans (2008) stated that "it is, unfortunately, anybody's guess as to how well we are doing in the New Zealand academic clinical programmes, as we have no evaluations of any of the programmes" (p. 7). Evans was talking about clinical training in general, not just bicultural training.

Course content: Add-on, or infused?

Some of the problems associated with university courses reflect the way that bicultural content is included and whether Māori have any control over the delivery, content, or outcomes. Thomas (1993) identified three distinct features of bicultural services provided in the education, community mental health, social work and health sectors that illuminate the way bicultural teaching is handled by dominant groups.

> 1. Training psychologists who are only familiar with Pākehā cultural patterns in competencies required for providing services for Māori clients (*Add-on pattern*)

> 2. Employing staff familiar with Māori culture (i.e. bicultural) to provide services for Māori clients. Such staff may or may not have training in psychology (*Partnership pattern*)

3. Supporting the establishment of a parallel Māori organization or group to provide a service which is run by Māori for Māori (*Parallel development pattern*).

Thomas (1993) considered that the add-on approach "has little or no relevance to the delivery of psychological or mental health services" and "that learning can only take place over an extended period of time with continuing feedback from a number of Māori people who are familiar with Māori culture" (p. 2). The add-on approach currently undertaken in Aotearoa-New Zealand Diploma programmes includes single topic lectures, single courses, or workshops that stand-alone.

A significant problem with the add-on approach is that programme staff and students are dependent on their institution for support; they are reactive to the demands of other staff and external agencies; and Māori are unsupported in their goals for self-determination and equality (Durie, 2003; 2007; Lawson Te Aho, 2002).

Not everyone thinks that the add-on approach is counterproductive for Māori aspirations. Durie (2003) commented that Māori attend schools, polytechnics and universities where a Māori dimension is added on to an existing framework (the Māori-added pathway) and that although limitations exist, Māori have benefitted from this approach.

The partnership pattern or collaborative approach is preferable to the add-on approach as it reflects the importance of shared responsibility for improving Māori participation in psychology. An example of this pattern is when psychology departments have an arrangement with Māori to provide training or education opportunities. Skogstad, Skogstad and Britt (2005) describe this approach, highlighting the benefits of Māori psychologists providing training for clinical students. In some cases it could be said that contracting Māori to provide additional training is an add-on approach; the test is the degree to which Pākehā are engaged, interested, and supportive of Māori colleagues and the benefits to Māori clients.

The parallel or Māori centered approach operates with a measure of self-determination or autonomy that is typically absent from other pathways.

Māori are often dependent on government funding, or state control, but by and large the environment, ethos and practices are developed by Māori, for Māori. Examples of this approach are kura kaupapa Māori (Māori language immersion schools) kōhanga reo (pre-school Māori language immersion schools) Māori health services, and research or training units within University departments (e.g, The Māori and Psychology Research Unit at Waikato University, MPRU).

Levy (2007) developed a framework combining factors that are currently operating, or need to operate, that could contribute to a Māori psychology (we agree that a distinct Māori psychology is possible). Her proposal includes: *multiple pathways* (training) consisting of add-on, Māori centered, and collaborative; a critical mass of leaders and producers. The need for *consolidation mechanisms* involves collective vision and collective capacity that leads to practice, research and teaching. Levy furthered her proposal by stating that the flow-on effect is the development of training programmes that affirm indigenous practice and has culturally relevant knowledge. Additionally, training programmes should confirm cultural identity and contribute to, and rely upon, a literature base created by Māori.

The approaches described above all operate with some form of Pākehā oversight mostly in the form of funding and or accreditation. This means that the delivery of bicultural training is still dependent on Pākehā systems of control. With this in mind, any programme that seeks to develop cultural competencies in students can only do so within an ever changing political, economic and social environment.

Elements of cultural competency programmes

In the United States, the range of possible influences and effects of multicultural training have been constantly evaluated and refined. Researchers have attempted an operational definition of multicultural training and found that such training needs to demonstrate broad and specific elements of training, including: broad philosophical perspectives or a statement of philosophy (e.g., a commitment to diversity) and having a culture-centered curriculum (Abreu, Chung, & Atkinson, 2000; American

Psychological Association, 2003). Further elements are that staff and student levels should reflect the diversity of the population and show positive attitudes about multiculturalism throughout all levels of training.

Additionally, internships, coursework and examinations should be diverse, and have standardised criteria to describe multicultural content and training experience in programmes (Speight, Myers, Cox, & Highlen, 1991). Staff should also show evidence of commitment to multiculturalism through their teaching and research outputs (Fouad, 2006; LaFromboise, 1991). The assumption here is that cultural competency education needs to have a solid base so that it can be developed and evaluated without being ad-hoc and meaningless.

Some researchers advocate for specific course content. Yutrzenka (1995) argued that graduate programs in clinical psychology should be accountable for demonstrating in their curriculum that students adequately learn about the importance of ethnicity and culture. In particular, how ethnicity and culture affected the experience of clients, the manner in which their psychological distress was expressed, and the way cases were conceptualised.

The focus on the ethnic identity of psychologists and their clients resulted in a proliferation of research into theories and tools designed to measure ethnic identity and its potential impact on the therapeutic relationship (Durie, 1997; Helms & Carter, 2001; Ponterotto & Mallinckrodt, 2007). Theories on ethnic identity and culture were also subject to criticism from indigenous psychologists who cautioned their peers not to create havoc by researching the mental health implications of cultural identity without a having a broad multidisciplinary understanding of the constructs of culture (Trimble, 2007).

With these views in mind, how do we know if students possess the necessary cultural competencies? Smith, Constantine, Dunn, Dinehart and Montoya (2006) commented that,

> In practice, multicultural education currently consists of a multiplicity of paths with signposts indicating a supposedly similar intended destination multicultural counselling competence—but

> many instructors do not avail themselves of guidelines provided by extant theoretical models (p. 133).

Without clear evaluation of the cultural competency components for students and staff, it is easy for cultural competency outcomes to slip off the radar.

Measuring cultural competency outcomes

The increase in paper offerings relevant to cultural competence invariably resulted in research aimed at identifying whether training was effective. Smith, et al., (2006) conducted a meta-review of the multicultural literature in response to the concerns that the field developed without sufficient empirical, theoretical, and institutional support. They believed that university courses were hasty in their development of multicultural education courses and that although those courses met the criteria for compliance, they were not carefully planned.

Although there has been a proliferation of studies describing multicultural education, there is a disparity between research and practice. Does multicultural education affect practice? A common difficulty with cultural competency training is that it is not always known how training affects outcomes for the client (Ramirez, Wassef, Paniagua, & Linskey, 1996). There is also wide variability among programmes with regard to the quality and content of bicultural (Evans, 2008) and multicultural training, and the level at which trainees incorporate their learning into practice (Hertzsprung & Dobson, 1998; Quintana & Bernal, 1995). Without valid outcome measures and an underpinning philosophy, training may have little impact on practice.

There is also some concern that knowledge acquisition is the primary goal of multicultural education. This concern reflects the view that knowledge alone does not translate to competent practice and that despite knowing about cultural competencies, psychologists are unlikely to follow best-practice guidelines (Downing-Hansen, Randazzo, Schwartz, Marshall, Kalis, Frazier, Burke, Kershner-Rice, & Norvig, 2006; Magyar-Moe, Pedrotti, Edwards, Ford, Petersen, Rasmussen, & Ryder, 2005; Quintana & Bernal, 1995).

The goal of acquiring knowledge suggests that students are not being exposed to diversity experiences and that knowledge alone does not provide a good foundation for developing broad cultural competencies. Priester et al's., (cited in Chipps, Simpson, & Brysiewicz, 2008, p. 133) content analysis of 55 APA-accredited course syllabi found that multicultural courses almost completely ignored the development of practice-related skills.

D'Andrea, Daniels, and Heck (1991) examined courses that focused on broader competency acquisition and identified that counsellor trainees who were exposed to multicultural experiences had significant increases in their levels of multicultural awareness, knowledge, and skills. Although such findings are encouraging, Steward & Morales, (1998) cautioned that trainees' completion of multicultural counselling coursework may not necessarily indicate an automatic embracing of multiculturalism.

Allison, Crawford, Echemendia, Robinson, & Knepp, (1994) surveyed 259 recent PhD graduates in counselling and clinical psychology to identify which training variables predicted therapists self-reported competencies in working with diverse clients. They found that therapists felt more competent to practice when they had worked with diverse clients, received supervision of those cases, undertaken diversity-related internships and completed relevant course work. Therapists who reported minimal diversity in their training felt less competent to practice (see also Sawrey, 1991).

Allison et al., (1994) found that the majority of respondents felt competent to work with European Americans, women and economically disadvantage populations (p. 795). They surmised that this was not unexpected given that 78% of the students were exposed to European American staff and that 96% saw European American clients.

As I noted earlier, there was an increase in programmes offering multicultural education due largely to accreditation requirements However, an increase in programme content may not translate to effective practice, and may not teach multicultural proficiency (Sammons & Speight, 2008). Ridley, Baker and Hill (2001) noted that most professionals in the United

States could not verify that their clinical practice actually demonstrated cultural competences, suggesting that perhaps their training was lacking.

In terms of cultural competency training outcomes, it is highly desirable that psychologists transfer what they learned in training to the workplace. Downing et al., (2000) surveyed 149 psychologists to see if "we practiced what we preached" (p.66) and found that participants were most influenced in their development of multicultural competence by personal and professional experiences, and that guidelines and codes were least influential. These studies suggest that exposure to diverse clients is an important part of cultural competency acquisition.

The lack of robustness in evaluative measures can result in a false perception that students are competent to work with minorities. Research conducted with students found that self-report surveys lacked adequate measurements beyond responses such as: "I feel more or less confident", or "I feel extremely" or "very competent". These questions are useful if one is asking about confidence alone, but they do not indicate whether students have processed their attitudes and assumptions about diverse cultures, or if they have acquired the necessary training to be competent psychologists (Allison, Echemendia, Crawford, & Robinson, 1996; Ducker, 2001; Kiselica, 1998; Kiselica & Maben, 1999).

In this next section, I describe some of the literature on the methods employed to measure cultural competency acquisition with a focus on case formulation. I argue later that a core skill in the clinical psychologist's repertoire is the ability to conceptualise the client's problem. In this thesis I expand on that skill by including the ability to include cultural factors in the formulation.

Formal measures of cultural competency acquisition

The question of how to measure competency acquisition has taxed many researchers, educators, and consumer groups. Methods used to evaluate competency include pen-and-pencil measures (checklists) (LaFromboise, 1991; Ponterotto, Rieger, Barrett, & Sparks, 1994); formal exams, portfolio assessments (Coleman, 1997); assessment of case conceptualisation, and

case formulation skill (Nezu, 2004). Other methods include oral presentations, case studies (Petti, 2008) and ratings by others, such as supervisors or educators.

Self-reflective methods include the critical incident technique (I describe this technique in detail in chapter 8) (Sammons & Speight, 2008), guided journals, and self-report measures (Leong & Kim, 1991). Other methods which have been employed include: measuring client outcomes via questionnaires administered to clients or professionals; and recording relapse rates, dropout or recidivism rates (Constantine1998; Ponterotto et al., 1994; Ridley, Li & Hill, 1998; Sodowsky, Kuo-Jackson, & Loya, 1997).

There are difficulties with assessing the efficacy and value of competency training. The types of measurements used do not have adequate psychometric properties and data collection does not follow a logical pattern (Petti, 2008). Rating scales may not reflect therapist behaviour with clients, evaluation is subject to individual biases, and student case reports lack the accuracy of direct observation (Petti, 2008). Bias refers to a tendency to report positive or negative outcomes when there is no evidence to support the finding, or a tendency to respond positively in a socially desirable way.

Social desirability refers to a pattern of responding that reflects some individuals' need to provide perceived socially acceptable responses to questions rather than to report their actual feelings or behaviours (Constantine & Ladany, 2000; Ottavi & Thomas, 1994; Worthington, Mobley, Franks, & Tan, 2000). The social desirability bias inherent in self-reporting impacts on the validity of a questionnaire, and ultimately, the programme that seeks to train certain students.

Universities in Aotearoa/New Zealand do not use specific measures of cultural competence (such as rating scales) other than what students choose to write in their case studies, or what an examiner might ask in an oral examination. Although scales have their limitations, when they are used with other measures such as evaluating case studies, or obtaining consumer feedback, the possibility of incrementally building a picture of the trainee's competence appears.

Incremental validity refers to the addition of a set of information to another set of information that leads to an increase in validity (Garb, 2005; Haynes, 2003). Individual questionnaires may be limited in what they produce for the reason described above, but that should not negate their use with other measures. The relevance of describing incremental validity in this research is to show that multiple data sources are required to appropriately measure the acquisition of cultural competencies in psychology students.

A starting point in evaluating whether students have minimum competencies is to look at case formulation. In this thesis, I propose that developing a good cultural formulation is an essential part of practice as it requires that the psychologist possess a range of appropriate awareness, knowledge and skill domains.

Case formulation

In terms of clinical competency, some of the most critical skills a student must possess prior to graduation are the ability to conceptualise the features of a client's problem and the ability to demonstrate interpersonal characteristics such as warmth and empathy.

Terms such as clinical formulation, cognitive-behavioural case formulation, case formulation, or case conceptualisation are often used (Collie & Ward, 2007). There is a lot at stake for students if this skill is not acquired and often the student who fails to show this ability has to repeat a year of training. The expectation for students to demonstrate the ability to incorporate cultural factors into their formulation is not so high. Based on my experience as a student and lecturer, students have passed by quoting a few published authors, or stating "I will consult with a cultural advisor".

Clinical psychologists depend on the clinical interview and case conceptualisation to obtain data about a client and to make judgments about current and future behaviour (Evans & Fitzgerald, 2007; Nezu, 2004). Case conceptualisation or case formulation is a set of descriptive and explanatory hypotheses encompassing phenomenology, etiology, management, and prognosis of a client's problem.

The case formulation is a meta-judgment and synthesis of several judgments about a client's problems and goals, their effects, related causal and mediating variables, and the functional relationships among such variables (Gasser & Tan, 1999; Nezu, 2004). Case formulation models have dimensions that enable a focus on the cultural and socio-political experiences of clients, but there is little training on the potential depth of those experiences.

Garb (2001), stated that the most difficult task for mental health professionals involves making causal judgments. Garb's review highlighted gender and race bias in clinical decision making. For example, Hispanic and African Americans are more likely than Whites to be misdiagnosed with schizophrenia. In Aotearoa/New Zealand, Māori and Pasifika peoples are often misdiagnosed or under-diagnosed (Baxter, 2008).

Critics of case formulation models argue that: little research exists to support the reliability or validity of case formulations (Garb, 2005); the case formulation is dependent on professional judgment and subject to personal and academic bias; and hypotheses and recommendations are vulnerable to error, particularly if the judgments (about the client's problem and treatment) are unstructured (Collie & Ward, 2007). Others argue that because the case formulation is structured, it provides some protection against heuristic biases (Collie & Ward, 2007) (e.g., availability, representative, anchoring heuristics; discounting bias, and race, gender, social-class, and labeling biases, p. 309)[13].

Cultural case conceptualisation

Multicultural case conceptualisation skill requires the integration of variables and judgment about the relationships between causal variables and the client's goals. In considering cultural dimensions, the psychologist is required to [1] comprehend and integrate the impact of various cultural factors on client's presenting issues; and [2] articulate an appropriate

---

[13] Collie and Ward (2007) proposed an alternative decision-making structure called the "abductive reasoning model" to assist clinicians with their judgments (p.310-313).

treatment plan for working with a client based on this knowledge (Constantine, 2001b). Multicultural conceptualisation ability has been defined as the extent to which counselors are able to identify and integrate cultural factors into conceptualisations of the etiology and treatment of a client's problem (Constantine, 2001a, 2001b).

Sue (2006) viewed cultural competence as a multidimensional phenomenon with three important characteristics: scientific mindedness, dynamic sizing, and culture-specific skills. Scientific-mindedness refers to forming hypotheses rather than making premature conclusions about the status of culturally different clients. It requires that psychologists develop creative ways to test hypotheses and to act based on acquired data.

Dynamic-sizing refers to knowing when to generalise and be inclusive, and when to individualise and be exclusive in working with clients. Dynamic-sizing also requires flexibility, an appreciation of the multiple worldviews a client may possess and a recognition that stereotypes exist for the client and psychologist. Culture-specific expertise requires knowledge and skills specific to the culture of the client. For example, a White-American psychologist should have knowledge that male, Muslim clients may experience frequent discrimination and have concerns about how he (the client) may be perceived by the psychologist.

These characteristics offer a way for psychologists to consider the clients' problem within a cultural context while maintaining a critical and open stance about their values and beliefs and those of the client. In a sense, these attributes reflect my view of the scientist-practitioner as someone who creates a picture of what is happening for their client in a critically-reflexive and meaningful way.

Evans and Paewai (1999) proposed that the structure within the case formulation model allows for the recognition of several factors that have implications for cultural considerations in assessment practices. Their model was the first published theorizing on a clinical technique for Māori. They suggested that the main factors in a formulation includes recognition that (a) the client's presenting problem may not be the focus of treatment; (b) the

client's difficulties often reflect the absence of critical behaviours; (c) problem identification may be based on a mismatch between individual characteristics and environmental expectations; and (d) broader contextual or ecological influences may be important in understanding the client and in designing meaningful interventions.

Evans and Paewai (1999) said that the hardest element to incorporate into a functional assessment is everyday knowledge of how people function and the more specific cultural knowledge of the kinds of variables that might be important when considering a client's cultural context. In response to this dilemma, they developed a checklist or "cultural audit" and explanatory notes to evaluate the appropriateness of case formulations.

Psychologists rated each item according to whether they had been addressed, mentioned, not addressed, or not relevant. For example, (item 7, p. 32): Automatic thoughts that precede the target behaviour (complaint) have been identified and categorised as (a) culture bound but inappropriate and maladaptive; (b) culturally acceptable but reinterpretable; (c) culturally inappropriate; (d) idiosyncratic. (p. 32).

An example of (b) was seen in Rebecca's case where she used symbols, patterns and colours from Māori culture specific to her iwi to protect herself from a bipolar episode. The attending psychiatrist did not consider the ethnic-cultural aspects of her behaviour: rather, he categorised them as features of her irrational and paranoid state of mind. When I read her file I knew that she was trying to protect herself in response to a lack of support from the mental health service.

The value of this model is that it was developed in Aotearoa-New Zealand; it incorporates the principles of Te Tiriti/The Treaty; and aligns with other models of cultural case conceptualisation. Using Evans and Paewai's cultural audit enhances the likelihood that cultural values, norms and worldviews are considered throughout the assessment and treatment process. The limitation of Evans and Paewai's model is that there is no mention of the psychologist as a 'bearer of culture' and what impact that may have on judgment (Love & Waitoki, 2007).

Other factors associated with the ability to conduct a case conceptualisation relate to the degree of empathy and tolerance for others shown by the psychologist. Constantine and Gushie (2003) found that school counselors who had higher levels of ethnic tolerance had higher cultural case conceptualisation ability than counselors with high levels of racism and low levels of ethnic tolerance. These studies highlight the need for students to be screened for racist attitudes and ethnic tolerance prior to entering training.

Constantine (2001a) investigated whether it was possible to predict counsellor trainees' multicultural case conceptualisation ability by identifying the roles of race or ethnicity (for students), prior multicultural counselling training, and interdependent self-construals (where individuals perceive themselves as fundamentally connected to others and tend to value achieving and maintaining harmonious relationships) and independent self-construals (where individuals perceive themselves as unique and separate from others, and they largely value autonomy and self-expression) (p. 33).

The self-construals are similar in principle to collective and independent identities. The most interesting finding was that higher independent self-construal scores were related to lower multicultural case conceptualisation skills, whereas higher interdependent self-construal scores were associated with higher multicultural case conceptualisation ability. Constantine (2001a) found that African-American, and Asian-American trainees had higher case conceptualisation abilities, possibly due to shared cultural experiences. Trainees who had prior multicultural training also showed greater case conceptualisation ability than trainees without training.

The high independent self-construals appeared to impact on the trainees' ability to consider the impact of various cultural and contextual issues in conceptualising the presenting concerns of culturally diverse clients. The trainees (the majority were African-American) who had high levels of interdependent self-construals better understood the role of cultural influences in their clients' lives. These studies show that prior training was better than no training and that having a shared and harmonious

relationship and connection to others was an important component of case conceptualisation ability.

The idea of teaching students the importance of having a shared and harmonious relationship resonates with a Māori worldview, but is fundamentally challenging for mainstream psychology in its current form. In many ways, the primary focus of bicultural and cultural competency education programmes is to develop empathy and tolerance in students through a variety of awareness, knowledge and skill-based strategies. Selecting suitable students for clinical training is highlighted as it would be a lot easier to teach them cultural competency and conceptualisation skills if they already possessed empathy and tolerance towards diverse cultures. I talk more about this after conducting the workshop in study one and three.

Summary

The literature on cultural competency education is compelling and fraught with socio-political subplots that threaten to destabilise attempts at addressing cultural diversity issues. Whether training programmes are producing competent psychologists depends on which institution is sampled, what type of student is involved and the evaluation methods used. What is evident is that there is a great deal of difference across training programmes to the extent that there are two options available to programme designers: pick and choose what works for each institution; or, do what I suspect happens regularly, which is to throw ones hands in the air and claim that cultural competency acquisition is too difficult, but claim compliance anyway.

I chose to do the former. Although I have largely criticised the scientist-practitioner model, I have retained the core principles of not using ad-hoc methodology when conducting research. My main concern with clinical training programmes in Aotearoa-New Zealand is that they are poorly designed and do not reflect the depth of analysis and critical thinking that psychologists ought to possess when working with Māori (or for that matter, diverse cultural groups). These issues are compounded when staff do not discuss optimum training programme criteria and evaluation standards with knowledgeable peers.

This research is an attempt to develop a training programme that incorporates the features of the cultural competency literature and the ethical and legal obligations for psychologists in Aotearoa-New Zealand. Despite the multiple criticisms of the add-on approach, there is no single route that will satisfy the wide range of Māori educational needs (Durie, 2003). With that in mind, I began by developing a pilot training programme using Sue et al's (1982) tripartite model of cultural competency *awareness, knowledge and skill* with the ethical and legal requirements that originated from within psychology, the Aotearoa-New Zealand Nursing Council's *kawa whakaruruhau* – Cultural Safety, and the APA guidelines.

I used the pilot programme to test whether the material I had put together was relevant and to identify whether students retained, and used the material in their workplace. Although the pilot and final programmes were conducted as add-ons in the sense that they were not integrated into the overall training curriculum, in the current training environment this was the only option available.

Although Durie (2003) commented that Māori have benefitted from add-on programmes, more could be done to improve them. In this study Māori psychologists and students (as participants) had input into the design and evaluation of the cultural competency programme. The next two chapters describe the methods used in the pilot programme followed by the results. The voice I use in the method and results chapter are somewhat typical of clinical report writing. I apologise in advance as I am still in the process of freeing my mind and with it, my voice.

CHAPTER 6: PILOT PROGRAMME

Study One: Method

The content for the pilot programme was developed from a review of the Aotearoa/NZ literature on cultural safety, Te Tiriti o Waitangi, the Code of Ethics, the bicultural content of clinical programmes at five universities, and the international cultural competency literature. Additional material for the programme was derived from my experiences as a lecturer in a clinical training course that I taught at Waikato University from 2001 to 2004.

Cultural support

The pilot programme was reviewed by a cultural advisor who worked with the Whare Wānanga of Waikato, and the local District Health Board. I already had a relationship with her as we worked in the same service. I approached her earlier when I was developing the pilot programme and asked if she would agree to act as a mentor and advisor. Although she would not accept any financial payment I provided meals when we met and I conducted training for her co-workers on cultural competency. The principle of tauututu in Māori refers to reciprocity. I am indebted to the cultural advisor for her support and will endeavour to return her generosity in the future.

Preliminary contact: University 1 and 2

I received ethical approval from the Department of Psychology's Ethics Committee at Waikato University. Four University clinical psychology training programme directors and/or their representatives were approached about their possible participation in the research.

My initial contact with the clinical staff of three universities occurred at an annual psychology conference and at a general meeting of staff of university clinical psychology programmes. On each occasion I provided a brief verbal description of the research and sought permission to telephone or email the relevant staff member within the next few weeks to schedule a meeting. I was acquainted with a staff member at one of the universities who arranged

for me to meet the director of the programme and she acted as a liaison person. Two directors (including the one she arranged) agreed to arrange a time to meet (the preliminary meeting) and discuss the research and what was involved.

The meeting began with a brief explanation of my experience as a psychologist and lecturer followed by a description of the purpose of the research, what was involved and how it will be used in future.

Both directors agreed to the research. Following the meetings, I sent a letter confirming our arrangement (Appendix A). I also gave them an outline of the research including the aims, and described what the director and students could expect as participants. I emphasised that the director and students were under no obligation to participate (Appendix B). Both directors said they would inform their students about the research and that they were free to participate or withdraw at anytime. Follow-up communication was either by email or phone call.

The pilot programmes were scheduled for the University Easter break and the mid-year semester break respectively to minimise timetable clashes. The dates, times, number of participants, room size and resource requirements were outlined and agreed upon through email.

The two universities had differing degrees of bicultural commitment. One was located in a city with few Māori, had minimal identifiable bicultural course content, no Māori staff in the department, and no Māori students in the clinical programme. The second University had a higher proportion of Māori on campus and living in the city. Its psychology department differed as it had Māori staff and students in the clinical programme.

Participants

University One and Two

The participants in the pilot programme were students enrolled in a postgraduate clinical training programme. Participants were in their third year of clinical training and were about to enter, or had already begun clinical placements.

There were fifteen participants (one dropped out on the second-day). In keeping with the cultural competency literature on validating multiple cultural identities, I asked participants to identify their sexual orientation. There were four males and 11 females from different ethnic groups – these included Pākehā, English, Dutch, Irish, and American. Fourteen of the participants spoke only English. One spoke Dutch and English.

The participants' religious affiliations included one practising Christian, one Bahai member, five non-practising Christians and one atheist. The remainder did not endorse any religious affiliation. The education level of the participants included Honour's, Master's and some engaging in Doctoral research.

The economic status of the participants was described as low with the majority engaged in part-time jobs, or scholarship recipients. One participant received the Domestic Purposes Benefit (for single parents). One participant identified as gay, the remainder identified as heterosexual. The average age of the group was 26.

Procedure

The programme was run within each psychology department. I met with a clinical staff member from the programme who had ensured that the room was properly equipped with good lighting, audio-visual equipment, comfortable chairs and tables, and good ventilation. Additional items included tea, coffee, and biscuits. The staff member introduced me and briefly described the process for the project. I was then left alone to begin the programme.

I began the process with a description of the research and a brief personal statement. I kept this brief because we were going to do whakawhānaungatanga later (more formal introductions). I informed them that it was a research project and they could choose not to participate without penalty. They were surprised by this as they had been told the workshop was compulsory. They were then invited to read through the information sheet and consent form so they could decide whether they wished to participate. I reminded them that they could leave at any time

during the two-days without penalty. I left the room for 10 minutes to avoid any possible coercion. When I returned they all agreed to take part in the research and subsequently signed the consent form (Appendix C).

Demographic Form

The demographic form (DemoForm 1, Appendix D) was provided prior to commencing the programme and contained questions to elicit information on age, educational status, gender, religion, sexual orientation family status, iwi and hapu affiliations, socioeconomic status, and previous bicultural training. The information on bicultural training was included in the *person analysis* that I describe in chapter eight. The pilot-pre-workshop questionnaire (pre-Q), (Appendix E) was administered.

I then described the goals of training and outlined how the programme would proceed. As a preliminary measure, students were informed about the importance of respecting each other's learning style and I asked them "to suspend your judgments about each other" as one of the training goals was to learn to speak openly and to learn how to challenge in a respectful and informative way.

It was of particular importance that students in the programme could say what they felt was important without being criticised or devalued for their comments. Finally I asked them to respect the confidentiality of each other's comments and not talk about each other outside the classroom, adding that confidentiality could not be guaranteed, and to be careful about what they chose to say.

The programme started when I offered to do a karakia if anyone felt it was important to them. One participant asked for a karakia which I conducted. I then described the whakawhānaungatanga process and how important it was to building a relationship with clients, and peers. I provided an example by describing my iwi and hapu links, my academic affiliation and experience, my clinical and academic interests, and my family composition. Then I presented a slide that outlined the basic components of a pēpeha and some prompts (family make-up, geographical origin, academic background, and clinical

interests). I asked the students to use micro-counseling skills to demonstrate that they were listening to each other and valued what they heard.

The process took roughly 30 minutes to go around the group. At the end of the whakawhanaungātanga I asked the students to use the information they had heard to look for similarities that enabled them to link with each other. I made notes of what each student said and used the material throughout the programme (I describe this process in more detail in chapter 9). I provided a copy of the slide presentation material and reading material for the following day.

The programme was scheduled over two-days with five 50 minutes blocks each day with 10 minute breaks between. The training method involved the use of PowerPoint presentation (didactic-instruction), small group exercises, group feedback, role-play, individual exercises and feedback from me and the students. I introduced Rebecca as a case-study which formed the basis of the case conceptualisation training and to highlight the application of the training material to Māori clients. For example, when we discussed the relevance of identity for Māori, I described Rebecca's distress at her brother's conversion to another religion and his subsequent rejection of Māori culture and the impact of that decision on his role on the marae.

I moved around the group to offer assistance when needed. Throughout the programme the participants were given focus questions related to the training material and organised into groups to discuss their views, reactions, or to practice a particular skill. These exercises took approximately 10-20 minutes and the groups were asked to provide feedback to the bigger group for further discussion.

I provided lunch for the participants (including vegetarian options). I had to adjust the menu on day two to meet the dietary requirements of one student participant who followed a strict vegan diet. I finished the first day by asking the students to comment on what they thought of the training and I gave them extra reading material in preparation for the next day. Participants were reminded that they did not have to return, and that there would be no penalty if they chose not to.

The training on day two involved the same teaching method as the previous day with different material. The students completed the post-programme questionnaire (post-Q) (Appendix F) and agreed to participate in the follow-up phase (retrospective survey). Nine students agreed to participate in the follow-up phase. As a koha, I gave each student a bibliography of my research literature on cultural competency and a certificate of participation.

Two months after the pilot programme I emailed the retro-Q to the students. The survey was returned as an email attachment, or posted to me. Two reminder emails were sent to the students. Eight participants completed the retrospective survey. There were two males and seven females. There were seven Pākehā and one Dutch person. Five of these participants came from the first university and two from the second.

Material

Pre-training questionnaire

The pre-training questionnaire (pre-Q) identified students' attitudes, knowledge, beliefs, skills and practices when working with Māori. A number of items were taken from the Multicultural Counseling Inventory (MCI) (Sodowsky, Taffe, Gutkin, & Wise, 1994) and reworded to reflect New Zealand language and Māori cultural content. The questionnaire used a Likert scale with 52 close-ended questions and four open-ended questions.

The close-ended questions had one of five choices ranging from 1 = *I strongly disagree*, 2 = *I disagree with this statement* 3 = *I am undecided about this statement* 4 = *I agree with this statement* 5 = *I strongly agree with this statement.* The open-ended questions were intended to identify what they thought about cultural competency training programmes, and their goals for training. For example – (1) *how can cultural competency training affect clinical practice? (2) What do you hope to gain from undertaking cultural competency training?*

Post-training questionnaire

The post training questionnaire (post-Q) contained the same questions as the pre-training questionnaire, with additional questions to identify what the

participants thought of the instructor, the programme content and design, whether they thought the learning was valuable, and what they thought would improve the programme.

Retrospective Questionnaire

The retrospective questionnaire (retro-Q) (Appendix G) was developed as a follow-up survey to identify what the students learned and whether the training had transferred to their clinical practice. Retrospective relates to the participants thinking back to the time before they did the programme. On one level it is a follow-up questionnaire, but its main purpose was deal with the problems that arise following training (e.g., gamma or beta changes). This issue is described later.

There were 23 items in the retro-Q. Eleven questions were open-ended and asked: whether student thought cultural competency training was important, and why; how their understanding had improved; what aspects of the training content, format, and teaching style they felt was useful; their thoughts about how the training could be generalised to their clinical practice; and what barriers, or support, they encountered when using the programme content in their workplace.

There were twelve forced-choice questions in which students were asked to think of themselves prior to training and rate where they thought they were in relation to the training material, and to then rate themselves after training. For example, *Q.10. How important is it to include assessment of Māori ethnic identity? Q.14. How important is it for you to be skilled at addressing the impact of socio-political variables on Māori?* The items in the retro-Q were designed to measure the acquisition of some of the Awareness, Knowledge and Skills (AKS) of cultural competency training, attitudes to training, and self-efficacy.

Table 1: An Example of the Range of Response Option in the Retro-Q

Before Training	After Training
1 – Did not think about it	1 – Did not think about it
2 – Somewhat important	2 – Somewhat important
3 – Important	3 – Important
4 – Very important	4 – Very important
5 – Extremely important	5 – Extremely important

The last four questions were designed to assess the behavioural outcomes of training. For example, *Q.21 - What, if anything, would you do differently with a Māori client that you would not have done before the workshop?* The students were then asked to rate the effectiveness of what they did. The response choice was 1- not effective, to 5 – very effective. Only students who had a Māori client since the workshop were required to answer these four questions. Those who had not seen a Māori client finished the survey at question 19.

Study One: Results

<u>Pilot Programme:</u>

Objectives

The pilot programme sought to:

1. Identify what training content should be retained, and what parts should be discarded in preparation for the final programme

2. Identify the potential value of the pre, post and retrospective questionnaires with respect to knowledge and skill acquisition

3. Identify barriers to student learning such as: trainer style, programme content and design.

Data from two institutions were analysed together, using the qualitative and quantitative pre, post and retrospective questionnaires. The open-ended responses were reviewed to gain a general impression of whether participants thought cultural competency training was important, what they found useful or not useful, and whether they used the programme material in their practice. I also provide a commentary of my observations of participants throughout the programme where relevant.

The results are reported in seven subsections: Importance of cultural competency training, utility of the workshop, awareness, knowledge, skill, participant's confidence and trainer style. These reports include examples of questions and responses from the questionnaires and my brief analysis. I changed the name of all the participants and also added basic demographic features, for example: Lisa, female, bisexual, and an atheist. This is not intended to reinforce stereotypes but to provide a sense of the person beyond gender, age or ethnicity and to promote the inclusion of a broad range of demographic data into data analysis.

Importance of cultural competency training

Participants are more likely to use what they learn in training if they think the material is important (Salas & Cannon-Bowers, 2001). In programme evaluation terms, the importance of training is linked to the utility of training, and/or the perceived usefulness of training. If participants in this study do not consider cultural competence as important, they are unlikely to engage with the material which impacts on their learning as well as their peers.

The participants were asked: *Why do you think the CC workshop is important or not for psychologists and participants?* In the retrospective questionnaire (retro-Q.3), they were asked questions about: their belief in the importance of cultural competency, its utility, and their level of confidence to work with bicultural issues. I also sought to identify whether there were changes to their levels of awareness, knowledge and skill using the pre, post and retro-questionnaires.

All the participants felt that cultural competency training was important prior to training and post training. The participants commented that clients benefited from cultural competency because psychologists needed to be aware of different worldviews between client and psychologist, to understand cultural differences in assessment and treatment, to understand the impact of culture on formulations, and to be skilled in addressing clients' diverse cultural needs. In the retro-Q, Seamus said that cultural competency training was important because,

> (It) covers key issues such as building a therapeutic alliance with someone from a different culture from you. Awareness of own culture and its impact (Seamus, male, Pākehā).

Client safety was a common concern: participants said that psychologists should not alienate clients with therapist ignorance or bias, and that there was a real danger that clients could be harmed if the psychologist was incompetent. The participants' responses showed their understanding of the value of training to learn cultural competencies.

Although they believed in cultural competency training, some added that the focus should not be on Māori alone as multicultural training was also important for working with diverse groups:

> A better knowledge of clinical issues regarding Māori clients, but I think we also have to work with Tongans, Samoans, Asian clients etc. and we receive no training in this… this is a problem - it should be multicultural training (Pier, 27 male, New Zealander, heterosexual, retro-Q).

Several participants reported that it was important to learn about multiple cultures and that clinical training did not prepare them for working with Māori, or any other ethnic group. A common criticism of bicultural training by participants and psychologists is that multicultural diversity is ignored and is a form of racism.

Others stated in the pre-Q that they thought there was too much focus on Treaty training but changed their belief in the post-Q. Some participants commented that because they would be dealing with diverse clients, it was important for them to learn to be culturally competent:

> Because a large majority of clients we will be working with will be Māori and from other ethnic groups, being Pākehā from the dominant culture in NZ, we do not get our views attitudes/way of life challenged very regularly and therefore are unaware of some of the views we hold that effect the way we deal with other people (Glenn, Pākehā, who had completed a two-day bicultural workshop, post-Q).

Glenn also highlighted the importance of addressing the assumptions that Pākehā as the dominant group and privileged members of society hold about other ethnic groups and the potential impact of those assumptions.

Relevance to the final programme

All the participants commented that cultural competency training was important and made suggestions about the content of training. The results from this section contributed to the final programme by identifying whether participants supported cultural competency training and why (or why not). This is an important part of training design as training buy-in (or not) has an

impact on the likelihood that participants will transfer their learning to the work environment.

Usefulness of the workshop and training transfer

Generally, participants endorsed the programme as useful. They added that they gained valuable knowledge about themselves and others, that they would use the material in their practice, and they were pleased to have a workbook as a reference source. Some participants highlighted the limitations of mainstream psychology training to prepare them for working with diversity. They maintained their belief over time as shown in the retrospective questionnaire,

> Workshop is important for psych so that they get a realisation (if not a total understanding) of the fact that different cultures have different views of mental health, spirituality, what is normal and what is not etc., which can affect the way they present and what treatment methods are going to be safest (Nero, Pākehā, heterosexual, retro-Q).

> Important because I will be working with different ethnic groups/individuals throughout my career and feel I haven't had this type of training/info/awareness in university so far (Robbie, Māori, heterosexual, lived in a Māori community, retro-Q).

Participants were asked in the retro-Q to identify what they thought was least useful as they may not consider that material in their practice. One of the difficulties with training students is that they may have preconceived ideas of how the programme should run or, because they have covered the topic previously, they have no need for further learning.

RQ6. What aspects of the CC workshop did you find least useful?

> Probably a bit too much information to go through and absorb in one day (Nero).

> Too many slides that were flicked through too fast" (Becks, 24-years old, had taken one undergraduate paper and a two-day workshop).

> The hurried nature. Trying to fit into 2 days. Meant that everything was glossed over and not much depth" (Carlos, Eastern religion, one Te Tiriti, Treaty workshop).

While these participants were mainly concerned by the amount of material I tried to cover in two days, Shaquille raised a different issue.

> Emphasis on race bias as colonisation, stereotyping, and white privilege, I have attended many workshop papers and worked through these matters. At this level I need assistance in generalising skills into my practice" (Shaquille, bi-sexual, Pākeha, 23-years old).

Shaquille said that she "had taken Treaty training before and that it would have been helpful not to do it again". She also commented in the retro-Q that the workshop made things worse for her. Her prior training consisted of one workshop, a university paper on *Whānau and Psychology* a non-psychology paper, *Māori and Pasifika Peoples*, counsellor training, a treaty workshop, and previous work with gay and lesbian cultural groups. Her participation style was distracted and uninvolved; she missed one-quarter of the workshop and commented to the group about how she "had done this stuff before".

Shaquille appeared to understand the importance of cultural competency, and asked some insightful questions. At other times she seemed to struggle with the content (i.e., female roles on the marae). It is likely that Shaquille was potentially the most insightful in the class, although I do not know whether she reacted to my style or, if she was bored with the topic and felt it was a waste of her time. Her attitude throughout the workshop appears to be a feature of resistant students; these students may react to clients who challenge them about their belief system.

Resistant students

Shaquille's comments highlight the importance of explaining to participants that although the material presented to them might have been covered previously, what they could potentially gain from training is different to others in the group. Resistant students may fail to see that the attitudes and beliefs that underlie their behaviour are barriers to learning introspection, being non-judgmental and developing their critical thinking skills.

Resistance in the classroom interferes with reciprocal learning. Resistance is driven by stereotypes and beliefs that students may hold about their history which excludes the histories of other peoples, by becoming aware for the

first time, or being reminded of the impact of student's identity on racism, discrimination, segregation and exclusion of others (Spanierman, 2008). To combat students' negative reactions, a number of authors have stressed the importance of using a range of methodological approaches and teaching strategies to obtain a more complete picture of students' perspectives and competencies.

Providing a safe environment for questioning is also important. I have heard Māori voice their concern about "having done this stuff before, and why should I have to listen while they process these issues?" My response to them is to explain that one of their learning goals in cultural competency training is not to react to difficult information such as privilege, racism, and discrimination that often presents on a daily basis (when there is awareness of this issue).

I also educate participants about the need to ignore, respectfully challenge, or control difficult situations while maintaining the client's, and their own integrity. Being challenged by clients happens often, particularly if the client takes issue with a particular characteristic of the psychologist. For example, psychologists may be accused by their clients or peers of being inherently racist because they are Pākehā; or a 'lesbo' (in the case of Shaquille), or 'the cultural advisor' (because they are Māori), or rich and privileged (as a professional psychologist). The underlying assumption of such comments is that the psychologist is unsuitable, or clients simply want to provoke their psychologist (this issue arose in study two).

The training environment provides an opportunity to process biases and assumptions that each person holds, not just one's own. Resistant participants require more attention as they often affect the learning of their peers in a manner similar to disruptive children in a classroom. Others argue that trainers must be non-judgmental, foster a positive relationship with students and provide a positive learning environment so that students feel *"psychological safe"* (where their integrity is respected and protected. I describe this term later) (Edmondson, 1999). On a final note, the trainer must be able to process their potential biases about resistant participants.

Personally, I think resistant and disruptive participants are part of the culture of teaching students.

Relevance to final programme

The comments about too many slides and some topics not receiving enough coverage highlighted a difficulty I had with delivering the training programme. I was also limited in the amount of time that participants had available. I booked the workshops a year before to take into account the programme's timetable, but I was only given two days. I reduced the number of slides and reviewed where I skipped slides, or did not cover a topic. I retained the focus on colonisation, stereotypes and Te Tiriti/The Treaty. I also reviewed the case formulation section and added a discussion and practice session using Evans and Paewai's functional analysis model (1999).

Awareness

The awareness section of the programme included: information and exercises related to identifying personal differences between psychologists and Māori clients; and information about the potential impact of cultural differences and beliefs on client outcomes. The whakawhānaungatanga exercise enabled each student to disclose information about their identity, goals, education level, whānau background, religion, and sexual orientation. The exercise also elicited new information that participants had not known about each other despite knowing each other for 2-5 years.

Additional content centered on broader awareness issues including, but not limited to: the historical and socio-political context of Māori experiences with Pākehā as the dominant group; limitations of psychology and racism and privilege. The results show that prior to training, the majority of participants were undecided about the importance of being aware of the impact of their ethnicity. Post programme changes show that over half of the undecided group disagreed with the question that ethnicity did not have an impact on the client.

Table 2: Participants Understanding of the Impact of Self-Identity

Post-Q.20. My ethnicity does not impact on my client's treatment outcomes					
Participants n = 13	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
	5	4	3	2	1
Pre-Q	0	2	7	3	1
Post-Q	0	0	3	7	3

Prior to training, only four participants disagreed or strongly disagreed that their ethnicity affected client outcomes. Post-training, the participants responses generally shifted towards disagreeing with the statement, with seven disagreeing and three strongly disagreeing. The results show that most of the participants did not know the impact of ethnicity on client treatment outcomes suggesting that they were not taught about this element in their clinical training. I found this was also the case for most of the content on self-awareness, power, privilege, discrimination and the impact of Te Tiriti-The Treaty breaches on Māori aspirations.

Relevance to the final programme

In light of these findings, apart from editing and reordering, I made few changes to the knowledge, skill and awareness training material. I reviewed parts of each section to limit the number of slides and focussed on retaining the parts that had exercises attached to them. The knowledge, skill and awareness domains of cultural competency were retained as they contained information that is not typically taught in clinical training (e.g., table 2). I retained the retrospective questionnaire with modifications (described later) and removed the pre and post questionnaire (appendix E & F) as they did not have specific questions from which I could draw conclusions about training transfer.

Knowledge

This section explores whether the students learned the information presented. Questions in the post-Q sought to identify whether participants

learned the information and the retro-Q sought to identify whether they had retained this knowledge and implemented it in their practice, and if not, what they saw were the barriers to implementation.

The programme included knowledge competencies such as: socio-political information about Māori involvement with psychology and the history of Te Tiriti/Treaty breaches and its effects on the education, economic, political, and health situation for Māori. Other topics included cultural knowledge about Māori, critical psychology and case formulation. Moral and legal imperatives of cultural competency were also taught, such as: The Health Practitioners Competency Assurance Act, Te Tiriti/The Treaty, Code of Ethics, and Cultural Safety. Specific competencies related to Māori clients included: identity; effects of racism and discrimination; and iwi, hapū and whānau dynamics.

The table below shows the responses from the retro-Q. Students were asked to comment about the importance of knowing about Māori identity and its impact on psychological wellbeing.

Table 3: Students Pre and Post Responses to the Importance of Knowing the Impact of Māori Identity on Psychological Wellbeing

Retro-Q.17. How important do you think it is for you to know about Māori identity and its impact on psychological wellbeing?					
Students n=8	Extremely important	Very important	Important	Somewhat important	Not that important
	5	4	3	2	1
Pre-Q	6	2	0	0	0
Post-Q	4	2	2	0	0
Retro-Q	5	1	0	0	0

The table suggests that training may have had little, possible even a negative effect on the importance that participants placed on knowing about Māori identity. Conversely, it may be that participants change is due to a response-shift bias. However, following training, Carlos made the following comment about the importance of knowing about Māori identity:

> I have a better understanding of the importance of acknowledging cultural identity and viewing individual's presentation in terms of cultural values, beliefs, norms, importance of consulting with cultural advisors (Carlos, retro-Q).

Skill

Several participants commented that they did not have the skill to work with Māori and diverse clients, either because they felt they lacked the necessary knowledge, or did not know how to transfer what they already knew into the therapeutic relationship. The participants were taught both "how to" skills and "what was needed" skills in relation to interview techniques and case formulation.

Many of the skills that trainees need involve self-directed learning, and/or arise from a range of contexts and cannot be taught on a course, whatever the duration. Although trainees have some idea about what they need to know, they also tend to disregard the fact they they there are many things they do not know, such as the relevance of Te Tiriti-The Treaty for Māori aspirations. Sarah felt that she needed to learn what to do "exactly". She did not realise that she answered her own question,

> I think this is the additional area of instruction that we really need. What exactly should we do differently with our Māori clients? I find it hard to answer so don't know. Maybe include cultural assessment and involve whānau if that's what the client wants and try to think about cultural factors all the way (Sarah, 22, hetereosexual, New Zealander, retro-Q).

The range of skills that the participants gained was consistent with the training topic. For example,

> (The) case study was very useful and being asked to reflect on ourselves (Winter, New Zealander).

> The formulation exercise was very helpful and getting involved in learning more about a culture and thinking about my own cultural identity (Seamus, 22, New Zealander).

Seamus and Winter's comments about self-reflection were encouraging as they showed that they had engaged with some of the fundamental components of cultural competency training.

Training transfer

The results from the retro-Q show that post-training, participants' attitudes about working with Māori clients had changed. These changes are some of the features that allow predictions about training transfer which I examine in more detail in the final workshop. The participants were asked in the retro-questionnaire (Q.8) *What do you think would help you generalise the training workshop content into your practice*; (Q. 21) *Did you do anything that was the result of CC training? What did you do?* and, (Q.23) *What, if anything, would you do differently with a Māori client that you would not have done before the workshop.*

The participants commented on a range of factors that influenced the use they would make of the training content in practice. Overall, it was an important outcome that some of the participants would do something different with their clients that they would not have done prior to training and that it related to the training programme. One of the participants, Carlos, showed little change,

> No obvious changes; just enhanced recognition of potential issues & would be more aware of checking them (changes) (Carlos).

Training transfer relates to participants' confidence in what they know, having the opportunity to practice, and trusting that in using bicultural practices they will not run the risk of failing their exams. The last point was discussed in the workshop because some participants felt that Māori practices were not taken seriously in clinical training. Some of those factors such as organisational support, or supervisor and clinical staff support are beyond their control. Shona and Shaquille were clear in their view about the barriers to training transfer:

> Not putting knowledge into practice using role plays and practice sessions, not having an interest in being cultural(ly) competent (Shona).

> Having processes in place that refer back to cultural aspects regularly. Being in environment with other professionals that value cultural awareness & competency. Having an understanding of the way culture relates to well-being (Shaquille).

Shaquille rightly noted that she would need workplace and collegial support. She also indicated that she needed to develop her knowledge about how culture relates to well-being. Shaquille's response shows that despite her disengaged style throughout the programme she knew the importance of cultural competency for clients.

Alice commented that she considered the workshop content on psychometric testing and culturally diverse populations but she did not incorporate that content into her practice.

> While I did consider this (competency training), given it was psychometric administration, I didn't adjust my behaviour (Alice, 31, American).

Alice may have not "bought into" the view that psychometric tests should be used with caution when applied to non-normed populations, and that any recommendations should consider cultural factors. An alternative is that she may not have the skill or confidence to administer and write her assessment in a way that is at variance with her clinical training.

Glen made an interesting observation about training transfer.

> It [cultural competency] makes clinicians aware of the importance of cultural issues in assessing & treating culturally diverse groups. However to a certain extent I am skeptical as to whether a clinician can effectively work with a person from a different culture, regardless of the quantity and quality of cultural competency training they have received.

I suspect that Glen may not have understood that the therapeutic relationship can be negotiated in a respectful collaborative way and that as the 'expert' or professional, significant background preparation needs to occur.

Relevance to final programme

As a result of the feedback, I added more detail about the case study on Rebecca and used it as the basis for an in-depth discussion and example on how to conduct a cultural formulation in the final programme. I did this so that participants would have a clearer understanding of the relevance of each aspect of the cultural formulation and how it can be applied clients.

Confidence

The ability to do a range of tasks is affected by confidence levels and trainees are particularly vulnerable to having their confidence influenced by: the training environment, the required task, the degree of perceived difficulty; and whether the students perceive they will be negatively evaluated. The students were asked to rate their level of confidence prior to training for addressing stereotypes, acculturation, Māori identity, cultural variables, stereotypes, socio-political issues and cultural case conceptualisations. The mean was calculated from the participants' pre and post responses across the six domains.

Table 4: Changes in Mean Level of Confidence Before and After Cultural Competency Training (n=6 participants)

	Pre	Post
19a. Acculturation	1.6	2.7
19b. Māori Identity	1.8	2.8
19c. Cultural Variables	2	3
19d. Stereotypes	2	3
19e. Sociopolitical Issues	2	3
19f. Cultural Case Conceptualisation	1.7	2.7

No confidence Some Confidence Confident Pretty Confident Highly Confident
1   2   3   4   5

The table above shows that prior to training the mean self-rated confidence level to work with Māori was between "none and some". Following training, the mean increased to lie between "some confidence and confident". The

participants' confidence levels are slightly higher for knowledge-related competencies than skill-related competencies. This finding is consistent with earlier comments indicating that opportunities to practice (i.e., role-plays and supervised practice with Māori clients) are important. The distinction is relevant as participants may report that they know about a particular competency, but they may not be confident in its implementation.

In response to the question about confidence to apply what he had learned, Glenn acknowledged that if he was not confident he tended to resort to what he already knew,

> Confidence and knowing when to apply knowledge I've learned. In difficult situations (I) tend to go back to what is comfortable which is not always the correct thing to do when working with people from a different culture (retro-Q).

Participants were also asked to provide behavioural examples of what they did that was a result of the training. They reported that they would do things differently now that they understood the impact of socio-political and cultural variables on their clients. Winter commented:

> I would be more aware of and ask more questions about their cultural identity, socio-political status and how this impacts on them.

Trainer style

Within the workshop environment it was important to ensure that the participants' views were respected and that they were not criticised. They all noted that they found the workbook and my style helpful, open, friendly and approachable.

> (The) trainer created relaxed environment. Content of workshop flowed well from general background information to specifics of bi assessment and treatment. Notes received were complete (not in brief summary format) which makes them easy to understand even a few months later (Nero).

There were times through the programme where participants were tired and bored. When this happened, I deliberately switched to an exercise to wake

them up and stimulate their thinking. Generally, the participants' comments and discussions were interesting and thoughtful.   They were caring and helpful to each other and although they were initially shy (looking down when they spoke, cheeks turned red, or apologized for what they were about to say), when they relaxed they talked openly about the topic and joked with each other.

Relevance to the final programme

The main purpose of collecting this data was to identify whether the participants felt comfortable and safe in the environment that was provided. In my experience as a lecturer and student, I have seen the ways in which students can be disempowered and ill-treated by trainers. It was important to me that the participants learned that bicultural training can be interesting, challenging and rewarding.

Summary

The results from the evaluation of the two pilot programmes showed the importance of testing the design, content and delivery of a bicultural workshop. After doing the programme, the majority of participants found the programme useful and felt increased confident to work with Māori. There were some criticisms identified which could easily be resolved, such as flicking through slides too fast, or not providing enough depth.

Less easily resolved criticisms were the call for more multicultural content and less on Te Tiriti/The Treaty.   As I mentioned earlier, this cultural competency workshop was developed to work with Māori clients. I retained the focus on the effects of breaches to Te Tiriti/Te Treaty and its relevance to health even if some participants believed they had covered it or that they did not need it.

The core topic areas (awareness, knowledge and skill) from this programme were retained, though my supervisor at the time, commented, that some of the material was too philosophical. I took that to mean that there was too much talking and not enough action (i.e., behavioural learning). On the basis

of his advice and the participants' comments, I added more exercises (role-play, team discussions, and a deeper focus on Rebecca) to the programme.

In hindsight, there is a possibility that my supervisor was not aware of the importance of emphasizing the socio-political experiences for Māori and the power and privilege that Pākehā take for granted. The cultural competency and cultural safety literature is explicit in stating that dominant group members need to be made aware of their role in perpetuating discrimination for non-dominant groups. Although I added more behavioural learning techniques, I retained the 'philosophical' material as it formed the background context for our role-plays and exercises.

A major outcome of this study, although I did not actually seek to measure this in any way, was the omission of Māori cultural practices and processes, and the experiences of qualified practicing psychologists. While this was apparent to me from the start, I believed that there was sufficient material in the literature to develop a workshop. I found that I needed to incorporate the voice of experience from within Aotearoa/New Zealand and set about doing that.

The following chapter describes the methodology for the Training Needs Analysis (TNA) and the critical incident technique (CIT) that I used to interview experienced psychologists. The results from that study were used to develop the final workshop.

CHAPTER 7: IDENTIFYING TRAINING NEEDS

Methodology

A training needs analysis (TNA) is a systemic approach used to identify deficiencies within an organization, either current or anticipated in relation to performing required tasks. It is considered one of the most important components in workshop development (Kraiger, Ford, & Salas, 1993; P Taylor, 2002; Wexley & Latham, 2002). The TNA should explicitly identify: meaningful contextual variations to include in training; the type of errors to emphasise during training; and the extent to which meta-cognitive skills are required. The TNA should also provide information on where training is needed (Reed & Vakola, 2006; Tannenbaum & Yukl, 1992).

For training to contribute to the goals of an organisation or professional group, it must be identified through an analysis that links training to relevant organisational outcomes (Taylor, 2002). The desired outcome from the TNA is the specification of learning objectives which shape the design, delivery and evaluation of training programmes (Salas & Cannon-Bowers, 2001; Taylor, O'Driscoll, & Binning, 1998; Wexley & Latham, 2002). The first steps in the TNA involve identifying where training is needed, what needs to be taught in terms of skills and knowledge, who needs training and whether training will be effective.

The most widely used method for identifying training needs has been McGehee and Thayer's (1961, cited in Wexley & Latham, 2002, p. 42) three-fold approach – organisational analysis, person analysis and task analysis. Taylor (2002) proposed that a demographic analysis also be undertaken as there are differences in training needs identified by males, females, and ethnically diverse groups. I will briefly describe the three-fold approach that I used in this research.

Organisational analysis

The organisational analysis involves identifying as a first step, the gaps between what an organisation expects to happen and what actually happens (Wexley & Latham, 2002, p. 44). Potential barriers and supports need identifying within the system-wide components of an organization that may affect the delivery of a workshop. Factors usually considered in the analysis include: organisational goals, support for transfer, resources and constraints, whether training will achieve the organization's goal, other alternatives to training, the attitudes to training, and the cost of training (Salas & Cannon-Bowers, 2001; Wexley & Latham, 2002).

These factors were not included in detail in my analysis, but are mentioned here to show that organisational factors are a powerful predictor of whether trainees transfer their skills to the desired setting (Reed & Vakola, 2006; Salas & Cannon-Bowers, 2001). The literature review described earlier show that clinical psychology students need training in cultural competency. Following the organisational analysis it is important to identify who needs training.

Person analysis

The person analysis (i.e., the trainee) involves identifying who needs skills training, what they need specifically, the discrepancies between the individual's expected and actual performance, strengths and weaknesses in knowledge, and the skills required for the job/task. Information sources for a person analysis include self-report measures, observation, surveys, or performance appraisals, surveys, and critical incident techniques (Taylor, et al., 1998). For the purpose of this study, the person analysis was derived from the students' responses on the pre and post surveys (pilot programme data) and the information provided by clinical programme directors.

Task analysis

The task analysis involves a systematic, empirically oriented, problem-based collection of information on the interaction between workers and the work tasks and conditions that constitute a job, or are connected with a job. Task

analysis methods can be differentiated on the basis of the domain of *job content* and what employees do in relation to the *descriptors:* evaluative statements about the task; knowledge, skill or ability; or examples of job behaviour (Wexley, 1984).

The job content domain has three components: **task** - performance or procedure in which employees engage to generate a particular output; **element** – knowledge, skills and abilities required to do the tasks; and **performance** – the interaction of the task and element domain and descriptions of observable worker activity (Wexley, 1984, p. 523).

The purpose of the task analysis is to identify the components of a task (i.e., working with Māori clients) that could be used to develop training material. The task analysis requires detailed descriptions of the behaviour and skills required to perform a certain job or task; the conditions under which the job is to be performed and the knowledge, skills, and abilities needed to perform those tasks (Wexley & Latham, 2002). The identification of specific content for training is possible through the task analysis and is particularly relevant when designing programmes (Taylor, 2002).

In the training literature, knowledge, skills and abilities consist of – Knowledge (K) of factual material that a trainee needs to learn; Skills (S) that a trainee needs to learn; and Abilities (A) - the possession of basic abilities that can be developed through training.

In this study, I did not use the term *ability* because I wanted to be consistent with the tripartite model's terminology *awareness* and because I did not see how ability was distinct from skills. Awareness relates to awareness of: personal, interpersonal and socio-political issues, and dynamics (I described this domain earlier). I use *awareness, knowledge and skill* (AKS) throughout this thesis.

The training needs analysis has traditionally focused on practical, readily observable tasks such as aviation, engineering, marketing and building. Information sources for a job/task analysis include a panel of incumbents,

supervisors, job descriptions, performance appraisals, and employee feedback (P Taylor, 2002; Wexley & Latham, 2002).

With the advances in technology and the movement into non-industrial job areas, training needs analysis is now used to identify employees who possess the cognitive ability to make decisions, inferences, judgments, meta-judgments and diagnoses (Ross & Altmaier, 1990; Tannenbaum & Yukl, 1992). This is particularly relevant for jobs in hospitals, prisons, security firms, the police force, management and the armed forces.

Process involved in the task analysis

There are five steps involved in conducting a task analysis:

1. Obtain a copy of the job description[14]
2. Identify the typical tasks performed
3. Identify the knowledge, skill and abilities (AKS) needed to perform the tasks (in this study, the *critical incident technique* was used)
4. Develop training objectives
5. Design the programme

In a training needs analysis, a job description is developed that includes the identification of tasks required within the job. For this study, the job description was unnecessary. Instead, I conducted an analysis of the tasks psychologists performed with a focus on tasks in relation to Māori clients. Study Two relates to steps 1-4. Study Three relates to step 5, and an additional step, the evaluation phase.

I now describe the literature relevant to steps 2 and 3 in relation to cultural competency. I have argued that these steps are missing from university training programmes and constitute the core feature of this research. The critical incident technique (CIT) was chosen for this study because it seeks to

---

[14] I reviewed the international and national standards of psychologists' tasks to ensure consistency between what psychologists reported they did and what they were expected, or employed to do.

capture the knowledge, skill and awareness of experts or people who worked with Māori.

Critical Incident Technique

Nearly sixty years ago, Flanagan (1954) developed the critical incident technique (CIT) as a method to identify training needs in industrial sectors. The technique had its roots in time sampling studies of recreational activities, controlled observation, and anecdotal records and was used primarily for aviation training (Flanagan, 1954),

> The critical incident technique consists of a set of procedures for collecting direct observations of human behaviour in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles (p. 327).

Since its inception, the CIT has become a widely used qualitative research method and is recognised today as an effective exploratory and investigative tool for nursing training, counselling training, and clinical psychology training (Butterfield, Borgen, Amundsen, & Maglio, 2005; Fly, van Bark, Weinman, Strohm-Kitchener, & Lang, 1997; Schluter, Seaton, & Chaboyer, 2008). Further uses have been in the development of psychometric tools, psychological assessment and psychological therapy (Bedi, Davis, & Williams, 2005; Roberson, Kulil, & Pepper, 2001).

In the workplace, the CIT has been used for future employee competencies, job analysis, job performance and communications, and qualitative research (Silber, Novielli, Paskin, Brigham, Kairys, Kane, & Veloski, 2006; Wexley & Latham, 2002). The CIT was also found to be well suited to identifying the interactions between stressful incidents, individuals' responses to these incidents and the consequences of various coping behaviours.

Critical incidents are events people in the studied population report having done or have been observed by others as having done in their work role. Flanagan (1954) referred to incidents "as any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act" (p.327). To be critical, an "incident must occur in a situation where the purpose or intent of the act

seems fairly clear to the observer and where its consequences are sufficiently definite and leave little doubt concerning its effects" (p. 327).

The incidents are classified by the reporter as effective or ineffective in achieving the desired job results. The descriptions can take the form of stories, anecdotes, reports, or observations related by peers, supervisors, or managers. Factual reports of behaviour are preferable to general opinions and impressions, and only those behaviours that make a significant contribution to the general aim of the study are considered.

Flanagan (1954) said data should be collected in a structured manner using seven steps because data collection is retrospective and subject to the vagaries of memory loss, and is influenced by bias on the part of the participant and the inexperience of the researcher.

More recently, researchers are paying less attention to the term critical, focussing instead on 'happenings' revealed by incidents. Norman (cited in Sharoff, 2008, p. 303) favoured the term 'revelatory' incident to 'critical' incident commenting that,

> An incident is revelatory if it contains (or reveals) 'critical happenings' that are 'critical' by virtue of being significant (important) to the reporter with respect to the general aim of the activity under investigation (p. 303).

Another reason for the preferring the term 'revelatory' instead of 'critical' is to help participants understand that the situation in question should be significant or meaningful rather than a dangerous situation (Schluter et al., 2008).

The critical incident method parallels behavioural description interviewing in personnel selection in which the antecedents, behaviours and consequences of behaviour are elicited via direct questioning of people about their experiences (O'Driscoll & Cooper, 1996). The typical method of obtaining critical incidents is to interview practitioners, or *subject-matter experts* (SMA) or experienced personnel. The technique is useful as it seeks to explore emerging data without any pre-existing competency labels or

preconceptions. The technique is also flexible which allows for comprehensive descriptions of cognitive processes (Ross & Altmaier, 1990).

Schluter et al., (2008) emphasised that the CIT provided an unique opportunity to establish a relationship with participants, a point often overlooked in many research methodologies. Schluter et al., (2008) used an interactive-relational approach to obtain data encompassing five components: self-awareness, authenticity, attunement, personal characteristics and new relationship.

In their pilot interview, Schulter et al., (2008) they reported that the data gathered appeared superficial and lacked depth. They adjusted their technique using the interactive-relational approach and found a notable difference in the quality of the data. They went on to say that,

> Exploration of the wider context and location of the individual within the situation aligns the interview with the CIT method's requirement of both understanding the individual perspective and ascertaining systemic implications of the event (Schluter et al., p. 109).

The value of the CIT approach in this research is that it provides an opportunity to collect data that aligns with Māori emancipatory goals and Māori worldviews (I discuss this point in the final chapter). The process of collecting data that I followed in implementing the critical incident technique was mostly consistent with that intended by Flanagan (1954, p. 341).

Subject-matter experts

Subject-matter experts, sometimes called incumbents or consultants, fulfill a variety of roles in training needs analysis. They are used to obtain data for the task analysis where they provide detailed accounts of the knowledge, skill and abilities required to do a certain task. They also provide judgments about the importance of specific tasks in relation to the frequency of performance, their importance, the trainee's ability to acquire proficiency or the level of difficulty in performing tasks (Wexley, 1984; Taylor, 2002).

Subject-matter experts are a vital step in the TNA as they determine what material should be retained for training and rank the importance of the material. There is some discussion in the literature about the reliability of the judgment of subject-matter experts with some authors expressing confidence in the inter-rater reliability of judges (Wexley, 2002). Others argue that bias, subjectivity, and personal views may have an impact on reliability (Butterfield et al., 2005). Bias was an issue in study two and for that reason changes were made to data collection and analysis that I discuss in the results section (chapter 9).

As a research tool in the helping professions, the CIT is valued for its systematic, open-ended nature. It is user-friendly, fosters critical reflection and learning and promotes personal expression. Because of its inductive approach, it allows for freedom of expression with a reference framed by the research question (Sharoff, 2008). Bedi et al., (2005) stated that "despite having positivistic roots, the CIT can best be understood to fall in the middle of the qualitative-quantitative continuum because it incorporates elements of both into a single method" (p. 460).

The use of the critical incident technique to develop selection standards for students is another example of the technique and its applicability to this research. Ross and Altmaier (1990) used the CIT to determine the critical dimensions of performance among psychology interns. They produced seven dimensions: clinical skills; commitment to own professional development, crisis and emergency situations, interpersonal relationships, knowledge, professional and ethical behaviour, and programming and consultation skills (p. 461).

The dimensions described above are consistent with the tasks required for clinical students in Aotearoa/New Zealand although crisis and emergency skills would typically be a feature of clinical skills rather than separate competencies. There was no mention of cultural skills.

The CIT has also been used in several psychology training studies of: ethical behaviours of students, selection procedures, and with consumers to identify therapeutic alliance building behaviours in counsellors. Fly et al., (1997)

used retrospective reports and a questionnaire to identify ethical transgression committed by students. They asked students and directors to recall how they learned of the ethical transgression, what action was taken, and why the situation involved ethical issues. The authors concluded that ethical decision-making is a critical competency that students should possess and serves as an important indicator of competent practice. They commented that the types of transgressions students committed,

> These seemed to suggest that the students involved either did not value or did not understand the importance of honesty and integrity in maintaining trusting human relationships, a central value in psychology training; and that most of the incidents occurred even after the student had training in ethics, suggesting the importance of focusing more attention in ethics education on these areas (p. 494).

With respect to the last point, would more training increase ethical behaviour? Either the earlier training was of a poor standard, or the students who transgressed knew their behaviour was unethical but chose to ignore their training.

Sammon and Speights (2008) used the critical incident technique to identify which components of training influenced trainees' learning. The trainees reported changes in terms of increased knowledge, increased self understanding, changed attitude, and new behaviour. They attributed these changes to didactic, interactive, and reflective activities, the influence of the instructor, and the course as a whole.

The difference between the national and international literature on cultural competency training is that limited research is conducted in Aotearoa/New Zealand university departments that seeks to identify the unique and effective components of training.

There are limitations to the CIT. First it is time-consuming and expensive because of the time required to conduct interviews, and run the multiple analyses required to identify valid training needs. Second, it relies on retrospective memory of an event. Third, the veracity of judgments depends

on the objectivity of the observer: because the events are retrospective, embellishment may occur (Flanagan, 1954; Sharoff, 2008).

There are also no studies that have used the CIT to identity cultural competencies (at the time this research was conducted). The major advantage of the CIT is that the identified competencies are more specific to the role being analysed than those derived only from top-down approaches (such as questionnaires, surveys or computer-based programmes).

Conducting the Critical Incident Technique

In his writing, Flanagan, (1954) stated that the critical incident technique "does not consist of a single rigid set of rules governing data collection. Rather it should be thought of as a flexible set of principles that must be modified and adapted to meet the specific situation at hand" (p. 335). Flanagan (1954) outlined five stages to conducting a CIT study: (1) determine the general aim of the activity; (2) develop plans and specifications for collecting factual incidents regarding the activity; (3) collect data; (4) analyse the information; and (5) interpret and report the outcome of analysis.

Sharoff, (2008) conducted a critical incident technique literature review and found that Flanagan's stages were still being used, though variations were made. For example, setting a prerequisite for evaluation of specific behaviours as positive (effective) or negative (ineffective) with respect to achieving the general aim of the activity.

Citing previous studies, Sharoff (2008) argued that it is not always necessary to ask for positive or negative behaviours as the behaviours offered should depend on the general aim of the study, the meaning and salience of the behaviour, the intent behind the act and/or its consequences. They also proposed that emphasis should be placed on establishing why an incident was seen as important rather than obtaining precise details from participants.

The principal use of the CIT is to create a functional description of an activity that could be used for training purposes. Determining the *aim or objective of*

that activity (stage 1) is necessary before other aspects of the study could proceed (Flanagan, 1954, p. 336). Butterfield et al., (2005) proposed that understanding the general aim of the activity is intended to answer two questions: (1) what is the objective of the activity; and, (2) what is the person expected to accomplish who engages in the activity?

The functional description specifies precisely what should be done and not done to ensure effective and competent job performance (Flanagan, 1954). The functional description should also use terms such as "efficient", "successful", "advanced", "effective development" or "proficient". The description should also be acceptable to users, is *slogan-like* in nature and should minimise confusion (Flanagan, p, 337) (the competency statements from study two are included in Appendix P).

Following stage one, experts are asked to review and agree on the validity of the functional descriptions. Stage two of the CIT, *develop plans and specifications,* requires specific instructions to observers so there is conformity about what is being observed (at this point there is no flexibility in the rules).

Flanagan (1954) proposed four components: (i) demarcate the types of situations to be observed; (ii) determine the situation's relevance to the general aim; (iii) decide the importance of the effect of the observed incident; and (iv) decide who is the observer (e.g. experts in the field, supervisors, consumers of the product or service, or individuals performing the activity). I describe this process in detail later.

Stage three *collecting the data* should be relatively straight forward if proper plans and specifications have been developed (Flanagan, 1954, p. 341). Data collection methods include observational or retrospective accounts. Retrospective data can be collected via individual and group interviews, questionnaires or record forms. Flanagan discussed the optimum sample size in relation to the number of critical incidents obtained proposing that some types of complex tasks may require thousands of incident reports, whereas simple jobs may only require 50 or so reports.

The fourth stage *analyse the information* is considered the most difficult due to the large volume of data and because there is no single way to describe the activity, experience, or construct under observation (Flanagan, 1954; Keatinge, 2002). The analysis stage includes: (i) determining the frame of reference to take into account the purpose of the data (i.e., training, selection, research); (ii) the inductive classification of the information and construction of categories that summarise and describe the data in a comprehensive and efficient manner (this part requires insight, experience and judgment); and (iii) determining the level of specificity or generality in reporting the data.

The ultimate decision is influenced by practical considerations and varies between several dozen general behaviours or several thousand specific behaviours (Butterfield et al., 2005; Flanagan, 1954; Sharoff, 2008). The influence of bias and judgment errors has been discussed in-depth in the training needs analysis literature with the recommendation that subject-matter experts are trained to make unbiased decisions. I discuss bias in the following chapter.

The fifth and final stage includes validity checks, interpreting and reporting findings. Flanagan (1954) proposed that the researcher reviewed the five stages to see what biases were introduced by the procedures adopted and the decisions that were made (p. 345). He was adamant that the researcher was responsible for pointing out the limitations, the degree of credibility, and the value of the final results obtained in order to avoid faulty inferences and generalisations.

The development of the critical incident technique to assess psychological constructs requires that credibility and trustworthiness checks be established. Butterfield et al., (2005) proposed routinely incorporating nine data-analysis checks:

(1) Extracting the critical incidents with independent coders

(2) Cross-checking by participants

(3) Using independent judges to place incidents into categories

(4) Clearly tracking the point at which the data is exhausted

(5) Eliciting expert opinions

(6) Calculating participation rates (I did not do this)

(7) Checking theoretical agreement by stating the study's underlying assumptions and comparing the emerging categories to the relevant scholarly literature

(8) Audio or video-taping interviews to ensure participants' stories are accurately captured; and

(9) Checking interview fidelity by getting an expert in the CIT method to listen to a sample of interview tapes.

I did not follow step six because of the low number of psychologists who agreed to participate. Also, at the time, psychologists were being asked to participate in research and they were becoming tired. In step eight I preferred to capture the incidents through note-taking and I checked their accuracy with participants. Step nine was not an option available to me in Aotearoa/New Zealand as there was no-one I could approach who was familiar with the CIT technique and cultural competencies (described later).

Summary

The critical incident technique has evolved since its development in the aviation industry and has been applied to an ever increasing range of situations and for a variety of purposes. A particularly useful development is that capturing critical incidents is less focused on the incident itself, but more on the thoughts, feelings and beliefs about what was done, the outcome, and the most satisfying aspect of the behaviour. This development leads into its potential application as a cognitive-behavioural tool but more importantly, it allows for in-depth descriptions of psychologists behaviour.

The training needs analysis in this study seeks to identify the typical tasks that psychologists perform when they work with Māori clients and to obtain examples of work undertaken with Māori clients. Those tasks and examples are then used to identify the *awareness, knowledge and skills* required to train

clinical psychology students to work with Māori clients. The results from the task analysis and CIT combined with the results from the pilot programme will be developed into a final workshop. I now describe the task analysis method.

CHAPTER 8: TRAINING NEEDS ANALYSIS

Study Two: Method

Psychologists Interviews

The criteria for selecting participants were that they worked with Māori clients, or had supervised someone who had worked with Māori clients and who had at least 3 or more years work experience as a psychologist. I recruited psychologists based on the 2003 Workforce Survey of the New Zealand Psychologists Board (New Zealand Health Information Service, 2003). The survey is sent to all psychologists who apply for an annual practicing certificate (APC) and shows the spread of psychologists across different work locations (total respondents = 1017).

The majority of psychologists worked in the District Health Boards (27.2%) private practice (23.3%), Group Special Education (10.8%) and the Department of Corrections Psychological Services (4.7%). The process of recruiting participants involved facilitating a discussion on cultural competency at the New Zealand Psychological Society (NZPsS) conference and the College of Clinical Psychologists (CCP) annual conference and presenting a poster presentation at another Society conference.

I also delivered a workshop to a group of psychologists, social workers and counselors where I asked potential participants to remain after the workshop. This was a mass-administration where audience members were asked the questions from the CIT interview schedule. It operated in a similar manner to a focus-group.

I also emailed service managers from the Department of Corrections: Psychological Services to ask them if they would discuss the research with staff and arrange a time for me to interview psychologists. I made contact after I obtained ethical approval from that Department. I supplemented this approach by using the snowball technique where I personally contacted

experienced psychologists whom I knew and asked if they would participate, or pass my contact details to other psychologists.

Data collection method

Twenty interviews were conducted using face-to-face contact; five by email, one by telephone, and one focus group (there were 13 in the focus group, but only four provided usable material). For the sake of brevity and to assist reading, the participants are grouped together regardless of the data collection method. I only describe the procedure for the face-to-face interviews.

Participants

Preliminary testing of interview schedule

Two psychologists agreed to test the questionnaire. They were both female, from Māori and non-Māori ethnic descent. One was from Te Rarawa descent and the other was from Ngāti Mahuta. They were aged 30 and 34. Both participants were post-graduate level educated, employed, non-religious, and heterosexual. The participants were interviewed together and tautuutu was offered as koha. The information sheet was provided prior to the beginning of the interview (Appendix H). I used the interview schedule (Appendix I described below) to guide the interview.

The pilot lasted approximately 50 minutes. Both psychologists agreed that the format and questions were easy to follow, and that my interviewing style was non-intrusive and both suggested small changes to clarify what was meant by critical incident. There was some concern that critical meant significant, or dangerous. The critical incident technique literature also mentions the confusion associated the term (Sharoff, 2008). I modified the information sheet to minimise that ambiguity.

CIT participant demographics

Most of the participants completed the consent form (Appendix J). Others commented that their korero with me (dialogue) constituted sufficient consent. Some of the data from the participants in the preliminary phase

were included in the final analysis. In the actual interviews, Māori participants received an information letter with a Māori introduction. Non-Māori participants received a letter written only in English.

Twenty-nine psychologists and one cultural advisor, who worked in one of the organisations, agreed to participate in this research (n=30). The criteria for inclusion was that psychologists had three or more years of clinical experience and had worked with Māori or had supervised someone who had worked with Māori. The average number of years as a psychologist was 8.4, with the two most experienced working 17 years and 25 years respectively.

The cultural advisor had worked with Māori in prisons for over 20 years. At the other end of the scale, two psychologists had been working for only two years. I chose to include them as they worked primarily with Māori clients and had received regular cultural supervision. These two psychologists had signed up for the study and I had only just met them that day, so it was important to me to whakamana or respect their willingness to participate.

Ethnically, the participants were: Māori, 10 – Ngāti Maru, Ngāti Mahuta, Te Aupouri, Te Whānau-a-Apanui, Ngai Tahu, Ngā Puhi, Ngāti Hine, Ngāti Huia, Ngāti Paoa and Tuwharetoa; one Samoan, one Chinese, three Afrikaans, two Scottish, one Canadian, 10 Pākehā (one person identified as Pākehā-Māori) and one American. There were 16 females, and 14 males. Two identified as gay-lesbian. Twelve stated that they had had no bicultural training in their psychology training; 15 had bicultural training at university. Two had undertaken bicultural training since becoming a psychologist.

I also interviewed/discussed my research with a cultural advisor from an organisation that employed a large number of psychologists. He had asked to speak to me about my research when I first visited the organisation. Following that meeting, he arranged for me to visit another branch to interview psychologists. He also offered to participate in the research and discuss his observations of how psychologists worked. His comments are embedded in the results section. I continue to work with him on mutual projects and we keep in regular contact.

The range of job locations were District Health Boards – Child and Family, Child and Adolescent, Adult Mental Health, Forensic Services; Employee Assistance Programmes, Psychological Services, Private Practice, Drug and Alcohol, Kaupapa Māori Services (mental health and addictions), and Group Special Education.

Interview Schedule

The interview schedule contained basic demographic questions (age, gender and ethnicity), two questions about the psychologist's work location and position, and a question about the typical tasks that they performed when working with Māori. This was accompanied by an example of the question and a detailed response organised by *situation, behaviour,* and *outcome* so that the psychologist knew what was expected.

The psychologists were asked to provide a narrative account of the incident which I have termed "scenarios". The critical incident question prompt was the same for all the interviews: "Start by describing a situation [with a Māori client] either effective or ineffective, in which you, a peer, or a supervisee was involved". Follow-up prompt questions were asked of each incident.

1. What were the circumstances surrounding this incident? What was the background? What was the situation? (To determine when a given behaviour was appropriate).

2. What exactly did you do that was effective or ineffective? (To identify observable behaviour).

3. What were the consequences/what happened?

4. What knowledge, skill and attitudes do you think a student/trainee should possess in order to do what you did (or to avoid doing what you did)?

Procedure

At the time I conducted this research, psychologists were being approached for a number of projects and I felt it was important that they were not pressured, and that they gained something useful from participating in this

study. The meetings occurred at Community Service Agencies, University, Iwi Organisations, Psychological Services offices and Paremoremo Prison. The participants were sent or given the information sheet and consent forms prior to the interview.

Most of the interviews began with a whakawhānaungatanga process which included an introduction or mihimihi followed by a discussion before the consent form was signed. Some participants wanted to get started straight away, while others were happy to talk about their whānau, whakapapa, work or general interests. The prison interviews began with a mihi-whakatau (formal process of introduction to establish relationships, connections and purpose) with approximately 10 staff members and three bicultural therapy workers.

During the whakatau I shared my pēpeha and explained the research goals. At the conclusion of the day, I was invited to participate in a weekly group meeting with the prisoners. This was a special (and unique) part of the research as it was unrelated to data gathering but was an opportunity to share in the role of the psychologist and their work with mauhere (prisoners). The purpose for me was to meet some of the prisoners and gain some insight into their worldview. The experience concluded with an invitation for me to consider working for the prison in the future.

The remaining interviews were conducted mostly after a shared meal and some before a meal. I began by talking about the research, my interests in cultural competency and how I believed clinical training could benefit from the input of the participants. As much as possible, I moved the interview along where necessary; at other times I let it drift until the participant was happy to get back to collecting data.

By using my clinical interview training during the interviews I was able to guide the flow of the information; at times it felt just like a clinical interview. In subsequent interviews I talked with participants about this to ease possible anxiety or discomfort. The incidents were provided as a narrative account of what psychologists did with Māori clients and will be referred to as "scenarios".

The seven steps process that I followed consisted of:

(1) *The interview* process was clearly described (this part related to process and establishing confidence in my ability to interview).

(2) S*ponsorship* - the mana or integrity of the researcher. I explained my experience as a psychologist, NSCBI member, Psychologist's Board member and University lecturer.

(3) *The purpose* or justification and benefits of the research were outlined and any opportunity for questions built into the allocated time.

(4) The rationale for *the group being interviewed* was clearly described.

(5) A guarantee of the *anonymity* of the interviewee (should he or she so choose).

(6) *The question* was made clear as possible, related to the general aim of the research, and described in terms of what was effective, or ineffective. In the pilot interview, the psychologists asked for more clarity about the term critical. The psychologists were asked for scenarios at this stage.

(7) The *conversation* was kept as structured as possible. I was neutral and showed that I accepted the psychologist as the expert. That was not difficult as I was genuinely impressed by the psychologists' depth of knowledge and experience.

When the psychologists could not provide any more scenarios, or the time was moving along, I asked them to review the scenarios. In this step, I asked them to identify the awareness, knowledge and skills components they thought a student/trainee should possess to do what they did. I also provided prompts to assist them to recognise areas of AKSs that they may have overlooked.

For example, I asked one psychologist to indicate the level of competency the trainee should possess when speaking the Māori language/te reo). He or she indicated (depending on the scenario) whether the student should possess a

basic ability to pronounce names and places correctly, to say a pēpeha, conduct karakia, or hold a conversation in Māori.

The AKS were reviewed, summarised and reflected back to the psychologists who checked them for accuracy (as described in more detail in the results section). At the conclusion of each interview I thanked the participant and offered them a koha (cd-rom), more food, an offer of future workshops, presentations, or clinical/cultural advice, and a summary of the finished research. The interviews averaged 90 minutes. Since conducting this research I have given a presentation to Psychological Service's Roopu Māori on cultural competencies, and provided feedback on several of their projects.

The following section describes the results from the training needs analysis.

Study Two: Results II

Typical Tasks Performed by Clinical Psychologists

The purpose of this section is to provide a description of the typical tasks that psychologists performed when working with Māori clients. The results for this section were obtained from psychologists who participated in the critical incident technique (CIT) interview by email, telephone, or kanohi-ki-te-kanohi. In the interviews, I asked the psychologists to describe the typical work they do with Māori clients.

The responses were consistent with the literature (at the time the study was conducted)[15] on the typical tasks performed by clinical psychologists. On the other hand, there was no information in the literature identifying core Māori-culture related tasks. The typical tasks that psychologists performed fell into two categories: *Assessment and treatment.*

Assessment

Assessment related tasks included the clinical interview, problem identification, goal identification, observation, and psychometric testing. The psychologists also performed supervision, teaching and liaison tasks but were not included as they were not relevant to training interns.

Treatment

Treatment related tasks included treatment planning, treatment implementation and treatment monitoring. Treatment was conducted in a variety of ways and settings (such as in prison, in a community agency, in hospital, clinics or psychologists' offices). Some psychologists provided joint therapy with allied health professionals located in separate organisations and meeting with other agencies relevant to their client base. *Typical treatment*

---

[15] The tasks were then matched to the O*NET tasks and New Zealand Psychologists Board Cultural Competencies document.

related tasks included: acute intervention; anger/violence prevention; and group and individual treatment including implementing psychological treatment models (cognitive, behavioural, psychodynamic, family therapy, narrative, schema, and drama therapy).

Additional tasks included: treatment for residential groups; monitoring treatment progress; assisting clients with deciding whether alternative/supplemental assessment and/or treatment options are preferred; visiting clients at home, hospital, and/or prison; teaching skills to control the emotional and physical sensations of distress; techniques designed to change unhelpful negative thinking patterns; and managing risk. Psychologists also engaged in *report writing and feedback:* providing reports to other agencies DHBs, hospitals, GPs, schools, family court, criminal court and parole board assessments.

Clinical-Cultural Distinctions

My analysis of the typical tasks showed that psychologists were influenced by two types of practice: Western-cultural practice; and Māori-cultural practice. I used the term Western-cultural to describe any psychological practice that did not have distinctly Māori features, and I used the term Māori-cultural to describe any practice that originated from Māori culture. I deliberately chose to distinguish the two practices because I wanted to highlight that Māori-cultural processes are used in therapy.

The problem with making a distinction between clinical and cultural practices is that what are labelled "cultural practices" are inevitably only those which are "different" to the unacknowledged norms of Western psychology. Moreover, the distinction implies that those cultural practices lie outside "clinical practice," which is positioned as "real" psychology, somehow beyond or above culture. It leaves unchallenged the claim that clinical practice is objective and (almost) universal. Thus, I argue that making a distinction between "clinical" and "cultural" tends to mean that culture-specific practices are marginalised and allows the cultural underpinnings of much clinical practice to remain invisible.

Given the dominance of Western cultural norms within psychology, much of what I describe as "Western-cultural" is in fact White cultural norms. In this regard, the term "Western-cultural" is unsatisfactory in that it leaves invisible the White cultural nature of clinical practice. My intention is that by using the term "Western cultural" rather than "clinical" to describe any practices which are not specifically Māori the reader will be reminded that clinical practice is not culture-free.

Using the term "Western-cultural" challenges clinical psychology's assumptions about the role of culture in practice, showing that the division between clinical and cultural is artificial and misleading. I am not advocating throwing out the term clinical; rather I argue that unless 'clinical' practice can be clearly divorced from White values and culture, then the term is a subterfuge to maintain a monocultural value system.

The issue is the inconsistent practice perpetuated by dominant groups of labelling forms of psychology that is not White, as foreign, exotic, cultural or ethnic; while labelling their psychology with terms such as empirical, scientific, clinical, valid, robust and proven. At the same time, Western psychology fails to highlight in training that those who label others are White or Pākehā psychologists. I discuss the clinical-cultural distinction again in chapter 13.

I now provide examples of some of the tasks described by psychologists that originate in an indigenous Māori worldview. These are followed by the tasks that originate in a Western worldview.

Māori-Cultural

Māori-cultural practices are those that derive from an indigenous Māori worldview such as: performing karakia (prayer) to open or close a session or to settle a client; and establishing a therapeutic relationship by using mihimihi (introduction, greeting one another), whakawhanaungātanga (establishing relationships), Māori language, manaakitanga (hospitality) or pēpeha (tribal aphorism that establishes identity).

Psychologists used Māori metaphors, oral histories and oral traditions (written accounts of history which was handed down orally) to reframe assessments and treatments practices (e.g, narrative therapy and psychometric test administration). The Māori-cultural practices were performed frequently enough to be considered part of the typical tasks that psychologists performed.

For example, *Mihimihi:* Haimona, a male, Māori psychologist (interviewee), aged 33 years-old, stated that a typical task for him was to conduct mihimihi. Haimona understood that engaging with clients required him to use Māori-cultural processes rather than using the standard clinical procedure of establishing rapport and trust by talking about credentials and experience. Haimona commented that "mihimihi included a greater tolerance on my part for personal disclosure about, iwi, hapū and whānau connections".

Haimona also recognised the power imbalance that existed in a therapeutic relationship and used mihimihi to show that he was willing to look for connections with clients rather than hiding them (because of boundary issues) and relying on the assumption that the professional-expert is trustworthy.

One of the purposes of mihimihi is the establishment of links and setting the foundation for a relationship. In a Western psychological context, a rough equivalent is "getting to know each other", and "building trust". However the principles and obligations underpinning mihimihi differ markedly from simply 'getting to know each other' and impacts on the relationship in a multiplicity of ways (which I describe later).

Whakawhanaungatanga: All the psychologists used this Māori-cultural practice with their clients such as: identifying the presence and degree of importance to the client (and whānau) of identity, including iwi, hapū, whānau links, and the importance or not, of these whakapapa systems to the client.

The way that clients' identities were assessed was grounded in a Māori-cultural worldview using te reo/language, oral histories and oral traditions.

This included: seeking information about historical tribal histories and geographies; and learning and using pēpeha, mihimihi, karakia, pōwhiri, poroporoaki, and whakatau. Whakatauāki and whakatauki were used to illustrate aspects of therapy, or used as metaphors. Māori models of therapy were also used including: te whare tapa-wha, te Paiheretia, te Wheke, Māori mythology and folklore, and story writing/pakiwaitara.

Western-Cultural

Western-cultural practices are those that typically derive from a Western psychological worldview such as using established cognitive-behavioural therapy (CBT) assessment and treatment modalities, and using specific Western psychometric tests. At times, the Western-cultural tasks were delivered, or presented using Māori-cultural practices (e.g., using Māori greetings, or karakia or collaborating with a cultural advisor).

The psychologists provided more in-depth detail about the Western-cultural tasks they performed. It is likely, although I did not ask, that these tasks occurred more frequently than the Māori-cultural tasks.

Establishing a relationship is critical to the assessment process and precedes the collection of information. The psychologists began this process by talking with clients about their role, addressing any concerns they may have, providing information about qualifications and the relevance of psychology. Discussions were also held about managing power differences between the psychologist and client, and listening to whānau who may be present.

Assessment has a number of components and is an ongoing feature of the psychological relationship. The clinical interview was the primary technique used by psychologists and involved: identifying the problem and problem history; goal identification, observation, and use of psychometric tests (using actuarial tools and clinical tools). Te reo/Māori language was used to provide clarity for clients.

Other tasks were: conducting risk assessments (to self or others); identifying timeframes, prioritising goals and case formulation. The psychologists reported that they worked collaboratively with clients to identify problems

and solutions, and monitored their client's progress (using diaries and records). Assessments were conducted in a variety of settings: schools, client homes, and marae, schools, prison, and community services.

Summary

Although there is some information in the literature about the importance of bicultural content in training, the reality is that bicultural concepts are rarely discussed in-depth and there is little direction about what psychologists actually do with Māori clients. Māori-cultural practice is often relegated to a subordinate position within psychology and no consideration given to the possibility that Māori processes can be used in a psychological way.

The task analysis contributed to the development of the final programme by showing the situations in which psychologists used processes derived from Māori culture such as: whakawhānaungatanga (with the underlying knowledge of whānau, identity, iwi, hapu, and Māori engagement methods), using te reo, pēpeha, mihimihi, karakia, and pōwhiri.

I already knew of the existence of typical Western-cultural tasks; what I did not know was that psychologists performed Māori-cultural tasks that they did not learn in clinical training. I also found that the Māori-cultural tasks that psychologists performed required a level of knowledge, skill and ability/awareness that psychology students are unlikely to acquire in their clinical training. This issue arises in the next section.

The pilot programme results enhanced the final workshop by enabling me to fine-tune the content and delivery of the training material. The training needs analysis provided an opportunity to discover what psychologists typically did in their work with Māori clients so that training can be linked to the actual job.

I now describe the process used to analyse the scenarios from the CIT interviews with the psychologists. The results from this analysis will be linked to the psychologists' typical tasks and then developed into training objectives for the final workshop.

Critical Incident Technique: Results

Study Two

<u>Analysing the Scenarios</u>

The general aim of this study was to identify training needs that could be incorporated into a workshop for clinical psychology students. The purpose of the critical incident technique was to interview *subject matter experts* (SME) psychologists[16] asking them to recall critical incidents (scenarios) from their work with Māori that had positive or negative outcomes. The psychologists described in detail between one and five scenarios each.

The critical incident technique analysis formed the major part of this study and comprised five levels of data collection and analysis: (1) asking psychologists to describe their typical tasks with Māori; (2) capturing scenarios using an interview schedule and discussion with the psychologist; (3) reviewing the scenarios together with the psychologist to identify *awareness, knowledge and skills* AKSs; (4) reviewing the data on my own and extra AKSs that we overlooked; (5) conducting a thematic analysis from the AKSs; and (6) developing training needs and competency statements for the final programme.

(A) Awareness includes awareness of personal values, worldviews, biases, assumptions, and insights gained from self-reflection. *Knowledge (K)* refers to factual material that students need to learn from basic level to in-depth, cognitively difficult material. *(S) Skill* refers to hands-on practice and includes basic entry level skill through to complex skills.

The process of analysing the data from the interviews involved the creation of a categorisation scheme to summarise and describe the data in a useful

---

[16] The literature on training needs analysis refers to the participants as subject matter experts. I have chosen to call them psychologists in this study.

manner, while at the same time "sacrificing as little as possible of their comprehensiveness, specificity, and validity" (Flanagan, 1954, p. 344). Flanagan pointed out several considerations involved in the analysis process. I note the following:

1. Determining the frame of reference: Each of the scenarios involved identifying the knowledge, skills and awareness that students needed to learn in order to replicate, or avoid doing what the psychologist did in their work with Māori clients.

2. Formulating the categories/themes: This process involved insight, experience, and judgment on my part, and trust in the expertise of the participants.

3. Checking for bias: I was careful to ensure that I did not misinterpret the data by asking the psychologist to check her/his responses, cross-checking with the literature and incorporating material from my experience. I carefully considered the potential for me and/or the psychologist to make faulty inferences and reflected on the development of the data throughout the analysis process.

4. Determining the level of specificity: I reported general behaviours and specific behaviours because they were so rich in information.

5. Reporting the data: I provide several scenarios describing what psychologists did with Māori clients, then a description of the AKSs that underpinned what the psychologists did. This is followed by a thematic analysis, and finishes with a description of the competency objectives that were used in the training programme.

Identifying awareness, knowledge and skill (AKS)

Each interview elicited a set of scenarios[17] describing situations where the psychologist performed certain behaviours when they worked with Māori

---

[17] The names of people, iwi, hapū, geographic and organisations have been changed

clients that had positive or negative outcomes. Sixty-five scenarios were collected. The scenarios were organised according to the *situation, behaviour* and *outcome.* The frame of reference used to analyse the scenarios was identified in the follow-up question to the psychologist *"what awareness, knowledge and skill (AKS) components do you think students need in order to do, or not do, what you did with Māori clients?"* The psychologist described what they thought were the relevant knowledge, skill and awareness competencies that underpinned their behaviour in each scenario.

The psychologist and I then *cross-checked* the scenarios, paying particular attention to the psychologist's behaviour, and the outcome of what the psychologist did to identify the knowledge, skill and awareness/attitudes items. The cross-checking procedure developed by Alfonso (1997, cited in Butterfield, et al., 2005, p. 486) is new to the CIT technique. Cross-checking enables participants to be respected as experts in their own histories and perspectives (Butterfield et al., 2005).

The psychologist provided his or her interpretation of the event, which we discussed and adjusted if the psychologist agreed. This process was only used with the psychologists who were interviewed face-to-face, by email (although in a more limited way) and by telephone contact. The focus group psychologists did not provide feedback on the AKSs as there were either no contact details or no response when I made contact.

I then re-checked the data looking for additional AKS items that I/we had not thought to include in the earlier analysis. A number AKS tables were created using this processes. To further clarify the process, an example is provided below of how the scenarios were recorded by *situation* (context), *behaviour* and o*utcome*, followed by the AKSs that the psychologist and I developed. The parts in bold indicate where I added other AKSs in the rechecking. *Emere* a female Māori psychologist, aged-34 described the scenario below.

Table 5: Example of Emere's scenario and the AKS that were developed

Situation 52 Effective - A young man (Tuhi) was referred following the death of his girlfriend. As part of the whakawhānaungatanga process the clinician talked about her Māori ethnicity, and whakapapa of Ngā Puhi. Tuhi was from Kai Tahu. His grandmother, from Kai Tahu rang the service in a distressed state and questioned the receptionist about the clinician's whakapapa and said that she "didn't want someone messing with her boy's head, who wasn't friendly".
Behaviour: The clinician (Emere) wrote down her whakapapa which also included Kai Tahu connections on a piece of paper for the grandmother. **Outcome:** *effective.* The grandmother agreed to the psychologist working with her son.

Awareness	Knowledge	Skill
That the grandmother might have been embarrassed to contact the psychologist; **awareness of power dynamics in client, psychologist, and whānau relationship;** that a client may have multiple cultural identities; **the importance of personal disclosure,** the importance of sharing-power.	Clients may use a variety of methods to air concerns; that the client's grandmother may not have wanted direct contact with the psychologist; roles of grandparents, tūpuna and parents in Māori families; **role of sons in Māori families;** understanding of another iwi and hapū characteristics; historic relationships between tribal groups (enmities); whakawhanaungātanga, **concepts of mākutu,** death, suicide and grieving.	To enquire about heritage/whakapapa; show respect for the grandmother's concern; relaying information to her in a non-threatening way, **managing power dynamics; managing personal challenges**

By using this framework, the psychologists and I produced a large number of AKSs (Appendix P). Two more processes remained: the thematic analysis to organise the AKSs, and the development of competency objectives.

Thematic analysis process

Identifying and creating themes

In the critical incident technique method the purpose of collecting the data is to develop competency statements, or training needs to use in a training programme. I used a thematic analysis framework to organise and categorise the data. I categorised the data into themes which enabled me to retain the essence of the stories. The AKSs provided the much-needed training material, and the competency statements resided within a meaningful framework that could be traced back to the AKSs and the scenarios.

Thematic analysis is a tool that identifies, organises and describes patterns, or phenomena (Boyatzis, 1998) and works both to reflect reality and to unpick or unravel the surface of 'reality' (Braun & Clarke, 2006, p. 81). I did not intend to conduct a full thematic analysis but I thought it was important to organise the competency statements under themes to assist with the programme design.

I chose to use the latent thematic method to analyse and describe the data. The value of doing a thematic analysis in this research was diluted by the fact that my main purpose was to look for specific competency statements to include in a training programme rather than exploring phenomena from which to develop theories (Boyatzis, 1998). Latent themes relate to "identifying and examining underlying ideas, assumptions and conceptualisations, and ideologies that shape or form the semantic content of the data" (Boyatzis, 1998; Braun & Clarke, p. 84).

Within the latent approach, broader structures and meanings are theorised as underpinning what is articulated in the data (Braun & Clarke, 2006). To achieve this, the thematic analysis allowed me to "...capture something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82). The identification of patterned response and their

subsequent interpretation is linked to the worldviews I hold about psychology and its relationship with Māori.

As a researcher, I acknowledge my theoretical positions and values in relation to the research, my position as a cultural member, and a cultural commentator, and I recognise that I am the instrument of analysis through which the data "emerged" or was created (Braun & Clarke, 2006; Sanchez-Jankowski, 2002, p. 80). Although I acknowledge this position here, it applies to the entire thesis not just in relation to the data analysis section.

My interpretation of the data reflected a multiplicity of influences: what I gleaned from the literature, my personal views and experiences with Māori and Pākehā interactions, my passion for Māori culture; and my beliefs about the value of Western psychology, and clinical training.

My role was 'active', when I looked at the scenarios and the related AKSs and 'sensed' (Sanchez-Jankowski, 2002) what the data set meant. I also attempted to show an empathetic understanding (Stiles, 1993) of the participants' worldviews and the voices of the clients imbedded within the scenarios.

In using the term appeared/emerged I acknowledge that themes do not simply appear and that if "[I] just look hard enough they will 'emerge' like Venus on the half shell. If themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we understand them" (Ely et al., 1997, cited in Braun, 2006, p. 80).

In creating the themes, I looked at what was *consistent* with the theoretical framework of the research, and consistent with the literature. I looked at the *prevalence* of items, and what was *created*, or what *appeared/emerged*. I was flexible in determining whether a particular theme should be included. I paid attention to the notion that prevalence relates to the space (taken up by the theme) within each data item and the prevalence and the number of speakers who articulated the theme across the entire data set (Braun & Clarke, 2006, p. 81). I viewed space as relating to the *impact* and *importance* that certain behaviours had on the client, the psychologist, or me as the researcher.

The analysis process

An example of how I followed the process above can be seen in scenario about *Emere*. Emere recognised the grandmother's seniority, that ancient animosities existed between her iwi and her client's iwi, and that the grandmother did not wish to confront her personally. Emere managed the challenges to her integrity in particular, the grandmother's comment: "did not want someone who wasn't friendly messing with her grandson's head". Emere knew that the grandmother was able to influence the psychological relationship and sought to establish trust with her by discretely sharing her kinship connections.

In Emere's scenario, I noticed that she directed her behaviour towards the grandmother; Tuhi seemed to fade into the background. Emere knew that she needed to gain the grandmother's trust and approval to work with Tuhi. Emere wrote down her whakapapa, which also included Kai Tahu connections, on a piece of paper for the grandmother. The process that Emere used was simple and effective. It also showed the grandmother that Emere respected and addressed her concerns in a non-confrontational manner.

From this scenario and others, I created the following themes: *accepting personal challenges, comfort with using personal disclosure,* and *recognising whānau influences.* The defining behaviours for these themes were: "I relayed information to her in a non-threatening way"; "I provided my whakapapa details"; and "I knew there were tribal animosities between my people and her people".

I also noted from this and other scenarios that psychologists used a variety of processes that reflected a willingness to share power and to engage in whakawhanaungātanga.

I created seven themes from the scenarios that are consistent with Māori-cultural knowledge and Western-cultural psychology.

1. Incorporating Whakawhanaungātanga
   a. Recognising whānau influences

      b. Comfort with using personal-disclosure: sharing stories

      c. Engaging with mihimihi, pōwhiri and whakatau

2. Using te reo/language

3. Acceptance of wairuatanga/spirituality

4. Accepting challenges

      a. Sharing power

      b. Modifying Western-cultural psychology practices

5. Considering identity

6. Managing socio-political and cultural influences

7. Maintaining relationships with cultural advisors and cultural supervisors

Māori-cultural concepts: Cultural appropriation

As I worked through the analysis of the scenarios and the AKSs I noted several Māori cultural concepts that should not be included in clinical training. For example, the Western critical incident technique that I used to develop training needs for Māori produced AKS competencies about *mākutu* and *wairuatanga.* The concepts about metaphysical knowledge and practice prompted my concern about the potential appropriation or distortion of Māori concepts and practices.

As a training theme, I identified the importance of discussing the existence and manifestations of mākutu and the need to consult with knowledgeable peers or advisors. However, I doubted whether it would benefit Māori to teach students how work with these cultural concepts within the confines of a Pākehā institution, and in a short timeframe. I expand on my rationale for this later.

I proceeded with caution when developing the training programme to minimise the risk associated with the limited opportunities that students have to practice or integrate cultural material, my lack of experience in part, and my reluctance to share Māori cultural material with the Western world. Also, acquiring cultural knowledge, skill and awareness necessitates a thorough understanding of cultural context, and Western psychology cannot

provide that understanding in a manner acceptable to the culture from which the material was derived.

The most salient example highlighting the problem with psychologists possessing cultural knowledge and power is seen in the scenario about a haka. The scenario below described as ineffective was provided by a male, Pākehā, psychologist (Josh). The scenario shows how Māori cultural processes can be misunderstood and improperly managed. I also include an example of the AKSs that Josh and I developed.

Table 6: Scenario Decision to Ban a Haka

Situation 35: Psychologist, male. Decision to ban a haka
Behaviour: Teenagers aged 15-18 in a Māori focus unit in prison. They were learning and performing a haka. When I received a translation of the haka lyrics, my instant reaction was to ban the haka on the basis that it was violent and was not appropriate for incarcerated adolescents. I spoke with the unit manager who implemented my instructions. I also banned the viewing of violent videos and dvds. I did not experience any reaction to this, but other staff did. The lyrics related to the Treaty of Waitangi and "kill Pākehā" and "they raped our land". In other contexts this haka might be appropriate but not with impressionable youths. I received cultural supervision after the decision was made.
Outcome: Inmates did not perform the haka. The tutors were reprimanded for teaching a violent haka. I was not allowed to talk with tutors. The other staff knew that the inmates were not happy with decision. However, videos and dvds continued to be smuggled into the unit for a period. Not sure of inmates reaction, but knew they were not happy.

The table below shows how Josh and I organised the AKSs that were developed from each scenario. The bold-type indicate where I added further items.

Table 7: AKS – Banning the Haka

Knowledge	Skill	Awareness
The meaning and applicability of haka – its use (mana tangata) purpose, time and place, meaning, translations – double meanings; **that haka has been appropriated and controlled by the police, media and the Rugby fraternity**	Being able to implement a decision knowing the "fall-out" might impact on others**;** Preparing staff so that decision to ban dvd/videos were supported; preparing others so that the fall-out is minimised; **the ability to consult on difficult issues; skill to consult with a range of people (stakeholders); humility to discuss why difficult decisions are made; self reflection and critical thinking;**	Openness to cultural expressions and their limitations; to discuss with others about the meaning of cultural expressions; **awareness of the source of personal biases and judgments; of the impact of cultural appropriation or distortion of Māori processes on the recipient and those who provide that knowledge (i.e., tutors, cultural advisors)**
The impact of violence literature/media on youths and prison population; impact of cultural expressions on cultural identity (haka); sociopolitical experiences of clients; impact of violence on youths; developmental theories; history of treaty breaches.	I could have spoken to inmates about the violent content of the haka and how it related to their situation. Seeking cultural supervision being able to discuss situation, and be open to possible interpretations; confidence in making what could be seen as a culturally insensitive decision.	**That the haka is often used to describe treaty breaches; awareness of power issues, awareness of cultural demographics such as age, and status (i.e., mauhere/prisoner; to not abuse power**

As I proceeded to analyse this scenario with Josh I saw his "instant reaction" and a lack of appropriate consultation prior to making a decision. Josh's personal reaction is understandable given the content of the haka "i.e., kill Pākehā". However, he showed no awareness of the socio-political context of the lyrics or insight into the basis for his reaction, or willingness to discuss the matter with anyone.

I asked Josh if he had sought cultural supervision prior to making his decision and he said that he did not. He added that in hindsight, it would have been helpful. Josh developed a number of interesting AKSs which, if they had been used, may have resulted in a different outcome. I suspect that although he

was concerned about the effects of his decision, it may have been too difficult to reverse.

I developed the AKSs relating to the impact of the historical and contemporary socio-political context on psychologists and clients (i.e., appropriation of haka for rugby purposes, and viewing Māori protesters who practice haka as rebels and activists). I also added AKSs (in bold type) that highlight the importance of not using Māori processes without supervision or advice.

Josh should have been aware of a number of indicators that would have alerted him to reconsider the implications of his "instant reaction". These include: the cultural concept of haka, the role and expertise of the tutors, the age and ethnicity of the youth and their status as prisoners.

Additional AKSs concerned self-reflection, critical thinking and an awareness of power differences. In particular, Josh needed to be aware of the impact of his decision as he did not consult with an advisor, the tutors, or the youth involved. Although Josh has experience working with cultural concepts and Māori prisoners, the way the decision was made ensured that the power remained firmly in his hands and no discussion allowed. A skill for any psychologist is to consider involving others in decision-making and to not abuse their power.

There is also a possibility that the translation of the haka was incorrect or translated literally, which would have altered its meaning. Although Josh assumed that the translation was correct, in mono-cultural Aotearoa/New Zealand, language translation or interpretation is fraught with assumptions. It may have been helpful if he had checked the translation with a cultural advisor, or licensed interpreter.

The scenario shows the potential for problems to occur when psychologists know about cultural concepts and processes and their expression, but are not able to recognise their personal limitations when there are conflicting worldviews. Josh noted that the haka might be appropriate in other contexts but not with impressionable youths. The AKSs for making that judgment are

also complex and the context was vitally important to consider. Josh also noted the importance of being confident to make what could be seen as a culturally insensitive decision.

Is it appropriate for a Pākehā psychologist to make a call on "cultural expressions?" Yes, if they have consulted and have a thorough understanding of the implications of their decisions. Otherwise, the recipients of inappropriate decision are disempowered and their rights to develop their cultural forms taken away because it offends the ear of the outsider[18].

Limiting the training needs analysis

The preceding analysis highlights the complexity of identifying training needs, and the importance of limiting the material that should be included in a short training programme. Some may argue the opposite if students are to avoid making the same mistakes. Māori-cultural training material should be embedded in a Māori cultural context and education system that considers personal values, power sharing, and self-reflection and constantly seeks advice. Without these delimiters, simply teaching the AKSs can be ineffective, just as it was for Josh.

My decision not to use complex cultural knowledge was guided by the many voices of tūpuna and kaumātua who said that Māori knowledge should not be shared. I was also guided by my experience in psychology of misappropriation of Māori-cultural processes. This view is strongly highlighted by Ngoi Pewhairangi, a prominent Māori elder,

> One thing hard for the Pākehā to understand is that our elders never allow us to sell any knowledge of anything Māori that is really tapu. To them it is really priceless…and this is the part of Māoritanga that you can never teach. You know it is there all right, you've got it there (Pewhairangi, 1975, pp. 10-11).

I stress the point that I am not reifying Māori-cultural knowledge and practices into the realm of the unreachable. Rather I am highlighting their

---

[18] Or offends Christian morality as the hula did in Hawai'i in the 1800s (Silva, 2000).

importance and mana by choosing not to randomly teach them in a time-limited programme. My view is that staged system of learning Māori concepts needs to occur that recognises the developmental process required for complex knowledge, in the same way that psychology is taught in tertiary institutions.

Māori cultural concepts

The list below contains Māori cultural concepts that were obtained from the scenarios and the tables of AKSs. The Māori-cultural themes used in the final workshop are in **bold** type. The *italic* type shows the concepts that were not included in the final programme. The remaining concepts were used indirectly or directly.

Aitua (misfortune)
Aroha (love)
Haehae (self-injury to express grief)
Haka (war dance)
Hapū (pregnant, or tribal group)
Hara *(crime/mistake/sin);*
Hongi (sharing breath)
Iwi (tribal grouping)
Ihi and wehi
Ira tangata (person's life essence)
Kaitiaki
Karakia (prayers, incantations)
Karanga (call)
Kaumātua (elder)
Koha (gift/present)
Ko wai au (identity)
Mamae (pain – physical and psychological)
Mai and atu (receiving and giving)
Mākutu (bewitching/curse)
Marae (tribal meeting place)
Manuwhiri (visitors)
Manaakitanga (hospitality)
Mana (integrity/status)
Mana tangata (integrity of a person)
Mātauranga Māori (Māori knowledge)
Matekite (clairvoyant, seer)
Mauri (life essence)
Mihimihi (acknowledgment)
Moemoea (dreams)
Noa (normal, not sacred)
Pēpeha (tribal saying)
Pono (truthful)

Pōrangi (crazy)
Poroporoaki (farewell process)
Pouri (sadness/dark)
Pōwhiri (welcome process)
Puhi (virgin)
Riri (anger)
Tauutuutu (reciprocity)
Tapu (sacred)
Teina (junior sibling)
Te reo (language)
Tikanga (protocols)
Tuakana (older sibling)
Tangihanga (funeral)
Tūrangawaewae (standing place)
Tuturu (being real)
Utu (payment/revenge)
Wairuatanga (spirituality)
Whaiora (seeker of health, or wellbeing)
Whakaea (repay)
Waiata (songs, singing)
Wairuatanga/Spirituality
Whakamomori (suicide, self-harm)
Whakapapa (genealogy) (he tapu to te whakapapa/genealogy is sacred)
Whakawhanaungātanga
Whānau (family)
Whāngai (Atawhai, Taurima A "tamaiti awhi" adoption on the other hand required a close genealogical connection between the adoptive parent and the child).

Themes obtained from the critical incident technique

Seven themes (some with sub-categories) were identified and arranged into two categories: *Māori-cultural practices* and *culturally-informed* practices. The term *culturally-informed* is intended to convey a sense that the psychologist has some knowledge, or will seek to obtain knowledge, about the cultural characteristics of the client, it may also be an alternative term for cultural competency.

I initially categorised the cultural themes as Western-cultural because I had come to think of cultural competencies as Western and North American. I now recognise I had given way to the notion that because the predominant research used in psychology comes from the United States, then so did cultural competencies. I had dichotomised psychological practice as Māori and Western and to a large extent ignored the multiple societies, peoples and cultures that influence the development and practice of psychology.

There is no evidence that the practice of psychology is the sole initiative of the West. In fact, the themes described in the culturally-informed practice categories (e.g., sharing power, modifying psychological practices) are largely ignored in Western, clinical psychology training. This is highlighted by the view of many of the psychologists who talked about the contradictions between what they actually did with Māori clients and what they were taught to do in clinical training.

The Māori-cultural themes that were created relate to using Māori practices for the purpose of building, maintaining and protecting relationships with Māori clients and the integrity of people within the relationship (i.e., whānau, community, and friends). Most often, Māori processes were used so that general psychological practices could be implemented.

The culturally-informed themes involved the use of practices that did not have a distinct cultural origin. This does not mean that Māori did not use the practices in some way. Culturally-informed practice reflects awareness, knowledge and skill to work with the historical and everyday social experiences of people who are shaped by their culturally unique beliefs,

values and practices. These culturally-defined, everyday, social behaviours are carried with the psychologist and the client into the therapeutic environment.

For example, the theme *considering identity* (theme five) relates to knowing about and responding to socially and culturally defined identities of not only the people in the relationship, but the wider cultural group within which they belong. 'People in the relationship' refers to the worldviews of psychologists, clients, whānau, cultural advisors, and also includes the identity of the organisation (see also Love, 1999 and Love and Waitoki's 2007 arguments about conceptions of self).

Culturally-informed cultural practice involves stepping outside the somewhat rigid clinical forms of engaging and working with clients and using everyday social behaviours – such as self-disclosure/sharing stories, or sharing power (i.e., recognising that clients bring something beneficial to the relationship).

Development of competency statements

The final process in the data analysis involved reviewing all the scenarios, and the tables of AKSs to identify functional descriptions (competency statements) relevant to each theme. All the AKSs comprised of several layers that suggested a developmental learning process and a systematic progression through the layers. In fact, the themes rely on each other and have overlapping competency statements and AKSs (e.g., mihimihi and whakatau rely on using te reo).

As an example the theme *psychologists are aware of impact of their privileged position* produced a number of other AKSs that were identified as necessary for training students. It is too simplistic to expect students to be aware that privilege exists on an intellectual level without also teaching them to understand the social, cultural and historical basis of their position and that of the client. In the competency statement descriptions, psychologists and students are those who are targeted for training.

The competency statements incorporated *awareness, knowledge, or skill* competencies as per the frame of reference in the interview and aligned with the theme and the goal of training. The first process of analysis produced several hundred AKSs. For the reasons above, not all of these were included in the second analysis process. The second set of results was culled for repetitive or ambiguous AKSs.   The competency statements describe specifically what to teach students to do, or not do when working with Māori clients.

I checked the competency statements to see if they were consistent with the literature, and my own experience of teaching cultural competencies. The competency statements were only included in the final programme if they met the following criteria: relevant to student's needs (obtained from the person and organisational analysis, the literature and the pilot programme); suitability for the trainee's level of ability; whether the competency could realistically be taught over two days; my competency to deliver the training material; and finally, the appropriateness of the material for Pākehā tertiary institutions[19].

In this section I set out the themes followed by an explanation, a selection of scenarios to illustrate my choice of theme, the AKS, and then the competency statements. The scenarios yielded a number of AKSs that elicited a large number of competency statements which together, resembled a manual. For that reason the data is included in the end section of the appendices (Appendix P). All identifying names have been changed.

Māori-Cultural Practice: Themes as Training Needs

Theme 1: Incorporating whakawhānaungatanga

Incorporating whakawhānaungatanga was a pattern that featured in most of the scenarios. The central word – whānau means family, including extended whānau. Whānau may comprise the self (whan-*au*/I/me), parents, siblings,

---

[19] Tertiary institutions or universities also refer to Whare Wananga – Māori tertiary institutions.

cousins, nieces/nephews, grandparents, great-grandparents, mokopuna, uncles and aunts (including their children and mokopuna). A whānaunga is a relative or whānau member, and may include hapu and iwi members. Whakawhānaungatanga is the process of establishing family connections. It is also used to establish whether a basis exists for a relationship.

Several psychologists described the ways that they attempted to engage with a client using processes that were distinctly Māori-cultural. My analysis of the scenarios focussed on the purpose of the psychologists' behaviour and revealed that in general psychologists were trying to establish a relationship or trying to protect the integrity of the people in the therapeutic relationship.

Building relationships for the purpose of therapy is quite different to whakawhānaungatanga for Māori. Māori processes of engagement occur for political, environmental, social, spiritual, physical, educational and psychological reasons. When Māori are required to meet, a process of engagement is required that depends on the situation. What is relevant is that in whakawhanaungātanga, Māori want to know who people are, how they are connected, and whether they can be trusted.

Establishing trust is an essential part of building a therapeutic alliance. Goldsbury (2003) found in her study of service-users' experiences with non-Māori clinical psychologists, that the therapeutic alliance was central to clients' perceptions of their therapist's cultural competency. She also found that participants' initial thoughts and feelings, cultural factors and the psychologist's characteristics and techniques were part of, and contributed to that alliance.

Goldsbury's results also showed that the quality of the alliance impacted on the quality of the outcomes as those participants who were most content with the therapeutic alliance, were also most content with the progress or outcomes they had achieved. By incorporating whakawhanaungātanga processes, the way is paved to establish a connection with clients that have deeper ties than simply providing information about expertise and credentials. Ideally, those ties should also enhance the therapeutic alliance.

Whakawhanaungātanga occurred in a variety of ways. Erena described how she worked with her client (Tahi),

> A nine-year old Māori boy was referred to the CAF service for assessment following a suicide attempt. The boy had a long referral history to the service. He had attended Te Kōhanga Reo, and Te Kura Kaupapa (Māori preschool and a total immersion Māori school). I thought through the referral information and wondered what had happened to this boy and questioned in my mind, why wasn't anything working? (Situ. 21).

Erena said that she focused on trying to make him feel special as his life was problem-saturated. She did this by speaking to him in Māori, beginning each session with a karakia and whakawhānaunga and by sharing her whakapapa and disclosing some personal information about her family situation. Disclosing personal information was a common pattern across the scenarios.

For the intervention, Erena and Tahi wrote a story together that he was to use and practice each day,

> We used a cognitive intervention of rehearsal and happy thoughts to help him cope with negative thoughts and his impulsivity. The story was written using Māori deities and beings (taniwha) (Erena).

The narrative script was written in Māori and English, and used Māori and English metaphors and mythological spiritual beings. Karakia was used to develop coping self-statements. Several outcomes occurred as a result of Erena's intervention. Firstly, Tahi turned out to be a skilled writer and his father took notice of his ability and became more engaged with his treatment.

Erena showed an advanced level of knowledge, skill and awareness to work with a client from a kura kaupapa Māori - total immersion Māori language school. She demonstrated knowledge of the difficulty for a young boy caught within a mental health system and family problems. She showed knowledge of Māori educational systems and Māori cultural concepts and myths and she also demonstrated competence in Māori language which was used to benefit Tahi and his family.

Another psychologist Jade (aged-35) also used whakawhanaungātanga to engage with a client, who would not talk to her,

> I talked to him about how difficult it might be for him to talk to a white, middle-aged white woman. I told him I grew up in his local neighbourhood and talked generally about the school that I went to in the same area. It turned out that we both went to the same school (Situ. 14[20]).

Jade said she used whakawhanaungātanga with her client because she found rapport difficult to establish. She described her client as a gang member who was suspicious and would not make eye contact with her. There was a hint of irritation in his behaviour and he sat facing away from her. When Jade and I were developing the AKSs she said that it was her view that "students should learn to consciously look for ways to engage offenders and clients and to look for points of commonality. Students should also try to break down barriers and to not be defensive".

When I reviewed the data on my own I added that students should have an awareness of the barriers to therapy and that personal disclosure facilitates the therapeutic alliance. Students should also be aware of institutional racism regarding the treatment of mauhere/prisoners and societal attitudes towards mauhere/prisoners and their mistrust of representatives of the justice system (that is, the mauhere distrust of "the system" "the man" and "Pākehā authority"). Students should also know that Māori are more likely to be arrested and imprisoned than Pākehā, about the relationship between gang culture and Māori, and about power differences in psychological relationships due to gender and ethnicity.

Theme 1a: Recognising whānau influences

The concept of whānau comprises any combination of people who are related through marriage, adoption or whāngai, or who are related socially, metaphorically or biologically (Metge, 1978). Whānau combinations

---

[20] A reminder that a full description of the scenario is in the appendix section.

consisted of tamariki (children), taiohi (youth), pākeke (adults) or kaumatua (elders) and people who, although unrelated, have stayed so long in the home that for them to leave would be like losing a relative.

Psychologists also need to have an understanding of the relationship between identity, mana, whānau, hapū, iwi, and whakapapa so they can manage the multiple variations and influences of whānau on their clients. Implicit within an understanding of whānau, is that not all Māori live with extended family influences, living instead as nuclear families.

Paul, a Pākehā psychologist aged 48, talked about a client who was having difficulties at work; Paul described his scenario as ineffective. During the clinical interview, Paul asked him: "What was the impact of a particular event on his life?" The client said,

> Well that is an interesting question: In order for me to tell you what I think about this I have to think about what my mother thinks, what my father thinks and in fact what my extended whānau think too – then I can tell you what I think (Situ. 44).

Paul said he did not take into account that although the client came as a single person, he carried his whānau with him at all times. Paul said he changed his individualistic worldview.

The next scenario also shows evidence for the theme *accepting challenges, sharing power* but was better suited for this theme because the psychologist had gained the family's trust by being well prepared and with established links to the community. Sean, a Māori psychologist (39 years-old) talked about a whānau who brought their son in for consultation; he described their initial distrust:

> They were emotionally charged. I had made prior contact with the whānau, I was well informed about the case file, I knew about the community.

Sean said that had he picked who made the decisions in the whānau.

> I was able to spot mana and show reciprocity – tauututu. They asked if I was the right person for the job and that they wanted the best. I

was not defensive. I was physically confident, happy to be submissive to restore equilibrium" (Situ. 63).

The outcome was that the whānau were comfortable with sending their son to the service.

These scenarios show the importance of whānau/family and highlight the worldview that some Māori whānau share experiences as a group. Paul recognised that he needed to ask about whānau, but he missed the need to be flexible and recognise when to vary questions to address different cultural worldviews. Sean showed that working with whānau is a long-term process that involves establishing a relationship with community groups and being comfortable with whānau tensions and challenges. I developed a few competency statements from the whānau-focused scenario including confidence and the ability to "spot mana".

Theme 1b: Comfort with using personal disclosure: sharing stories

Implicit within whakawhanaungātanga, mihimihi, pōwhiri and whakatau is being comfortable with self-disclosure. A number of psychologists stated the importance of being able to talk flexibly about themselves to clients who were unsettled or mistrusting.

Most of the psychologists endorsed some form of self-disclosure. This finding is significant as there are real restrictions on what is considered appropriate levels of disclosure, and students often struggle to keep within those boundaries. Across the scenarios, there was no evidence that the disclosures were inappropriate (although others may disagree).

The term personal disclosure on its own limits a full understanding of the range of actions, purposes and consequences that may arise from the disclosure. There was evidence across the scenarios that psychologists 'shared stories' as a way of engaging with clients.

I did not explore this potential theme, choosing instead to adhere to the conventional term, personal disclosure and attaching '*sharing stories*' as I think this more accurately reflects the interactive process of disclosing personal information and experiences. The overarching premise is that

psychologists need to be prepared to talk about personal information and to share their stories.

Whakawhanaungātanga processes imply that a connection is being sought; at times, it conveys an obligation (often unstated) between the parties once the connection is established. Implicit within whakawhanaungātanga is the necessity to share stories. Erena's personal disclosure to Tahi that she had mixed-racial parents who were also separated sent a message to him that she understood the dilemmas that he had faced, because she had experienced them too. Tahi had a reason to trust Erena because she understood him, used his native language, and shared his worldview.

Jade's scenario where she disclosed personal information to her client (a violent offender) is also relevant here. Jade told her client that as a child, she had lived in the same neighbourhood and attended the same school. The disclosure allowed her to connect to her client and evoked a power-sharing dynamic. In this scenario, the 'power-holding professional' showed that at one time she too, was just like him, a school child.

I suspect the client knew that Jade's disclosure was risky but she had made the first move and showed her willingness to reach out. The effect was that "he visibly relaxed and looked up" (Jade). The barrier had come down because Jade treated her client as a person with value when she shared her childhood memories with him.

The competencies that were created from these scenarios relate to personal disclosure and awareness of body language. Another competency is the willingness on the part of the psychologist to reach out and connect, in what could be, in the eyes of others, an unethical or dangerous manoeuvre.

In my follow-up analysis, under the knowledge competency, I added that students should know the barriers that exist between psychologists and clients on the basis of ethnicity, profession, gender, age, and/or educational level. Students should also know that personal disclosure or sharing stories helps to remove barriers.

Across the entire data set, some psychologists said that it is important to be flexible and not too controlling and that information will present itself at the right time. Flexibility speaks to the attributes of the psychologist to *negotiate therapy* and to *accept client challenges* with the understanding that there should be a variety of methods in the 'tool-kit' with which to gain trust, and control of the interview.

An example of the AKSs (K = Knowledge) that were developed for the theme incorporating whakawhanaungātanga and three subthemes include: **Knowledge:** of family roles – such as grandparents, parents, brothers, sisters, eldest, youngest, mokopuna. Knowledge of: colonisation history of Aotearoa/New Zealand (i.e., land confiscation), own history (which might not be in Aotearoa/New Zealand) and the client's cultural history and possible historical linkages. Psychologists also need to know the cultural mores, behaviours, worldview and beliefs related to the whānau with whom they work.

The AKSs were then analysed and a set of competency statements were created to use as training needs. A sample is provided below[21]:

i.   Psychologists recognise that Māori may present with emotional reactions and worldviews based on a culture of discrimination and colonial oppression and has considered the impact of their position in the relationship

ii.   Psychologists are prepared to build the relationship at a pace that meets the needs of their client

iii. Psychologists know the socio-political history of government policies designed to break-down whānau groups (i.e., promoting nuclear-family configurations, pepper-pot housing practices, Social

---

[21] A full description of the competencies for the whakawhanaungātanga theme is in the appendices.

Welfare[22], Work and Income New Zealand (WINZ), Child, Youth and Family (CYFS) practices.

Theme 1c: Engaging with mihimihi, pōwhiri, and whakatau

The scenario below provides another example of the importance of whakawhānaungatanga but the theme that I created *recognising the role of pōwhiri, whakatau and whakatau* (theme: 1b) relates to specific processes used in formal and informal settings. There is also support for the theme *using te reo and modifying Western-cultural practice* as te reo is often the primary language used and that incorporating those processes into psychological practice requires some adjustment of Western-cultural practices.

Mihimihi is a distinctly Māori-cultural process comprising introductory speeches that occur at the beginning of a gathering, meeting, or pōwhiri and is a process used to establish a connection between two or more people. The speech may comprise significant tribal knowledge, or may be a simple statement of welcome. The purpose, context and audience also determine the level of formality.

A common way of establishing a relationship is by using a predefined template or pēpeha that includes: identifying tūrangawaewae (geographical standing place), waka (ancestral canoe), maunga (tribal mountain), moana (tribal ocean), awa (tribal river), hapu (sub-tribe), (eponymous ancestor), iwi (tribal group) and marae (sacred meeting place). Speeches, waiata, physical contact and silence are features of mihimihi that must be attended to carefully.

Mihimihi carries within its meaning and actions the acknowledgement of people and their position, deeds, or future actions. It is not uncommon to

---

[22] This name is no longer used, but it is relevant to retain it here as some clients have had experiences under that service.

shorten mihimihi to mihi[23]. To 'mihi' to someone is to acknowledge and show respect for something they have done, for example, "*kei te mihi, kei te mihi, kei te mihi*". Mihimihi can occur (albeit infrequently) without trying to form a relationship whereas whakawhānaungatanga is specifically for relationship building and relationship maintenance.

Stephen, a Pākehā psychologist aged 37, had developed his language competency and his ability to mihi in Māori to the extent that he is a proficient speaker and was often called upon in formal settings. Stephen described a positive outcome in his scenario,

> I was not able to attend the residential-service pōwhiri and so was introduced to the current residents prior to conducting their weekly progress review. The Programme Manager recommended that I go through a whakatau process with the residents where I would mihi to them in Māori. After the whakatau and during the whakawhānaungatanga, several of the Māori residents reported to me that they appreciated the effort I had made to learn some Māori. Another individual later said that this encouraged him (in a good way) to learn more himself because he wanted to catch up on the reo (Situ. 5).

Josh (who was introduced earlier) was invited to attend a pōwhiri on a marae as part of the reintegration process for a released mauhere/prisoner who had raped one of his whānaunga/relatives. Josh had arranged for a cultural advisor to accompany his team to the marae and to be welcomed formally. Josh was comfortable attending and engaging in pōwhiri and whakatau, although he described the outcome as ineffective,

> There was a formal pōwhiri with waiata, and afterwards there were more waiata, and speeches. It appeared to be a happy occasion. There was no opportunity for the victim to speak (Situ. 38).

Josh reported that he was quite distressed about this process. He felt that the marae process should have taken the victim's perspective into account. It

---

[23] Doubling the word mihi produces an intensifier – mihi is to greet, mihimihi is greeting (for that matter 'kei te mihi' also means greeting).

would have been appropriate for him to seek cultural advice and cultural supervision to assist him to understand why the hapū were quick to accept the whānau member back into the community and why the victim did not speak. Josh had a view on how the reintegration process should have proceeded but it was necessary for him to accept that reintegration should be determined by the whānau/hapu group and is a process that is largely beyond his control.

When I think about this scenario, I consider that the hapu may have been influenced by whānau hierarchies, sexism or victim-blaming, or it may be that they genuinely forgave their whānau and that the victim did not wish to speak. Josh's scenario generated a number of AKSs and evidence for other themes *accepting challenges, modifying Western-cultural practices and maintaining relationships with cultural advisors and cultural supervisors.*

Stephen's and Josh's experiences and those of other psychologists suggest that students should have a full understanding of what pōwhiri and whakatau involves and that psychologists' privilege is tenuous in these situations. A sample of the competency statements that I developed is included below.

Competency statements

a. Psychologists know the purpose and meaning of pēpeha and waiata

b. Psychologists can say their pēpeha, an appropriate karakia, and sing waiata

c. Psychologists understand the Western origins of psychological processes of engagement and uses processes that recognise Māori worldviews

d. Psychologists can participate in the arrangement of a pōwhiri and or whakatau while enabling Māori to retain control of the process

e. Psychologists understand the stages of pōwhiri and whakatau, is aware of their purpose and can respond appropriately

f. Psychologists demonstrates a commitment to participating in pōwhiri/whakatau throughout the entire process[24]

g. Psychologists can identify the mana whēnua[25] of the area in which the pōwhiri/whakatau is held

h. Psychologists know the roles of tāngata whēnua, manuwhiri, kaumatua, kuia and koroua and are prepared to be flexible

i. Psychologists who have whakapapa connections with a client is able to manage conflicts and potential expectations that clients may have of them[26]

The ability to participate in whakawhanaungātanga, mihimihi, pōwhiri and whakatau requires understanding and comfort with speaking, or hearing a different language. A number of psychologists described situations where te reo was used, or where understanding te reo would have been useful.

Theme 2: Using Te Reo

In my analysis of the scenarios, language competency featured explicitly and implicitly. I asked the psychologists what they thought students needed to know in order to speak Māori competently. Some psychologists said an ability to pronounce names and places correctly, while others said that being able to say a karakia, or pronounce a person's name was very important.

Continuing with the objectives of this study, I developed several functional descriptions of language competencies to reflect the most basic of language requirements (correct pronunciation, simple words), through to more

---

[24] Sometimes this is not possible; however I refer here to the propensity for some psychologists to not attend pōwhiri or whakatau and arriving later without making any attempt to engage with using Maori processes.

[25] Mana whēnua refers to the iwi, or hapu who are considered by Maori to be the paramount tribe of that area.

[26] Tauutuutu described earlier is a considerable ethical dilemma for Māori psychologists. I do not propose an answer to this situation, but consideration must be given to whose worldview should prevail.

complex requirements (such as conversation, karakia, mihimihi, conducting hui). I also developed competencies that took into account the wider socio-linguistic and political issues within which language is used, taught, and represented.

Knowing how to speak a different language requires more than knowing the rules of grammar, vocabulary, and the context for using language formally or informally. In a psychological context, the minimum requirement of language is proper pronunciation, humility, respect, awareness and knowledge of the socio-political context within which language occurs.

The scenarios show that psychologists are aware of the importance of language even when mistakes were made. I developed the competency statements to reflect that te reo Māori/the Māori language is in a state of crisis with little movement from government to halt the decline, and that te reo/the language is a taonga that needs preserving for the benefit of Māori identity and self-determination. I also considered the empowering nature of language to Māori who have been dispossessed of their language. Although *using te reo* is under its own theme it should be considered part of each Māori-cultural theme.

Jean, a Pākehā psychologist, aged 55, described her simple act of pronouncing her client's name correctly. The context for this behaviour was that Jean and her client's father, Te Ikaroa, were in a multidisciplinary meeting with a psychiatrist, a nurse and a social worker. The team wanted dad's permission to send Eruera to a health camp. Jean sensed that Te Ikaroa was uncomfortable and that no effort was made to make him feel at ease. Jean said that knew she had to engage with him,

> I sat next to the father and called him by his full name and made an effort to pronounce it correctly. I think I did pronounce it correctly. The father lifted his head and looked at me directly. I saw that he had heard me. He began talking to me.

Te Ikaroa agreed to send Eruera to a health camp for a few weeks and he showed improvements when he returned. A sample of the AKSs that were created from this scenario are provided below:

Table 8: AKS for Using te Reo Themes

Skill	Knowledge	Awareness
Correct pronunciation of te reo; sharing personal space with clients; recognising client discomfort; recognising and understanding body language.	The importance of language; impact of power imbalance; correct pronunciation of client names; Māori processes of engagement: use of language; Māori language revival; Te Ture Māori/ Māori Language Act, 1987); the significance of names for Māori.	That language and identity are interrelated; power issues in client therapist relationship; that Māori (clients) are disadvantaged in a group meeting without support, worldview of client based on ethnicity and his status as a service user; media and societal views of Māori language.

Other themes that were created from this scenario were *knowledge of socio-political issues,* and *sharing power.* Jean used te reo to: establish a relationship, address the power issues that existed in the team meeting; and to empower Te Ikaroa by using his proper name rather than a garbled mispronunciation. As training items, te reo competencies are important as they may have an impact on aspects of therapy such as building a therapeutic alliance, empowering clients, goal setting and maintaining the therapeutic relationship.

A further example of language use is provided by Stephen. He described a scenario where he had mistakenly used the wrong iwi name for his client: "I was interviewing a client and discussing his background. He described himself as being of Kahungunu descent. In my report I reported him to be of Kahungunu (misspelled) and misattributed the region (out of ignorance)". The client corrected his spelling and coached him in correct pronunciation. Stephen said that he was "majorly shamed". Stephen could easily have minimised or brushed-off his action. Instead, he showed humility, knowledge and awareness of his error.

I placed this scenario under language because the psychologist should have checked what the client said. The language mistake reflected a limitation in the psychologist's knowledge about that particular tribe. The competency is

crucial for training because Māori identity is often misreported, ignored or minimised when there are difficulties with language, and vice versa.

The competencies from this scenario should be read in conjunction with *considering identity, accepting challenges, and power-sharing* themes as they relate to recognising the importance of clients' cultural/whakapapa identities; and accepting that clients may have to educate psychologists.

Theme 3: Māori processes: Wairuatanga and karakia

The ability to accept Māori processes and explanations was strongly represented throughout the scenarios. Māori processes included: accepting wairuatanga/spirituality, using karakia, paranormal experiences, and Māori worldview explanations for illness and wellbeing. Some psychologists had direct or indirect experiences with wairuatanga and they believed it was an important component of training that should be carefully managed. Wairuatanga/spirituality reflected Christian and Māori cosmology, Māori astronomy and Māori beliefs about mental, emotional and physical health.

Karakia was a predominant Māori-cultural practice that initially stood out as a separate theme. I considered whether it could have come under theme five *modifying -cultural* but, after reviewing the scenarios, karakia appeared to fit best under the theme *accepting wairuatanga/spirituality.*

Karakia was used by psychologists, clients, whānau, and cultural advisors to open or close sessions, to settle clients, and to clear or cleanse (whakanoa) clients, whānau, psychologists, cultural advisors and/or space of spiritual or emotional elements. Karakia was also used therapeutically to reduce distress, engage with whānau, or deceased whānau, or to remove tapu.

Removing tapu relates to some clients feeling that they were in a state of tapu, or that a room was tapu which required karakia, sprinkling of water, or food to make the place safe (noa - deconsecrated). At other times, karakia was used before and after pōwhiri and whakatau. The use of karakia reflected psychologists' observations that a non-clinical process was necessary.

Some psychologists described scenarios that involved deeply spiritual experiences that could not be explained using Western-cultural psychology without pathologising clients or whānau. Māori explanations of illness were offered by clients, whānau, cultural advisors, and psychologists. Although some psychologists talked about their paranormal experiences, these were only briefly touched on in the training programme. I have used paranormal to describe the experiences that are outside the normal, everyday range of experiences of most people, although for some Māori, paranormal experiences are normal (i.e., talking with deceased ancestors, or relatives).

Most of the psychologists received cultural supervision, or advice, to develop fluency and an understanding of the purpose of karakia. The scenario below is interesting because the psychologist was comfortable using karakia within the context of her client's mental state. Stacey, a female Pākehā psychologist (late-20s) had a client referred to her for group therapy. She was not keen to have him as a client,

> He was prone to bipolar flare-ups. When I met him he greeted me in Māori. I asked him if he wanted to open with a karakia. He identified straight away as Māori (strongly). I always open with a karakia. I asked him if he preferred to work with the BTM (bicultural therapy model) and work with a tohunga. Client believed he had a mākutu on him. His presentation was fidgety and seemed to be responding to something (not present) although he denied this (Situ. 21). The outcome was positive. He was visibly excited (not due to bipolar disorder) with being able to open with a karakia. He appeared calmer and was more responsive in the session (Stacey).

Stacey's client showed a number of signs that indicated he might want to use karakia – he greeted her in Māori, he identified strongly as Māori, he believed he had a mākutu on him, and he presented as fidgety and responding to external/internal stimulus. The AKSs for this scenario are relevant for training as this client could have been pathologised as delusional on the basis of his presentation and current diagnosis. A particular knowledge competency that arose from this scenario is that psychologists do not assume that the current diagnosis is correct and considers multiple meanings of body-language.

Melanie (Samoan-Pākehā, 41 years-old) described an equally challenging situation,

> She disclosed that she could see spirits, hear waiata and voices which she attributed to a hara or wrong-doing. The client had lived for most of her adult life with guilt and shame about the death of a significant person in her life. The death occurred when she was a child (Situ. 13).

Melanie discussed the spirits and the context of their occurrence with a cultural advisor. Together with the cultural advisor she was able to normalise the client's experiences for her and show that while paranormal, her experiences did not indicate she was psychotic.

The scenarios above show a complicated range of AKSs that relate to wairuatanga, relationships with cultural advisors, modifying Western-cultural practices and understanding Māori "paranormal experiences," such as mākutu and hara. Further competencies are knowing about Māori views of shame and guilt, and their expressions. Stacey and Melanie also recognised the limits of their expertise and that they needed help from tōhunga, cultural advisors and the Bicultural Therapy Model (BTM) provider.

There were several scenarios that described paranormal experiences that produced multifaceted AKSs and competency statements and significantly challenged Western-cultural standards of mental health. Emere shared a complex scenario where a young woman was referred for suicidal ideation, and "cutting" behaviour,

> She was a young mother from another country who lived with her in-laws despite the fact that the father of her baby abandoned her in NZ. The grandfather (Māori) of the baby was unable to understand why she was cutting herself and feared that his grandchild might find his mother dead. The grandfather believed that the young woman was "pōrangi" (mad) (situ. 49).

Emere explained to the grandfather that historically Māori women in mourning often cut themselves to release their emotional anguish. She described to him how some women "cried tears of blood" because of the facial cuts. Emere's explanation was outstanding. She used Māori cultural

concepts that the grandfather understood as she conveyed to him the intensity of the young woman's distress and hurt. Emere went on to say,

> The grandfather was intensely moved by the depth of the young woman's suffering. He said he understood what she must be going through.

Although the young woman was not from Aotearoa-New Zealand, her behaviour could still be considered in Māori cultural terms. It is not uncommon for distressed women to cut themselves to relieve intense emotions and cognitions. Emere's scenario provided a rich source of AKSs and competency statements, some of which were not included in the final programme.

The decision not to include them stems from my argument that complex Māori processes should not be taught by those who have limited experience, and should not be taught to novice students within a largely unsupportive environment (i.e., university psychology departments).

In the following section I describe the themes from the interviews that did not have a distinct Māori psychological component. As I commented earlier, I labelled these culturally-informed themes.

Culturally-Informed Practice: Themes as Training Needs

Theme 4: Accepting Challenges

Psychologists face a myriad of challenges when working with Māori and it is important for them to understand the complex nature of clients who present for therapy. Clients often push boundaries and generally test their psychologist to see if they can be trusted. The theme reflects the requirement that psychologists need experience, confidence and the ability to deal with challenges in a culturally appropriate and courteous manner, taking into account the power imbalance in the relationship.

Many of the challenges that psychologists faced in the scenarios are not raised in clinical training and some are not unique to Māori. The challenges highlight that limited bicultural training and experiences can propel

psychologists into passive or reactionary behaviours that are counterproductive. Conversely, psychologists who were familiar and comfortable with Māori processes, and I hypothesize, secure in their knowledge, skills and awareness competencies, were more likely to manage challenges without being defensive.

Some of the typical challenges were personal in nature: "Do you have children? How old are you? What would you know about my life? And, "you're ok; you've got heaps of money". Other challenges relate to professional or academic orientation and experience or when psychologists found their own reactions, or their clients' reactions, difficult to manage.

Whatever the situation, clients often challenge when they doubt the experience, knowledge level or the ability of their psychologist to empathise with their situation. Or, clients simply want to upset, or derail their psychologist. It is then incumbent on the psychologist to manage these is issues in a 'professional' way.

In my experience, the term 'professional way' generated debate. Most often students/psychologists are told to behave in a professional way at all times. There is no recognition in Western psychological practice that the idea of 'professional' means to look, act and sound like a member of the dominant Pākehā group. Students, Māori and non-Māori, who do not look like the 'norm' are often targeted for change.

Challenges also occur when Māori-cultural processes are used, as they often convey an obligation that is in opposition to Western-cultural processes. Quinn, (a male, Pākehā psychologist) wrote a report on his client (Jake, aged 34), a mauhere/prisoner with whom he had shared a hongi,

> Jake presented with safety issues related to violence and sex offending. He said he was not into that Māori stuff and did not want the Bicultural Treatment Model (BTM). He was aggressive and threatening and he beat up people a lot. He threatened to beat me up. Did not like praise (Situ. 37).

Quinn described a range of emotional reactions over the period that he worked with Jake. He said he initially felt intimidated, but managed to

control his reaction and work with his client. Quinn said that he felt shame at writing a report about Jake knowing the significance of hongi and the connections it established in their relationship. Quinn described his scenario as effective and ineffective and felt shame for letting his client down, despite working well with him,

> After five sessions the client came up and hongi'd [sic] me. Started to feel accepted by the client after that, but I felt that I had let him down when I wrote his report. I thought that I had betrayed him after he let his guard down and shared his breath (hongi) with me (Scenario 37).

In this scenario, my contributions to the AKSs highlight the importance of managing expectations when there is a relationship that is personal and professional, particularly when the client could be disadvantaged by the psychologist's job requirements. The scenario also shows the confusion that can occur when cultural practices (e.g., a hongi) are used without fully exploring the implications of that practice.

The AKSs also point to seeking cultural advice, cultural supervision and discussing potential conflicts with clients. I also used this scenario to create the theme *maintaining relationships with cultural advisors and cultural supervisors.*

Stephen described a scenario where he was challenged by a client in a group context on the basis of his identity. Stephen's behaviour reflected an ability to recognise the truth in a client's comments and to shift the power dynamic by whakamana/empowering his client. Stephen said:

> I was challenged in group therapy by a Māori client that I didn't understand what it was like to be Māori. I responded by saying that I agreed with him and went on to say that I was also middle-class, privileged, rarely subject to racism, and probably the most straight (proper) psychologist he would ever meet. The last part was tongue in cheek. I said that while my working with him was limited to my own learning he had the opportunity to take any feedback from me with this background acknowledged. I also said that I would try and respect and value his experience as best I could. My client

responded by saying that he respected his korero and being up-front (Situ. 6).

Stephen acknowledged the limitations of his ability to understand his client's worldview in a respectful and gracious manner. He did not get defensive; instead, he used good micro-counselling reflection skills to let his client know that he heard him and pointed out other characteristics that might limit his understanding of his client's worldview. Stephen also invited his client to choose to accept his help thereby shifting the power dynamic back to him.

Competency statements

An example of the competency statements developed from these scenarios are:

i. Psychologists are aware of their identity and any biases and assumptions they may hold about others and that others may hold about them

ii. Psychologists recognise the construction and classification of Māori identity by non-Māori and the resulting social and psychological impacts

iii. Psychologists can talk about ethnicity with clients in a respectful manner

Theme 4a: Sharing power

A common feature of what the psychologists did was to recognise the power difference in the relationship and to try and shift that imbalance in some way. I noted that psychologists typically used self-disclosure, changing locations, utilising cultural advisors or facilitating whānau involvement. I chose the theme sharing power as it recognises the significant impact that psychologists have on clients. The scenario below overlaps with the whakawhanaungātanga competency but is described as shifting power because it appeared to stand out more than establishing a link with a client.

Toni, a Māori, female psychologist, aged 35, had arranged to meet her client Ngaruiti at her client's home as she said she got a sense from her file that she

may respond better to seeing a psychologist in her own home. Toni said she guessed that Ngaruiti distrusted the District Health Board system despite seeking help from the crisis assessment team (CAT).

> I spent half of the first session talking to Ngaruiti about her family, my family, why I was there, and where we went to school. We also discussed kura kaupapa Māori education. We talked about what she hoped to gain from our meeting. In the second half of the session we delved into her presenting problems. I spent 3 sessions of at least 2 hours interviewing and talking with her.
>
> When we discussed difficult issues, she made us a cup of tea and smoked while she kept talking. It seemed to me that it helped Ngaruiti to be in her home environment with her husband who was close-by, as her initial mistrust of me quickly disappeared. I also interviewed her husband in the third session. He commented that no-one had ever asked him for his opinion on what was happening to his wife and how it affected his whānau (Situ. 50).

The shared themes in this scenario are: using personal disclosure, recognising whānau influences, and managing socio-political and cultural influences. An example of the AKSs that Toni and I developed is *Knowledge that barriers exist within health structures due to client's education level, economic status, ethnicity and sub-cultural affiliation and knowledge of the impact of those characteristics on clients lives.*

Theme 4b: Modifying Western-cultural Practices

Ashlee (Pākehā/Māori, 33 years-old) tried a standard clinical psychology introductory approach with her client. She found that this approach did not work with her client. She reported,

> I began the session by offering refreshments. I also asked her how she would like to start. She said you start. I talked about my background training, and where I was from. Overall this was ineffective. The client (female, Māori) took charge of the session and I was unable to regain control (Situ.9).

Ashlee said that although the client had taken charge, she came back for another session, which was unexpected. In the second session Ashlee modified her approach by using the cultural information she had gathered

the previous week. She talked to her client about her cultural identity, her marae affiliation, her whānau, and her children attending kōhanga reo.

Ashlee regained control of the process in the session, gained her client's trust, and obtained specific information about her client's presenting problem and a range of possible solutions. This scenario was also used to develop AKSs for the themes *recognising whānau influences* and *considering identity.*

The ability to control the direction of the clinical interview provides an interesting challenge for psychologists. Control relates to using a structured process to gain information about clients' problems rather than simply letting clients talk without being solution-focused. On one level there is an issue of cost per session to the client or the organisation. On another level, there may be safety or other concerns, in which case, information is urgently needed. Whatever the issues may be, getting clients to talk, or stop talking is not an easy process.

Control also relates to the power a psychologist holds and often reflects a worldview that clients should passively provide information when asked. This position can be misinterpreted or backfire when a trusting relationship has not been established.

In the scenario below, Chan Ju, a female, Chinese psychologist (aged-30) identified that her client, Shane, had difficulties understanding the relapse prevention programme that was being taught to him in a group setting. Shane was a 40 year-old Māori, with a history of brain injury. Chan Ju did not know the extent of his injury but noticed that he had cognitive deficits and decided to try individual treatment with him. Chan Ju said:

> I needed to know what was happening when he did group work. I used a white board to explain every concept that the group facilitator used – except that I used Māori concepts: Riri (anger); Ruaumoko (deity of earthquakes); mamae (pain) (Situ. 24).

Chan Ju said that "Shane was able to participate in the group intervention and was able to demonstrate that learning had occurred. He also appeared to actively engage and participate in the group". Chan Ju's scenario suited this

theme as she changed the delivery mode to work individually with Shane so that he could participate in group therapy.

She said that it was also necessary to show concern and compassion to engage with Shane. Chan Ju's use of Māori metaphors to explain the process of anger management suited his individual needs which were most likely due to his head injury, or possibly limited education. She also recognised that it was a combination of factors that produced a positive outcome for Shane rather than just the use of Māori metaphors.

Identifying that combination is the key to culturally competent practice. It is easy enough to teach students the importance of conducting individual therapy; recognising the dynamics associated with that need is described in the theme *managing socio-political and cultural influences.*

The majority of psychologists modified their practice using te reo, whakawhanaungātanga, using te whare tapa wha, disclosure, or by focussing on wairuatanga, whānau and identity. The AKSs derived from the psychologists' practices highlight the importance of being able to modify practice to suit the client's needs.

An example of the **skills**[27] AKSs for the scenarios above are: ability to identify whether the use of cultural concepts are appropriate; to appear confident and relaxed where appropriate; and correct use of Māori metaphors (maunga, awa, waka). Other relevant skills are the ability to manage client tensions when using Māori and non-Māori psychological constructs to explain illness, and wellness. The competency statements from this theme overlaps with other themes and should be considered together (these are described in the appendix).

---

[27] An example of the knowledge competencies relate to knowing about the prevalence of head injury and lack of education on Māori, male prisoners.

Theme 5: Considering identity

The identity theme relates to the ability of psychologists to learn, understand, recognise and manage the impact of identity on clients. Implicit in this understanding is the recognition that identity is largely constructed by the dominant group with the underlying assumption that their cultural practices are superior to minority group members[28].

Scott, a male, psychologist, of Scottish descent in his mid-40s, described his client (a Māori, male, late 40s) as passive-aggressive and anti-Pākehā.

> Ten minutes into the session he said he didn't like Pākehā. He said, not you though, you go beyond true (his term for trustworthy). He was part-Māori. He wanted to explore his identity. He self-identified as Māori but was identified by others as Pākehā – he didn't want that. A background exploration revealed that he rejected aspects of Māori self-determination, such as, land claims and Treaty issues (Situ. 52).

Scott said that he tried to build a connection by sharing personal information, and offering to do karakia. He also told his client that he could relate to the effects of colonisation because his people had also been colonised by the British. Scott said he knew that he had established a connection "If there is a connection you can pick it. If there is a space between you there is no connection. If there is space, I try a karakia".

Scott's client was open to exploring cultural identity prior to working on other psychological processes affecting his offending behaviour. He may not have been amenable to working on his offending behaviour if his issues with identity were not addressed. When considering identity it is important to understand the constellation of Māori views about identity that have been shaped by whānau, the media, school, and the work environment – in the same way that Pākehā views about Māori have been shaped.

---

[28] These assumptions were covered in chapters 1-4.

The assumptions about Māori identity need to be carefully managed. Māori who look like Pākehā often benefit from the unasked for privilege of looking Pākehā. Conversely, they may bear that burden of not looking Māori enough. Furthermore, some Māori (whether they look Māori or not) may view Māori in negative ways seeing them as dole-bludgers, or "on the Treaty gravy-train". The implication here is that there are multiple influences on identity formation and that developing or enhancing a healthy identity needs to be carefully managed.

Another point is that Scott could benefit from considering whether it is helpful to describe his colonisation experiences to Māori clients without considering that the Scottish people were also responsible for colonising Māori. His comments could be considered patronising and naive to Māori clients. An example of an awareness competency from this scenario relates to psychologists understanding that not all clients will readily understand their historical and social experiences.

Sienna, a female, American psychologist, aged-33, described how she worked with a Māori female client (Amy, aged 22) who was referred for social phobia. Sienna said that Amy strongly identified as Māori.

> Amy told me about her whakapapa early in therapy. We discussed openly our different cultural backgrounds, and any possible connections. We both formed and maintained links between our separate communities, with me meeting some of her family and her seeing photos of mine and hearing stories about them (as appropriate), and her natural support systems (whānau, hapu) were utilised by her as well.

> She agreed to me consulting with kaumatua during therapy. We agreed that the worldview of Amy, not me, was the important thing in that it was the cultural context for what brought her to therapy (Situ. 37).

I chose to place this scenario in the *considering identity* theme because the client's identity precipitated Sienna's decision to use disclosure and whakawhanaungātanga to build a trusting relationship with Amy. As Sienna worked with Amy she constantly modified her practice to meet Amy's needs.

The competency descriptions I developed from Sienna's scenario should be read in conjunction with *recognising whānau influences,* and *negotiating therapy*: "We agreed that I would maintain a stance of cultural naiveté and respectful curiosity. That is, there was an open recognition that my cultural awareness was limited".

Another theme is *recognising Western psychology as cultural:* "We had an understanding and sharing of values from each of our cultures. We acknowledged the potential power differential between us in differing credentials, status, wealth, and theories". The theme *sharing power competencies* is also relevant: "We openly discussed sharing power in decision-making, and a strong rapport grew from mutual respect".

Discussing power differentials is consistent with the literature on cultural competencies. Sienna's scenario prompted the creation of AKSs and competency descriptions related to psychologists being aware and skilled to manage the potential impact of their multiple identities (e.g, educated professional identity, (perceived) wealthy identity, sexual orientation identity, or religious identity).

Sienna's open use of personal disclosure was evident in her discussions about her family, sharing stories and pictures, and talking about their cultural groups. Sienna was determined to develop the relationship and implement a treatment programme that reflected Amy's cultural worldview. Sienna described Amy as,

> Very proactive and almost demanded that the "3 Ps" (partnership, protection, and participation) be a template for therapy, such as, when she chose to incorporate parts of her culture into therapy to achieve her desired outcomes.

In addition to developing the AKSs and competency statements, it struck me that this relationship highlighted the close and personal mentoring that occurs within some therapeutic relationships. Sienna and Amy's interactions mirrored a tuakana-teina relationship – where an older sibling supports and nurtures a younger sibling. This particular Māori-cultural dynamic is pertinent to training programmes.

Theme 6: Managing socio-political and cultural influences

This theme relates to the awareness, knowledge and skill (AKS) base that is necessary to understand the soci-political context for Māori such as: the impact of legislation on Māori economic aspirations, land loss, health, language, education and political aspirations. The competencies for students are that they need to understand the cultural origins of the psychological paradigm in which they are trained, and can recognise its limitations and potential to harm clients.

My analysis of all the scenarios showed that psychologists needed to possess AKSs related to socio-political and cultural histories, and contemporary experiences and relationships between Māori and Pākehā. An interesting finding from the scenarios is that some psychologists may be unaware of the impact of certain behaviours unless it is pointed out. For example, what significance does wearing a belt have to a client? Stephen's scenario highlighted how symbols of an organisation can trigger defensive reactions in clients.

> I wore my prison issue belt to group for sometime before a Māori resident commented that he had taken a lot longer to trust and get to know me because he identified me with the prison hierarchy when seeing that belt (Situ. 7).

Examples of some AKSs in the area of managing socio-political and cultural influences are:

Awareness**:** micro-aggressions that occur for Māori – hassles with government organisations, schools, medical clinics, being followed or ignored in shops, hassles with the police, privilege, power, negative media representation on a weekly basis, low visibility of Māori in the media doing well.

Knowledge*:* Treaty of Waitangi, Waitangi Tribunal, theories of kaupapa Māori, Code of Ethics; relevant legislation governing psychologists training and practice; the influence of socio-political events and policies on client's daily life; socio-economic history of client and own ethnic group; Māori

grievances; the impact of mainstream schooling on Māori education rates and family structures; purpose and philosophy of Māori services and institutions.

Skill: Managing issues that arise from the above; seeking assistance, supervision, or professional development; how to consult and gather more information about Māori worldviews. Examples of the competency statements for this theme are included below (like the other themes, the full set is in the appendix).

Competency statements

a) Psychologists are aware of the implications of the Treaty of Waitangi, the Code of Ethics, the HPCCA, and Code of Health and Disability for Consumers

b) Psychologists are aware of legislation (current, recent and historical) which has breached Te Tiriti o Waitangi/The Treaty of Waitangi and disenfranchised Māori

c) Psychologists know the socio-political situation of Māori (e.g., poverty, stereotyping, stigmatising, land and language loss and marginalisation) and its effects (e.g., identity formation, and manifestations of illness, health issues, poor education, lack of employment).

Theme 7: Maintaining relationships with cultural advisors, supervisors and Māori communities

Working with cultural advisors is rarely touched on in clinical training, yet psychologists who do not have access to cultural advice or supervision risk harming their clients. The scenario 'banning the haka' is an example of why cultural advisors are vital. The majority of psychologists reported that they had either used a cultural advisor, cultural supervisor, had acted in these roles for other psychologists or allied health professionals, or said they should have used one. Some psychologists described the importance of building a relationship with a cultural advisor or supervisor in advance of

needing one and being prepared in advance rather than simply turning up and asking for help.

Marianne, a Pākehā (aged 56) psychologist attended a tangihanga (funeral) with her co-workers to pay their respect to family members of a colleague who had passed away. They also attended the blessing of the house[29]. Although this scenario did not involve clients Marianne felt it was important that students know about tangihanga protocol as they may need to attend a tangihanga at some stage.

Marianne was also a regular clinical supervisor and had contact with students for the past 20 years. Marianne commented that her colleagues initially did not want to go to the tangihanga because they did not know the deceased, and they were not familiar with marae protocol. Marianne said that she encouraged them to go because they had a close relationship with the staff member who lost a family member.

The AKSs which were created for this scenario related to what can be expected at Māori tangihanga, attending tangihanga, and knowing that iwi and hapu conduct tangihanga in different ways. I did not create competency statements for this scenario as they were not included in the training programme for the reasons stated earlier under Māori-cultural practice.

The following scenario fits well in the *te reo* and *modifying Western-cultural practice* themes. I chose to include it here because of the way the psychologist showed respect for the cultural advisor and the client. Sophie's (Pākehā, aged-32) client requested a Bicultural Therapy Model cultural advisor. Sophie had offered to open the session with a karakia which her client accepted. He then asked if he could have all his sessions with the BTM provider conducted in te reo/in the Māori language.

---

[29] Blessing the house is a ritual where karakia, and water is used to whakanoa (deconsecrate) the house and to encourage the wairua of the deceased to leave the earthly world and depart for Rarohenga, the spirit-world.

Sophie consulted with a cultural advisor with whom she had a good relationship and her supervisor. She then arranged to have the sessions done in Māori, with her present. Sophie said that her client: "was able to discuss in detail the issues confronting him. At later sessions it was easier to develop a relationship with him" (Situ. 16).

The scenario above shows that the psychologist respected the wishes of the mauhere and arranged to have a cultural advisor present[30] and also showed that she was willing to "hand over power" to the cultural advisor and sit with him while the sessions were conducted in Māori. When I spoke with the cultural advisor, he offered his observation that this particular psychologist had a special skill when working with Māori mauhere and was not easily disturbed when discussing Māori paranormal phenomena.

Anna, a Pākehā psychologist, described her work with a 22-year-old Māori/Samoan, female client, Masina.

> I usually had a BTM provider in sessions, but then she missed one, and Masina was quieter, less talkative, more distracted. I commented on her distractibility. Session went ok but would have been better if BTM was there (Situ. 32).

Anna was not sure whether to use a BTM provider in the next session but it was suggested that she take one with her to see what happened as Masina had a history of violence and "being all over the place". Anna said that the BTM providers have different boundaries than those taught in clinical training. She said that the BTM provider, kissed, hugged, and touched Masina and she "wasn't sure what was appropriate" (Anna). Masina told Anna that it was nice to have a BTM provider as a support person. The outcome of taking the BTM provider was that the sessions were easier and Masina was more relaxed and happy to talk.

Anna had a number of experiences with BTM providers that challenged her worldview about the relevance of clinical psychology for some Māori clients,

---

[30] In Psychological Services mauhere and clients are offered the choice of bicultural services.

> I planned to take the BTM provider with me, but the provider was late and I was left with the client. When he (the client) asked me to describe who I was, I was really unsure about whether to talk to him. I told him where I was from. I had just had a cultural supervision session where we talked about whakawhānaunga and making connections. The outcome was that he was happy to come back for further sessions (Situ. 30).

In another scenario, Anna said that her client kissed her cheek but she had come to accept this as normal. Anna and I developed AKSs that reflected comfort with personal contact, sharing close personal space and personal information. The competencies for this scenario are also relevant for the *whakawhanaungātanga* theme and subthemes. The ability of psychologists to accept and respect alternative psychological techniques is also evident in these scenarios.

Anna and Sophie were comfortable sharing power by deferring to the cultural adviser despite being unable to understand the language used in the session (see also the language competency). Anna was unable to engage with Masina and accepted that she may need help. Although she was apprehensive about the physical contact displayed between the client and the BTM advisor because she had learned not to touch clients in clinical training, she came to accept this behaviour (see also theme 4b).

Anna also showed that she trusted the cultural advisor using the training she had received on whakawhānaungatanga. Her faith in an alternative psychological method is notable. It is a possibility that less confident psychologists would have defaulted to their clinical training to establish a relationship.

The psychologists who used cultural advisors spoke highly of their skills and how they would not be able to work with their clients if they did not have cultural support. Ultimately, clients benefit from having cultural support in the sessions as shown in another scenario that Anna provided.

> The BTM provider was late. The client was apprehensive, closed down, looked at his feet, and gave me short answers. The BTM

provider arrived and did a karakia, 'laying of hands' (there was no suicidal ideation since that happened) (Situ. 31).

Laying of healing hands is used to treat emotional, spiritual and physical illness (although not serious injuries); although I know about the practice, I am not familiar with how or why it works for some people. The scenario shows that the client was uncomfortable being alone with the psychologist. This may be due to Anna's gender, age, or power status.

Anna did not question the BTM provider's actions. She accepted that she was unable to help or engage with her client without support. She also knew that her role was to facilitate the BTM provider's work, rather than impose her training on the client.

I created a number of competency statements that reflected the dual role that cultural advisors play and the importance of ensuring that their skill and knowledge are appropriately recognised and respected as a significant component of therapy. Another important finding was that psychologists needed to share power with other professionals, understand and accept the limitations of Western-psychological practice and support alternative therapies. These competencies were included in the training programme.

Summary

This chapter describes the results of the critical incident technique which was used to identify core knowledge, skill and awareness competencies that trainee psychologists needed to possess when working with Māori and to develop competency statements for the training programme. The task analysis contributes to the overall study by highlighting that psychologists used Māori cultural practices with clients in assessment and treatment, and that they used processes that are not typically taught in clinical training.

It was also necessary to identify the type of tasks psychologists performed with Māori so that the training programme could include material relevant to those tasks. Although the task analysis was not a significant part of the study, the findings are consistent with the existing literature showing how Māori psychologists work with Māori clients.

The CIT was used to collect, organise and analyse the effective and ineffective behaviours of experienced psychologists and formed the primary data collection method of this study. Two categories of training needs were developed (seven in total) that showed Māori-cultural concepts (Māori psychology) and cultural concepts. There is a great deal of overlap between the themes, to the extent that for the purposes of training, some competencies require others from which to gain a deeper understanding (i.e., te reo, mihimihi, karakia and pēpeha). Braun and Clarke, (2006) argued that overlapping themes is desirable and helps establish validity for the themes.

The themes, competency statements and AKSs from this study were incorporated with the results from the literature review and pilot training programme into the final programme. While the pilot programme provided useful information about planning, delivery and content, the primary benefit of this study to the final programme is the inclusion of specific Māori cultural concepts.

Although the literature highlights the need for Māori processes, it does not spell out in detail what those processes looked like. The value of the psychologist's input is that I now have a clearer picture of what psychologists do with Māori clients that work and do not work and can adjust training accordingly.

The training material obtained in this study made a difference to the programme development by providing an evidence base for what should be included in training psychologists to work with Māori and a framework for organising the training material. The principles of cultural safety and cultural competency are also evident in the themes and provide a more robust foundation for the training programme design.

Another useful feature is the development of the competency statements that will be used to focus training goal and as the basis for developing training strategies. While there may be some criticism to having a 'cookbook' type approach for cultural competency, there is some value to having guidelines for practice. Not all the material was used because of time restraints, and the limitations to my abilities and those of the students.

The material for the final programme was obtained from:

▷ Socio-economic material related to breaches of the Treaty of Waitangi; the status of Māori health, income, housing, education, schooling and families

▷ Bicultural training in universities in Aotearoa/New Zealand, multicultural competencies

▷ The Code of Ethics

▷ The Cultural Safety model

▷ Te Tiriti o Waitangi/Treaty of Waitangi; Health Practitioners Competency Assurance Act (2003)

▷ Literature on Māori cultural concepts

▷ The cultural competencies publication for psychologists by the New Zealand Psychologists Board

▷ The pilot programme

▷ The training needs analysis:
   o A person analysis (obtained from the pre-programme training questionnaire) to identify the deficits in participants' cultural competencies
   o
   o A task analysis of the types of important tasks psychologists perform when working with Māori
   o
   o The critical incident technique: Interviews with experienced psychologists to identify awareness, knowledge and skills necessary to do those tasks and the development of competency statements.
   o

The methodology and evaluation of the final programme is described in the next chapter.

CHAPTER 9: EVALUATING TRAINING

Evaluation Methodology

Training evaluation is defined "as a set of procedures designed to systematically collect valid descriptive and judgmental information with regard to the ways in which a planned change effort has altered (or failed to alter) organisational processes" (Synder, cited in Wexley, 1984, p. 539).

Evaluation should identify whether job performance is enhanced as a result of training and "is concerned with issues of measurement and design, the accomplishment of learning objectives and attainment of requisite knowledge and skills" (Kraiger et al., 1993, p. 136). The literature reviewed thus far shows that clinical psychology educators have not considered whether the training they provide has produced students who are competent to practice with Māori.

Kirkpatrick's evaluation framework

Kirkpatrick's (1987, 1994) four-level model has been the most extensively utilised for evaluating training. The four levels are often referred to as levels of training criteria (Taylor, 2002). The choice of evaluation criteria determines whether appropriate outcomes are measured, identifies where change occurs, and ensures a higher level of certainty about the effectiveness of training (Wexley, 1984; Winfred, 2003).

Kirkpatrick's four levels include: (1) Reaction – trainees' affective and attitudinal responses to the training programme (whether they liked training, satisfaction); (2) Learning – the extent to which the trainees absorbed the knowledge and skills based on their performance on in-class assessments; (3) Behaviour – the extent to which the trainees can apply what they have learned during training to their job setting (using learned principles, techniques or information); and (4) Results – organisational benefits stated in terms of organisational performance or return on investment (productivity, company profits, goals, desired outcomes).

Kirkpatrick's model has been criticised for not providing sufficient depth (within the levels) to show where and why training was effective and for not showing sufficient breadth (not enough levels) to show how and where an organisation benefited from training (Kaufman, Keller, & Watkins, 1995; Phillips & Phillips, 2001; Winfred, 2003).

Kraiger et al. (1993) argued that Kirkpatrick did not provide clarity regarding what specific changes may be expected as a function of trainee learning, and what type of measurements are appropriate given those expectations (e.g., learning skills and learning facts often require different measurements). They argued significantly more guidance is needed to ensure that the trainees are assessed using appropriate measurement tools.

Additional concerns about the model relate to the assumption that change in each level is caused by the previous level (i.e., that the levels are correlated). For example, previous studies show no relationship between enjoyment (at the reaction level) and the other levels and that there is no guarantee that training will transfer to the workplace, or that an organisation will benefit, because the trainee enjoyed the programme (Phillips & Phillips, 2001).

Reaction measures provide information about the content and design of training and certain types of reactions are linked to job performance (enjoyment of training, perceived usefulness, and perceived difficulty (Phillips & Phillips, 2001). Negative reactions are particularly useful to measure as they have been shown to affect training transfer (Alliger et al. 1997).

Augmented framework

To address the limitations of Kirkpatrick's model (1987), Alliger et al., 1997 proposed that the criteria be expanded to allow for a more accurate evaluation of training. Alliger et al's., (1997) augmented model is the result of an earlier study of the relationship among training criteria in Kirkpatrick's model (Alliger & Janak 1989, cited in Alliger, et al., 1997, p. 339). The earlier study showed a slight correlation between level one and the other levels which provoked questions about whether there was a relationship among criteria on the same level (p. 339).

The benefit of Alliger et al's augmented model appears to provide the depth and breadth missing from Kirkpatrick's model, and for that reason, it was used to evaluate the effect of training in study three. The table below shows where Kirkpatrick's model was augmented with Alliger et al's model.

Table 9: Augmented framework for evaluating the final workshop

Kirkpatrick's Taxonomy	Alliger's Augmented Framework
Level 1: Reactions (enjoyment of training, whether they like the trainer)	a) Affective reactions b) Utility reactions
Level 2: Learning (did the participants learn? What did they learn?)	a) Immediate knowledge b) Knowledge retention c) Behaviour/skill demonstration
Level 3: Behaviour – demonstrate learning	a) Transfer
Level 4: Results – who benefits?	a) Results/Organisational benefits

- Level 1: *Reaction* measures participants' attitudes and suggests an immediate response about whether they enjoyed the training programme and what they thought of the trainer (Kirkpatrick, 1956; Alliger et al, 1997).
- Level 1a: *Reactions as affect* identifies affective reactions in the same way as Kirkpatrick's model.
- Level 1b: R*eactions as utility judgments,* asks "was this training programme useful to you?" Utility-type reaction questionnaires were found to be more predictive of training transfer than perceived enjoyment and more predictive than level 2: learning measures (Aguinis & Kraiger, 2009; Alliger, 1997; Salas & Cannon-Bowers, 2001).
- Level 2: *Learning* relates to whether participants have acquired the necessary knowledge and skills to do particular tasks (training objectives).

Measurements include pen-and-paper tests, (e.g., multiple-choice, self-reports) and performance measures where mastery is required (e.g., case studies, establishing rapport, and administering psychometric tests). These measurements are distinguished as declarative knowledge (verbal or written demonstration of learning) and procedural knowledge (skill demonstration after learning) (Aliger et al, 1997).

Evaluation researchers argue that although trainee learning is necessary, it is not a sufficient prerequisite for behaviour change (Tannebaum & Yukl, cited in Winfred et al., 2003, p. 235). While it is recognised that behaviour and learning are conceptually linked, researchers have been unsuccessful in demonstrating the relationship because behavioural criteria are susceptible to environmental influences (Alliger, et al., 1997; Salas & Cannon-Bowers, 2001).

Aliger et al's (1997) augmented model includes three subcategories of learning:

- Level 2a: *Immediate post training knowledge:* knowledge that is assessed immediately after training (most common) where trainees are asked to indicate how much they know about the training topic by using pen-and-paper and skill demonstration

- Level 2b: *Knowledge retention* – is similar to Level 2a but also seeks to identify if trainees have retained the knowledge and skill taught in the programme. Typical measures include follow-up interviews, focus-groups, surveys, supervisor reports or performance monitoring (Phillips & Phillips, 2001; Wexley & Latham, 2002). The measures are administered after training and/or at a later point in time.

- Level 2c: *Behaviour/skill demonstration* – is assessed immediately after training and seeks to measure whether behavioural change occurred as a result of training. A limitation of Kirkpatrick's term *behaviour level* is that it does not indicate if behaviour change should be demonstrated in the training setting, or on the job (Aliger et al., 1997).

By measuring behaviour immediately after training and then again on the job, evaluators can be more certain that the newly acquired skill was a result of training. Typical measurements include immediate post-training measures of behaviour and skill demonstration, behavioural role plays, behavioural reproduction, and ratings of training performance (e.g., performance reviews, or ratings of customer satisfaction).

- Level 3: *Transfer* – refers to the extent to which knowledge, skill and abilities (AKSs[31]) acquired during training are applied, generalised, and maintained over time (Salas & Cannon-Bowers, 2001). Aliger, et al., (1997) replaced behaviour with transfer to emphasis the on-the-job nature of criteria in this category.

Knowledge retention remains at Level 2 because it is application to the job that, in most cases, defines training success. Measurement examples include performance ratings, supervisor feedback, work samples, and work outputs. Performance may be evaluated anywhere up to 2 years after training.

- Level 4: *Results* – refers to cost-related outcomes and identifies the benefits of training for an organisation such as: profit, sales, productivity, cost, staff turnover, customer satisfaction, safety record and quality (Phillips & Phillips 2001; Wexley 2002).

Aliger et al., (1997) commented that Kirkpatrick was vague about results level criteria adding that organisational results criteria represent the ultimate criteria as they are perceived to be fundamental to training success. The cost of training is an important factor that may outweigh the benefits and as such, must be factored into training development and evaluation.

A limitation of the results/organisational benefits was noted by Kaufman et al., (1995) who argued that organisational evaluations are typically self-serving and do not incorporate aspects that measure results beneficial to

---

[31] In the organisational psychology literature AKS(s) relate to knowledge, skill and abilities. In this research I have used knowledge, skill and awareness to reflect the cultural competencies tripartite model by Sue, et al (1996).

society. They proposed a fifth level that places evaluation in an holistic framework: Level 5: *Societal consequences and payoffs*. Their proposal challenges organisations to consider whether their practices are ethical and reflect principles of social justice. The evaluation of societal benefits could be included in Kirkpatrick's Level 4.

Organisational psychology's potential contribution to cultural competency training is under-utilised as the training needs analysis and evaluation methods are scarcely used in Western-psychological, and multicultural competency literature. Organisational psychologists tend to focus on training cultural competencies in response to employee diversity, and training staff to work in international settings.

Diversity training programmes, however, suffer from a lack of systematic evaluation with reaction measures the most common type of evaluation measure. Additionally, little is known about the effect of diversity training on employee behaviour (Roberson et al., 2001).

Adler (1983, cited in J. S. Black & Mendenhall, 1990, p. 113) reviewed 24 management journal articles and found that of 11,000 articles from 1971-1980 only 1% focused on cross-cultural work interaction. A few years later the situation had changed marginally when Littrell et al's, 25 year review (cited in Aguinis & Kraiger, 2009, p. 454) found that overall cross-cultural training was effective in predicting expatriate's success on overseas assignments.

Criterion measurement

The type of measure selected to evaluate any one or more of the four levels must ascertain which types of change have occurred and reflect the intended outcomes of training (Salas, Cannon-Bowers, 2001; Wexley, 2002). Pre, and post self-report scales can be unreliable because of social desirability issues, although many test items are designed to measure biased responses (Wexley, 2002). The other reported difficulty with pre and post self-reports lies in the definition of change.

There are three types of change that occur as a result of training: alpha, beta, and gamma. *Alpha change* occurs when the observed difference between pretest and posttest corresponds to change as a result of training. *Beta change* (also called response shift bias) occurs when there is a recalibration of the scale used to measure the objective of training. For example, a trainee's pretest response score may indicate average ability and following training, the trainee may continue to think their ability is still average. The issue is not with the training, but that the scale does not adequately address where change occurred. A way through this problem is to have a sliding scale that ranks the degree of change (e.g., "how much do you think you have changed since doing the programme?") (Sprangers & Hoogstraten, 1989).

The third type of change is *gamma change* – or *response shift.* This refers to a change in a trainee's internal standard for determining his or her level of function on a given variable being measured (Sprangers & Hoogstraten, 1989; Wexley & Latham, 2002). After training, trainees may have a different understanding or awareness of an element of training from what they thought on the pretest or their post-test rating.

For example, on a pretest measure, a clinical psychology trainee may rate their ability to establish rapport with a client as average. Following training the trainee may learn that the conditions for establishing rapport with diverse clients require different AKSs. On the post-training measure the trainee rates their ability to establish rapport as average, which may indicate that they did not learn anything novel or that may have learned that they did not know enough to warrant rating themselves as average in the first place.

A common method of understanding the types of gamma change is to use a *then* measure (also known as a retrospective pretest) after training, and after the pretest and posttest measures (Terborg et al. cited in Wexley, 2002, p. 161). In the retrospective measure, trainees are asked to how they perceive themselves to have been prior to training. Since Then and Post ratings are obtained within a close time period, it is expected that both ratings will be made from the same perspective or internal standard, and are free of response-shift bias (i.e., gamma change) (Salas & Cannon-Bowers, 2001;

Sprangers & Hoogstraten, 1989). The retrospective measure is useful at levels two and three of Aliger et al's (1997) framework.

Evaluation of training requires systematic criteria measures that provide unambiguous interpretation of results that accurately represent the intended outcomes. The influences on evaluation outcomes occur throughout the process of training implementation and needs addressing at each level to ensure training validity. Ultimately, evaluation seeks to ensure that the change in behaviour was a result of the training and not extraneous influences.

Training transfer

The primary assumption of training programmes is that what is taught in training will transfer to the trainee's organisation. Transfer refers to the degree to which trainees apply the knowledge, skill and attitudes learned in training to the job (Aguinis & Kraiger, 2009; Wexley & Latham, 2002). A large body of research highlights the importance of incorporating strategies to minimise the negative effects on transfer and to select appropriate targets to measure whether transfer occurred to the job.

Factors that have an impact on transfer include learner characteristics (e.g., cognitive ability to reason or make judgments, problem-solving ability, and the ability to conceptualise complex and abstract information); and how the trainee learns (e.g., learning style, motivation, personality, perceptions, expectations, self-efficacy, or attitudes about training) (Kraiger et al., 1993; Salas & Cannon-Bowers, 2001).

Dickson, Jepson & Barbee (2008) proposed that the degree of "cultural ambience", which relates to the day-to-day practices, attitudes and behaviours that contribute to an environment in the training institution, was a good predictor of positive cultural attitude in students. The degree of cultural ambience exhibited by an institution or organisation is a crucial element to determining whether cultural competency is supported and maintained over time.

Some of the learners' characteristics are a function of their education level, worldview, and their learning ability and, as such, are subject to manipulation by training. However, in order to maximise the training experience, these characteristics need to be built into the design and evaluation of the effectiveness of training. The characteristics of the trainer are also influential and these are typically measured using reaction-type responses (e.g., what did you think of the trainer's style?).

Other influences on training transfer includes the training programme's design and delivery, the quality of the needs assessment information and stated outcomes, and the activities of trainees and the trainer during delivery (Burke & Hutchins, 2008). The transfer "climate" can also have a powerful effect. This includes: the quality of supervision or mentoring, social and peer support, encouraging risk, flexibility and workplace expectations.

Climate influences also includes awareness of barriers; the presence of rewards or punishments, means of accountability and opportunities to practice. Practice is affected by timing issues as delays between training and practice can cause learning decay (Wexley, 1984; Salas, Cannon-Bowers, 2001; Aguinis & Kraiger, 2008).

The effects of transfer are most commonly obtained from observers within an organisation and involve perceptual judgments by peers, supervisors and/or customers. Taylor, Russ-Eft, & Taylor et al. (2009) conducted a meta analysis derived from a range of rating sources (i.e., self, peer, supervisor, and subordinate) to identify effect sizes for the transfer of managerial training. The results revealed that transfer effects were largest when raters (1) knew whether the manager being rated had attended training; (2) when criteria were targeted to training content; (3) when training content was derived from an analysis of tasks and skill requirements; and (4) when training included opportunities for practice. I was able to include elements 2-4 in the workshop design.

Summary

The literature on training evaluation highlights the importance of considering the influences of learning on training transfer. Organisational

psychology offers a way to improve the limitations of the current models of training and to improve evaluation procedures.

With the training content identified, the next task is to determine whether Kirkpatrick and Alliger et al's. (1997) framework for evaluating training was useful in this study. I now describe the method that I used to develop and evaluate the final training programme.

Programme Evaluation - Method

Study Three

Participants

I used the method from the pilot programme to recruit participants for the two workshops (e.g., contacting programme staff, organising timetables) (Appendix K). There were 14 participants, from two universities in the workshop who were enrolled in a clinical training programme. They were in their final year (3rd year) of clinical training and were about to enter, or had already begun clinical placements. There were 11 females and three males. The average age was 31 years (youngest 25, oldest 46).

Eleven of the participants did not affiliate to a religious group; two were practising Roman Catholics, and one a former practising Roman Catholic. Seven participants described themselves as New Zealander, one Asian, one English, two Dutch, one Latin American, and two Māori (Ngā Puhi, and Ngāti Kuri). None of the participants described themselves as Pākehā.

Fourteen participants started the programme and three pulled out after day one. One of those participants completed one and a half days but had to go home to a sick child. The other two did not provide an explanation. Seven participants were at University one, and four at University two. All of the participants described themselves as heterosexual.

Four participants had children, eight had no children, and one was expecting. In relation to income, two were supported by partners and one managed a farm. These students also received an income from their internship placement. The remaining four received their income from their internship sites (average $29,000).

Eleven participants completed the pre and post-questionnaires. Only four participants completed the retrospective questionnaires and one provided a case report (only participants who had seen a Māori client were asked to submit a case study or report).

Demographic Form

The demographic form from the pilot programme was used to elicit information on age, educational status, gender, religion, sexual orientation family status, iwi and hapu affiliations, socioeconomic status, and previous bicultural training.

Previous bicultural training

The participants mentioned a range of current and previous bicultural training that included: university-based training - undergraduate papers within and outside of psychology; organised hui (workshops) as part of clinical training; coursework within the clinical programme; Treaty of Waitangi workshops, and readings. Work-related training included: District Health Board cultural workshop, Chinese culture workshop, and staff training, weekly cultural meetings, and internship cultural programmes, cultural supervision, cultural advisor meetings, migrant training.

Self-directed training included: Māori studies at university or wānanga, night classes in Māori language and personal reading. Five participants had four or more of the above training experiences and four of the participants had three of more. One participant had no prior bicultural training but had worked overseas with different cultural groups. Two of the participants had attended a bicultural workshop as part of the clinical programme.

Procedure

The procedure for this study was similar in delivery to the pilot programme. The programme was delivered over two days. I used a combination of teaching aides: powerpoint, cd player, didactic teaching, discussions (group and pairs), role plays and quiet reading and reflection followed by further discussion. With regards to the material obtained in study two, I used the themes as training topics which were backed up with examples of scenarios. I also used the awareness, knowledge and skill (AKS) and competency statements to highlight the components of each topic. The workshop outline is in Appendix L.

Materials

Pre-training-Questionnaire

I designed the pre-questionnaire (pre-Q) (Appendix M) to reflect the changes from the pilot programme and the results from chapter seven. The questions are also more behaviourally specific, focusing on several of the awareness, knowledge, and skill categories identified in the literature review and the Māori cultural themes from study two (i.e., Rate your level of knowledge to do a pēpeha. Participants could choose either: *1=none, 2 = a little, 3 = good, 4 = above average and 5 = high)*. There were 40 questions in total.

Post-training-Questionnaire

The post training questionnaire (post-Q) (Appendix N) contained the same questions as the pre-training questionnaire, but had three open-ended questions to identify what the participants thought of the instructor (Q. 40. How did you find the trainer's style of teaching?); What they found useful; (Q. 41. What do you think has been the most useful component of the workshop for you?); and what they found least useful (Q. 41. What aspects of the cultural competency workshop did you find least useful?).

The participants were asked to consider their responses with a focus on programme structure and content. Although I intended for them to think specifically about the content, format and trainer, they may have responded with different intentions because of how the question was worded. The expectation was that they were free to respond as they wanted. I think it was helpful that they gave a range of responses that showed what they liked or did not like about the training programme and the trainer.

Retrospective-Questionnaire

In the retrospective questionnaire (retro-Q) (Appendix O) I retained some of the questions from the pilot programme which was a combination of qualitative and quantitative responses. The main additions were related to the knowledge, skill and confidence to work with Māori cultural themes (from study two), (e.g., 21. *Rate your level of knowledge of Māori family structures*).

I also asked the participants to indicate if they had used the material with Māori clients. For example, retro-Q.36: *Rate your ability to do a functional analysis using cultural variables for Māori*; Retro-Q42. *Have you had a Māori client since you did the training programme? If so, what did you do with this client that was a result of the workshop?* As a reminder, the retro-Q measures what the participants thought about aspects of cultural competency prior to and after completing the workshop. The retro-Q was administered two-months after the programme.

Case Report

At the beginning and end of the programme I asked the participants if they would supply an annonymised copy of a case report of their work with a Māori client. The purpose was to see if participants could formulate cultural features in their report as they were taught in training. Despite my attempts to acquire work from other participants, Mas was the only one who gave me a case report. I present the results from Mas' report later. The following section describes the results of the full-training programme.

Programme Evaluation Results

Study Three

The purpose of this study was to evaluate the effectiveness of a training programme and show the linkages to training. The data for this study came from the pre, post and retrospective questionnaires, observations of the participants' interaction styles, comments made during the programme delivery and the evaluation of one case study. As I described earlier, for the retro questionnaire, I asked the participants to think back to the time prior to, and post training, rather just after training as is the case in most follow-up questionnaires. The results are organised following Aliger et al's. (1989) augmented framework.

Observations

My observations of the participants' behaviour indicated that they appeared interested; they readily discussed the material; participated actively in the exercises; and were respectful of each other. I found that they were less attentive and possibly bored by 3:00pm. This also happened during the pilot programme (I describe later what I did to 'wake-up' the participants).

Throughout the workshop, I observed two students who seemed uncomfortable with discussing the history of Māori land alienation and its effects on Māori. One of these students (Mika) was from a European country and the other was a Pākehā, New Zealander (Margaret). Mika commented in the post-Q "I am from a different culture. Not Anglo and not Māori" and that she did not have to meet Treaty responsibilities. When Margaret discussed her identity and the effect of colonisation on Māori she often brought the subject back to "what about us New-Zealanders, we have suffered too" in a manner that showed frustration and a touch of anger. In my view, Margaret and Mika's comments and reactions are not uncommon.

A limitation of conducting a workshop in such a short time frame is that there was not enough time spent working through personal views to fully uncover

the layers and move participants closer to thinking critically and deeply about their beliefs.

Mika said she had more experience with diverse cultures than the other participants and implied that she was already culturally competent. I have heard on occasion from other psychology students from multicultural societies that a blank-slate or melting pot approach is effective in meeting the needs of Māori or that because the student is from a different culture they are not required to meet Te Tiriti/Treaty obligations. Furthermore, there is an assumption that they are more culturally competent because of their experiences. Nonetheless, living in a multicultural society is not a guarantee of cultural competency because the ability to identify, critically reflect on and unpack worldviews and assumptions about diverse groups requires more than a shared living space. If it were that simple then all Pākehā would be culturally competent to work with Māori.

I found that it was useful to have an open dialogue with students so that they could learn to express their views and to listen to others who may challenge them. In this study, Mas and Tuts respectfully challenged their peers although I noted that they began to get frustrated with their peers towards the end of the day.

Level One: Reactions

Affective reactions

In the training literature, the value of affective type questionnaires is reported in a contradictory fashion. Some authors claim that affective (e.g., I liked the programme, feel-good) questions having no predictive value in determining whether a trainee will transfer learning material to the workplace (Salas & Cannon-Bowers, 2001), whereas others report that dissatisfaction (an affect) predicts outcome (Wexley & Latham, 2002). With this mind, I did not conduct an in-depth analysis of the participant's affective reactions; rather I asked what participants thought about the training programme, and the trainer.

The participants provided affective type comments in response to questions 41 and 42: *What aspects of the cultural competency workshop did you find most useful. What aspects of the cultural competency workshop did you find least useful?*

Post programme, eight participants commented that they enjoyed the programme. The responses ranged from good to excellent and also show that the participants felt secure and stimulated.

> Ka pai (Tuts, Māori, female, Ngā Puhi[32]).
>
> Fab (Tas, New Zealander, female).
>
> Fantastic, enriching (Tania, Asian, female).
>
> Warming and non-threatening (Margaret, New Zealander, female).
>
> Excellent laid back (Mas, English, male).
>
> Awesome (Megan, Dutch, female).
>
> Interesting and informing (Mani, New Zealander, female).

None of the participants reported that they disliked the programme, only that they were unhappy with particular topics or aspects of delivery. In general they engaged with the training material, exercises, and each other.

Reported dislike

As I highlighted earlier, it is important to identify what participants did not like about training. Four participants disliked the rush to get through some of the material. The issue with timing was identified in the pilot programme; unfortunately some of the material was rushed through because more attention was paid to other sections.

Megan's comments show that she did not like missing out on some of the workshop content,

> That we did not get through the planned information. The earlier aspects took the majority of the workshop (retro-Q).

---

[32] Upper Northern Māori tribe. http://www.ngapuhi.iwi.nz/

Megan was referring to the whakawhānaungatanga section. Although Megan said that the earlier aspects of training were least useful, she had in fact implemented that material in her practice. She commented further on in the retro-Q that those aspects of training had increased her confidence to work with Māori,

> Will now confidently ask if there is any special way the family would like to begin our session together.

Megan's comments could be considered an endorsement of the whakawhanaungātanga training. However, I chose to place it here because it is a reported dislike of the programme, and it has obvious contradictions. Mika commented that she found the awareness and knowledge section on stereotypes the least useful. When the material was presented, Mika did not engage with any discussions and she did not elaborate on what she did not like about the stereotypes.

During the session, some of the participants commented on the lack of relevance of some of the images, particularly the images from North America. Although I agreed with their comments about North American images being less relevant to Aotearoa, I explained to them that the purpose was to demonstrate the influence of the media on stereotypes and the global prevalence of erroneous and damaging beliefs.

Tuts provided verbal feedback to the group at the end of the workshop about what she disliked, which I thought was very brave. Tuts was tearful and angry when she made these comments,

> …insulted that other participants are not here to benefit from the workshop as they will be working with Māori. Insulted that staff are not here to properly thank and farewell the trainer (Tuts).

In the retro-Q, Tuts made these comments,

> The lack of participation in the workshop was a barrier to their learning and that the lack of support from the staff of the clinical programme was also a barrier to their continued learning.

Tuts and a few other participants also commented that they knew they were expected to learn to work with Māori but due to a lack of training

opportunities and the perception that programme staff were uninterested, they had little confidence that they would be supported in their practice with Māori. Tuts was especially affected as she knew that her absent colleagues had a responsibility to develop their ability to work with Māori and that it was staff responsibility to support and encourage them.

Support relates to training transfer and with that it is important that students know there is trust, respect and a belief that their learning is valued by programme staff. Others might see lack of support as permission for them to minimise the need for training, or to ignore it altogether.

Tuts' reaction is understandable as she knew that her colleagues who did engage with cultural competency training will work with Māori clients, and that despite their lack of training, they would pass the course. That is, the workshop was not part of the participants' formal assessment, and that their overall cultural competencies are unlikely to be meaningfully assessed if staff are uninvolved.

Tuts expressed to the group that she was insulted on a cultural level that a process for closing or showing manaaki towards me was insufficient. I did not have any expectations. Her comments give support to the research undertaken by Paterson (1994), Barnett (2004), and Gavala & Taitimu (2007) about Māori students' experiences. Some of the staff from University B (Māori and Pākehā) came at the end to thank me and they gave me a gift. The programme director from University A was the only staff member in this research who asked if he could participate; I thanked him and declined, explaining that students needed to be free to express themselves.

Confidence

It is necessary for students to feel confident in their cultural competency at their particular level to work with Māori not only because they have received training, but because they have a better understanding of what is needed. Confidence is not whakahihi (boasting), it is knowing how to work in a culturally competent way, which has been observed and verified by others.

The participants' confidence levels were assessed pre, post and retrospectively: *Rate your level of confidence to work with Māori* 1= no confidence at all, 2= some confidence, 3= confident, 4= pretty confident, 5= highly confident).

Figure 1: Results of the pre, post and retro-Qs on participants' confidence to work with Māori

The results show that prior to the programme, participants felt *some confidence* to work with Māori. Post programme, three participants showed no change in their confidence with the remainder showing improvements ranging from *confident, pretty confident, to highly confident.* Tuts only completed the post and retro-Q because she started an hour late, missing the administration of the questionnaire.

The results from the retrospective survey show that after 2 months, two participants reported an increase in confidence and that two did not show any change. Mas' results show that his confidence decreased after training and increased after the follow-up period. The reduction in confidence followed by an increase in confidence could be due to a *gamma* change where Mas may have shifted his internal standard of his abilities and as a result realised that he needed to know more. A possible explanation for the increase in confidence shown in the retro-Q could be the result of Mas undertaking additional learning, or engaging in cultural supervision.

The participants were also asked open-ended questions in the retro-Q about what they gained from the programme. These responses also show most participants had increased confidence to work with Māori, increased self and other awareness; and increased knowledge about Māori processes and its applicability to practice. Megan (retro-Q) reported how she felt increased cultural awareness and understanding of Māori concepts which helped to increase her confidence to work with Māori,

> Raising my cultural awareness, and raising my awareness and understanding of my cultural competency when working with Māori.
> I actually feel more confident to work with Māori since the workshop.

Megan's response shows the linkage between training and increased confidence. She commented that her awareness and understanding has increased since doing the workshop. The linkage between awareness, understanding and confidence is important. On their own, the factors do not provide sufficient impetus to propel students to change their behaviour. If there is too much confidence without awareness and understanding the client is at risk; awareness without the confidence to act also places the client at risk.

Utility Reactions

Utility reactions relate to the participants' perception of the usefulness of the programme and the programme material. It is important to identify these features as it indicates the likelihood that the participants will engage with, and use the material, in the workplace. As noted earlier, training transfer is more likely to occur if participants think they can use the material in the workplace, or that there is something to be gained from using the material (such as competency reviews or salary bonuses).

Perceived usefulness

In the post-Q (immediately after training), the participants were asked: *What aspects of the cc workshop did you find most useful?* Nine participants answered this question. The range of responses varied and indicated two main themes: *whakawhānaungatanga* and *case formulation*. These two components of training were endorsed as being the most useful.

Whakawhanaungātanga – establishing connections

The whakawhanaungātanga component was initiated at the beginning of the workshop and throughout several other sections. The introduction phase of the workshop (or the whakawhanaungātanga phase) took 2 hours to complete because there were a number of features I incorporated into the exercise such as: pepeha, mihimihi, tūrangawaewae (where they connect geographically). I also guessed that the participants did not know each other as well as they thought. The majority only had basic knowledge about each other (married, with children or not, work or academic background).

At the completion of the formal component of the whakawhanaungātanga (mihimihi, tūrangawaewae), the participants were coached in applying the format to each other and to establish closer connections based on what they had heard in each mihimihi (i.e., going to the same school, employment history, geography, children, age, marital status, shared language or immigrant status). I described how to engage with each other on the basis of the smallest connection and how self-disclosure is a necessary component. I illustrated how whakawhanaungātanga works by using several scenarios provided in the critical incident technique.

At this stage I introduced Rebecca to the class and gave them a part of her story as a practice session for establishing connections. I explained to them how I established connections with Rebecca to help engage with her and gain her trust. Building trust is one of the essential components of the whakawhanaungātanga processes.

I think that when clients come for help there is nothing that connects them to the psychologist other than their problem. It is helpful to break down barriers and misconceptions through knowing that the psychologist and the client have something in common that suggests a shift in power and shared experiences.

Some of the participants found the most useful part of the workshop involved learning how to connect, and share discussions about personal experiences, and experiences of others. Mas commented,

> That increased cultural awareness will benefit clients by finding connections and the importance thereof across cultures (retro-Q).

While Tuts commented that,

> It was useful to share stories (retro-Q).

Megan said that the whakawhanaungātanga section enabled her to learn how,

> to develop connections and finding shared values and meanings. (post-Q).

The results show that for some, the whakawhānaungatanga-related content gave them insight into the importance of self-disclosure and sharing experiences. Self-disclosure was a theme that emerged in study two. I talked to the participants about the importance of sharing personal information within limits, of exploring connections, and of recognising that clients share deeply personal information that should be respected.

The last point is important for participants to understand; if psychologists expect clients to divulge deeply personal information then they should be able to give something back to show that the relationship is reciprocal and meaningful. Megan commented that learning about Māori processes and whakawhanaungātanga was the most useful aspect of the workshop and she could see the relevance to her work,

> I now have an understanding of Māori cultural processes and protocol and this has also increased my confidence in participating in these processes, and reduced my apprehension of these processes (Megan, Retro-Q).

The whakawhanaungātanga theme was a core finding in study two. The finding that participants valued that theme in their training is promising.

Case conceptualisation

The components of the training programme were structured in such a way as to build the rationale for a cultural formulation. Whether I talked about power, privilege, racism, Te Tiriti/The Treaty, the monocultural values underpinning clinical psychology, discrimination, or Māori cultural

processes, they were all linked together. I used Rebecca throughout the programme and highlighted the relevance of each section of training to her story, and to the scenarios provided by the psychologists in study two.

In this way the training content was pinned to the experiences of the psychologists, their clients' experiences, and Rebecca's story. For example, I mentioned in my description of Rebecca that one of the catalysts for her episode was her brother's conversion to another religion. As a result of her brother's conversion, Rebecca was deeply concerned at the loss of whānau tradition and its ongoing impact on her whānau as there was no-one to take over from her father as orator on the marae.

The cultural formulation training (using Rebecca's story) included how the participants could consider cultural questions related to identity, gang-culture, and the influence of tribal corporate entities (e.g., trust boards or councils). Additional factors included awareness of the media's role in perpetuating negative views about Māori. The theme *recognising whānau influences* (from the CIT) was also relevant. We discussed the importance of whānau, iwi and hapu and its many configurations, the roles within whānau, and roles on the marae.

The participants said that they did not initially understand the relevance of asking about hapu, or iwi, or even the importance of knowing local iwi and hapu, until they saw how it related to Rebecca and some of the clients in the scenarios. Four of the participants found the case study, cultural formulation, and functional analysis the most useful part of the programme.

Tania said she liked the case study as it enabled her to better understand the new skills and issues she learned, and would need in the future. Mas commented that he had always wanted to work with Māori.

> I particularly sought out an internship at corrections (Psychological Services, Department of Corrections) so as to receive training to work with Māori. I am looking forward to this workshop to extend upon and reinforce this learning (post-Q).

In his retro-Q, Mas said that being able to discuss concerns was one of the most useful parts of training for him.

The affective and utility reaction responses extend the evaluation of participants' thoughts and feelings about the training programme beyond simply asking if they liked, or enjoyed the programme. Their specific value lies in identifying exactly what was useful or not useful and finding ways of linking those responses to the training objectives and training transfer.

Conducting a functional analysis

This section relates to the participants' perception of their ability to conduct a cultural functional analysis. In the previous paragraphs they commented that they liked the case study and case conceptualisation the most. The material below could also sit in the behavioural/skill section, but as it is a perception-based question rather than a behavioural question, I chose to place the results here.

The participants were asked on the pre, post and retro-Qs (Q.33) *Rate your ability to do a functional analysis using cultural variables.* The response options ranged from: 1= none, 2= a little, 3= good, 4= above average, 5= high.
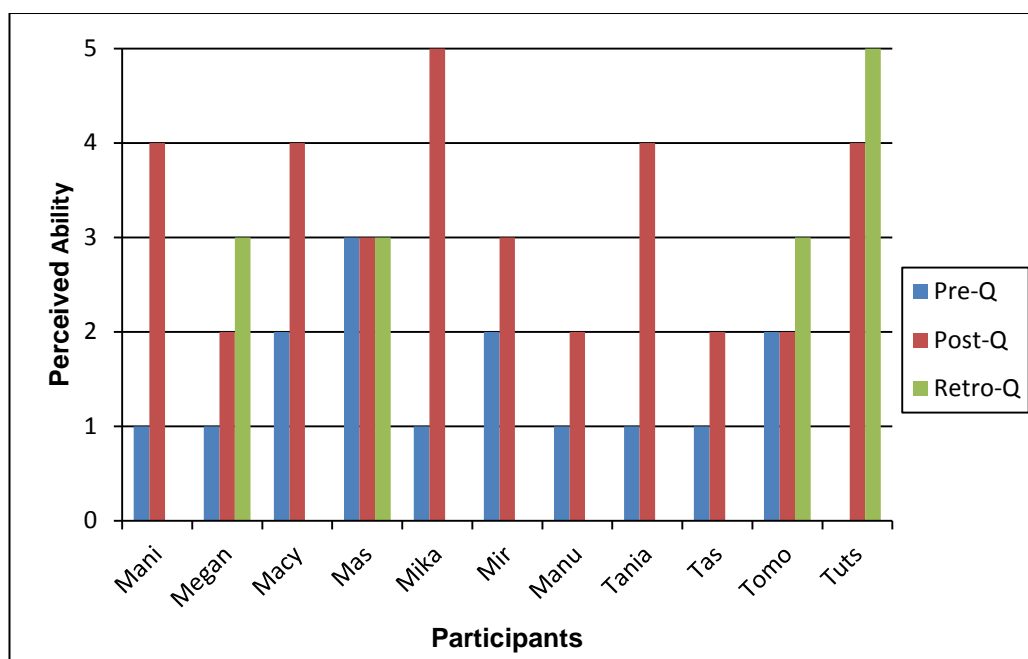
Figure 2: Changes in perceived ability to do a functional analysis using cultural variables

The results show that, overall, the participants' perceived ability to conduct a functional analysis for Māori improved after training. The average pre-programme response was 1.5. The average post-programme showed a

reasonable change to 3.1. Megan's responses show an incremental change over time, while Mani, Macy, and Tania show changes from "none" to "above average" ability.

Mika showed the most change pre and post programme. Her results are interesting as she commented several times during the programme,

> Psychologist only needed to keep an open-mind, and start with a blank-slate when working with people from different cultures.

I am uncertain as to whether Mika overrated her ability to do a functional analysis or whether she learned a new skill in the training programme.

One participant had no change in her pre and post scores. That could be due to beta or gamma change as Rebecca's case study was very intense and required significant knowledge about Māori cultural practices and values to understand their impact. For example, Rebecca had not slept for over a week. The psychiatrist saw this as evidence of mania. In fact, Rebecca had not slept because she was consuming up-to eight cans of red-bull each day. She had forced herself to stay awake so she could continue working on governance issues within her marae.

Although Rebecca's stress management was not optimal, it was not a reason for misdiagnosis. The functional analysis training focused on a number of factors that could have provided clues to Rebecca's behaviour. Some participants provided their own ideas about the meaning of particular behaviours that Rebecca exhibited that showed they were not quick to offer a diagnosis (although some did).

The results on the retro-Q show that the only Megan, Tomo and Tuts changed in their perceived ability to conduct a functional analysis. The change is not great but it moved from no ability for Megan, and very little for Tomo, to "good" which shows promise.
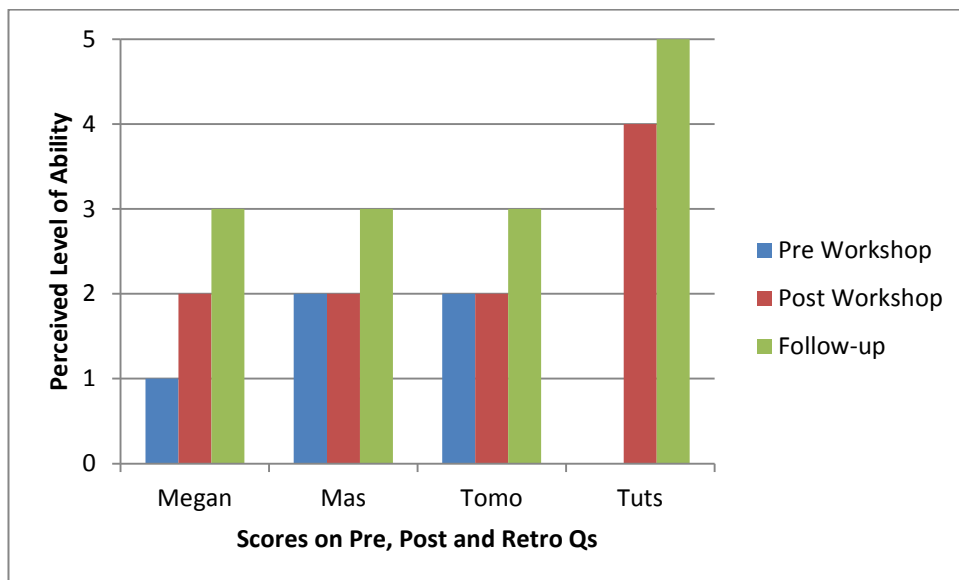
Figure 3: Rated levels of perceived ability to conduct a functional analysis at three time periods.

The value of doing a good functional analysis cannot be overlooked as it is one of the core dimensions of clinical skill. Moving on from usefulness measures, I asked the participants to rate their ability to perform certain tasks.

Perceived difficulty/ability

The training literature highlights the importance of identifying participants' perceptions about their ability to perform tasks from the training programme. Perceived ability is also influenced by factors such as level of confidence, type of training, and cognitive aptitude. I did not specifically ask how difficult the material was to learn or implement; rather I asked the participants to rate their ability to perform certain behaviours (e.g, *Q.3. Rate your ability to whakawhanaungātanga with Māori*).
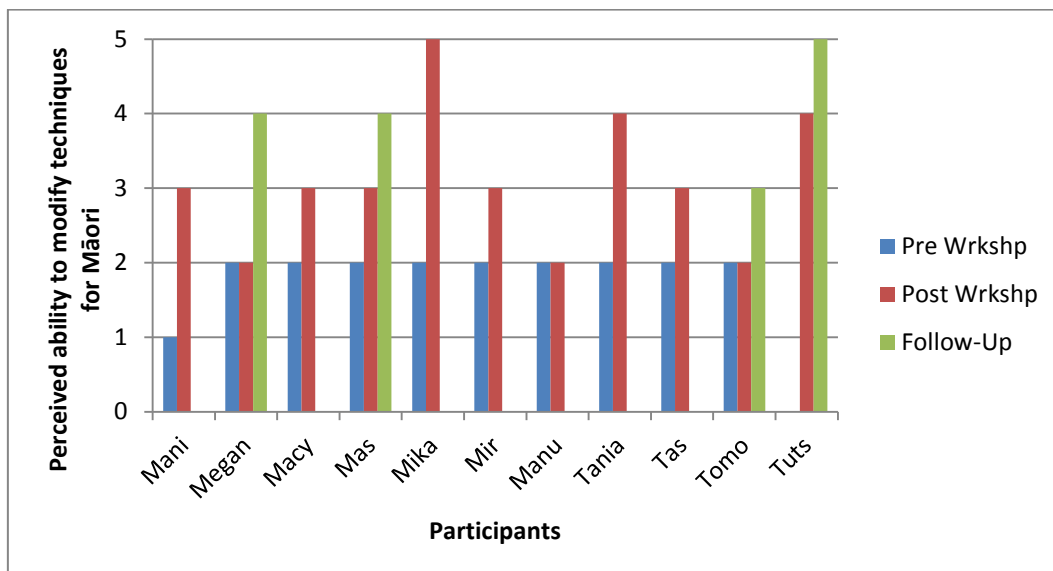
Figure 4: Participants perception of their ability to modify psychological techniques for Māori clients.

In each questionnaire, participants also rated their ability to (Q.34) modify therapy techniques for Māori as low prior to the programme at 1.9. The rating increased marginally post programme to 2.8. The retrospective results for the four participants showed continued improvement with an average of 3.5. In general the majority of participants showed an improvement in their perceived ability to work with Māori.

Level Two: Learning

I asked several questions to identify whether participants had learned the training material and whether they could demonstrate that learning. The questions related to: (a) immediate knowledge; (b) knowledge retention; and (c) behaviour/skill demonstration that impact on training transfer. Changes in attitudes and values were also analysed from comments provided in the open-ended questions.

Immediate knowledge
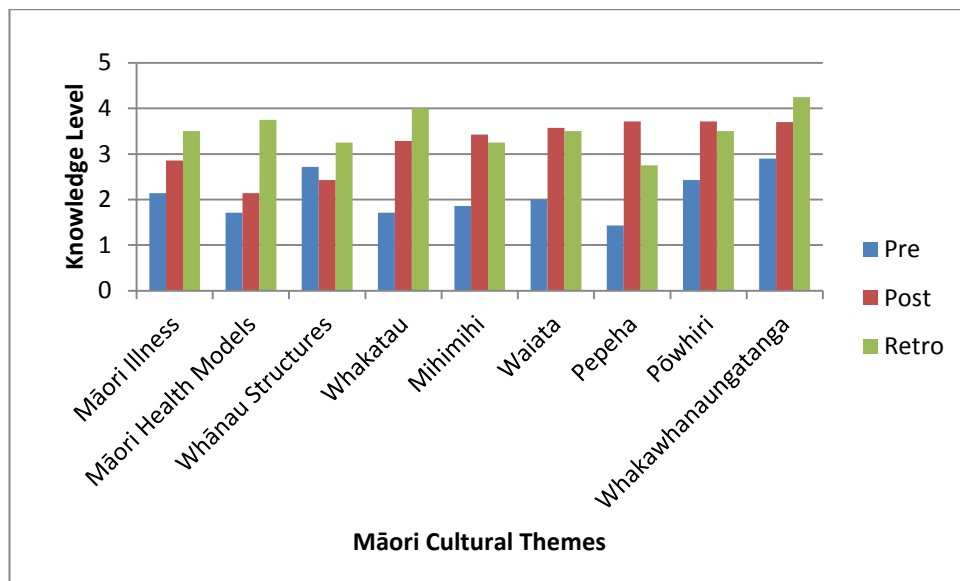
Figure 5: Changes in knowledge about Māori cultural themes

Figure five shows that on average, participants considered they had little knowledge about Māori cultural themes prior to training. The limited pre-training knowledge about whakatau, mihimihi, waiata, pēpeha and pōwhiri was expected.

The changes post-training are reasonable although not significant. Several participants commented that they found the Māori cultural concepts the most useful such as: mihimihi (Mani); learning about Māori processes, cultural formulations and Māori processes (Mas); and processing their own issues regarding experience of culture (Megan). The small gain in knowledge about Māori health models is predictable as this topic was not discussed in-depth. I noted earlier that this was one of the topics that suffered due to timing issues.

Awareness competency

This section of the results is organised using the awareness, knowledge and skills tripartite model (which is part of the cultural competency framework). I thought it was still relevant to include data that reflects the tripartite model because it underpins my argument about what should be included in training programmes. The sections are headed: awareness, knowledge and skill with examples of changes (or not) in the participants' pre, post and follow-up (retro-Q) results.

The participants commented frequently on the value of an exercise called the 'tree'. This was a knowledge and awareness teaching aid that provided a visual representation of the intergenerational effects of colonisation, land and language loss, and whānau disenfranchisement. Two trees were drawn on a white board. One was a healthy kauri tree representing pre-colonial Māori, the other a sapling Norfolk pine representing Pākehā (1800s).

To set the context for the participants, I read a description of a list of Acts of government (e.g., Tohunga Suppression Act, or Foreshore and Seabed Act), council bylaw, or government policy since the 1840s and asked the participants to decide if Māori were advantaged or disadvantaged by the Act, bylaw or policy. If Māori were disadvantaged, a healthy branch or leaf was taken from the kauri tree and placed on the sapling.

By the end of the exercise, the kauri tree was shriveled and stunted with little foliage left, while the sapling was bursting with new branches and green leaves. The branches that remained represented components of Māori culture that survived; language revival and kura kaupapa Māori education, ongoing Pākehā and Māori activism. During the workshop, the participants commented that the tree was an excellent metaphor for Māori wellbeing.

Continuing with the awareness domain, I asked the participants to rate their levels of awareness of some of the issues that affect Māori clients, for example: *Q. 1. Rate your level of awareness of cultural competency; Q.4. Rate your level of awareness of how your identity and culture can affect how others perceive you; Q.5. Rate your level of awareness of the impact of stereotypes and discrimination on Māori; and Q.6. Rate your level of awareness of how cultural factors in clients and yourself can affect judgment.* The results across all the participants were averaged and are presented below.

Figure six shows that prior to the workshop, on average, participants had a moderate level of awareness of the importance of cultural competency. Post-programme, there is a minimal increase in reported self-awareness. The participants who completed the retro-Q show the highest gains in self-awareness. There is no conclusive information to say that the gain was as a result of the workshop, but this does seem likely.

The participants' levels of *self-awareness of the impact of their identity* on clients show the most gains across the three time periods. In the third bar-set, the participants' average results on the question related to *awareness of the impact of culture on judgment* increased marginally.

Two participants in the retro-Q did not complete the question which affected the results. Finally, the average result for *awareness of stereotypes and their impact* showed incremental changes after training and at follow-up. In summary, the participants appear to have become more aware of cultural competency issues after attending the workshop.
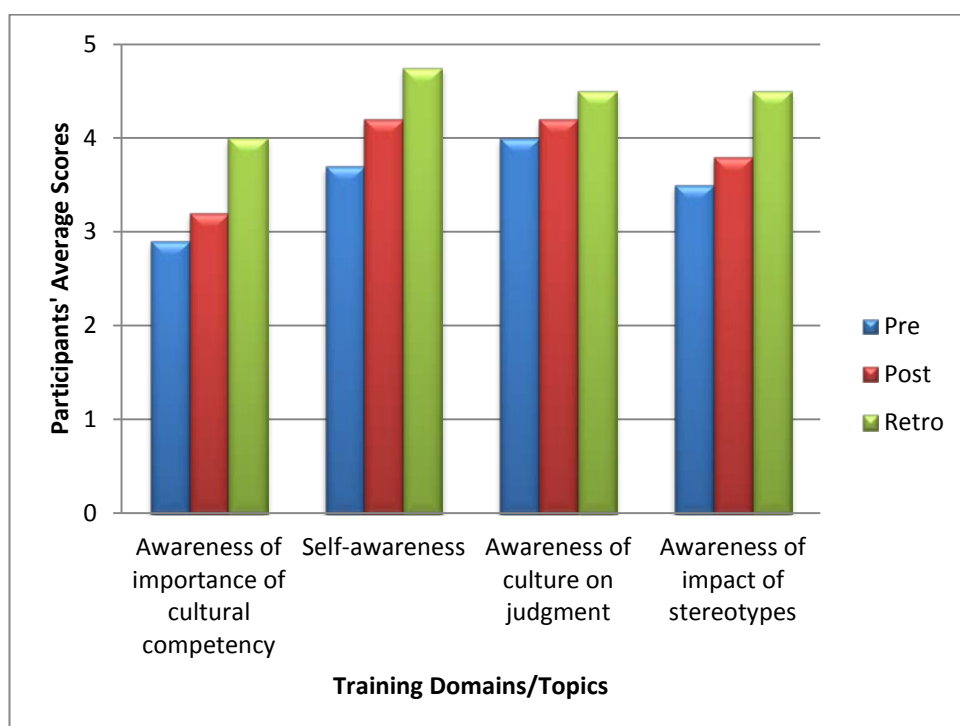
Figure 6: Changes in awareness competency

Knowledge retention

Figure seven below shows the results from the retro-Q to identify whether participants retained specific cultural competency knowledge. The questions related to socio-political material on the Western foundation of psychology, racism, power and privilege, and Te Tiriti/Treaty issues. The results show that participants began the workshop with a limited amount of knowledge of socio-political issues and gained mostly from the session on racism, privilege and power. The change is positive as sociopolitical issues receive superficial attention in university training.

Retention of Knowledge

[Figure: Bar chart titled "Retention of Knowledge" showing Retro-Q Participant Averages (y-axis 0 to 4.5) against Socio-Political Themes (x-axis): Racism, Privilege, Power, Treaty Issues, Western psychology. Legend: Pre (blue), Post (red), Retro (green).]
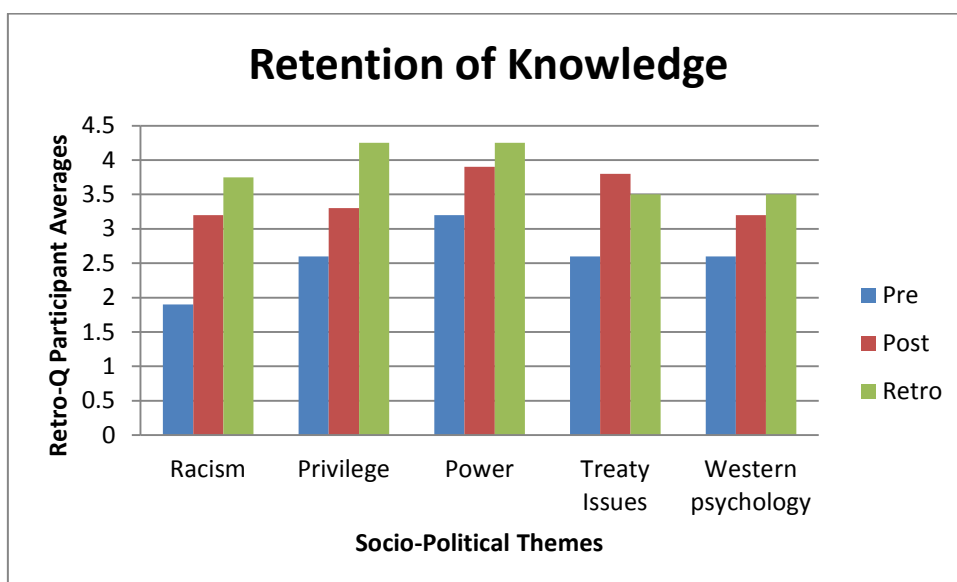
Figure 7: Knowledge retention: Socio-political issues

The participants show that their knowledge increased after two months. This could be due taking on additional learning opportunities, and an increased commitment to changing their practice. In response to the question: *Since doing the workshop, what changes, if any, have you made to your practice?* Mas commented that,

> I have done more reading about myths and legends of Māoridom, and have made efforts to discuss each Māori client with my cultural advisor. I have also made efforts to consider a range of culturally important variables in my formulations (Mas, retro-Q).

I found it interesting that Mas read oral history material (i.e., written accounts of history and traditions handed down orally). There were a few psychologists in study two who used oral history in their work with clients and perhaps he felt that this material could be useful to him. Mas also said that he consulted more with the cultural advisor. I believe that the knowledge he was acquiring will make an interesting dynamic in their discussions. Megan responded that she had,

> A renewed commitment to the principles of the Treaty of Waitangi when working with Māori clients. Will now offer services to Māori with more confidence, e.g cultural consultation. Will now consider cultural aspects and include in the formulation (Megan, retro-Q).

Megan's response reflects a positive attitude change that is strengthened by her further comments about being more confident offering services to Māori.

Level Three: Behaviour

Behaviour/skill demonstration

The purpose of identifying behaviours or skills is to be able to say that a participant's behaviour changed as a result of training. The behaviour may be demonstrated during training, but it is more useful to see the behaviour in the work-place environment. A way of determining whether participants have learned to critically analyse contentious material is to observe their interactions with others, and to listen, or read their remarks.

The main topics that I have found to be fairly contentious for some students are: being referred to as Pākehā; perceiving Māori as unfairly advantaged by "Treaty issues"; scholarships only for Māori; and the perception that Pākehā should not be held to ransom for their ancestors actions. Whether participants have learned the workshop material was evident in the quality of their arguments and their affective or behavioural reactions to contentious issues.

I expected the participants to demonstrate awareness, knowledge and skill in the following ways: the ability to counter established misconceptions with factual arguments, remaining cool-tempered, accepting that they were in a privileged position, and showing humility and grace. In general, I observed the participants engaging with the new and challenging material in respectful and insightful ways. The majority were open to having their views pulled-apart and examined without being defensive or hostile.

The data I collected during training was useful to gain a deeper understanding of the characteristics of students who are the most receptive, or resistant to cultural competency training. I have often found that students who are resistant cannot help themselves and constantly labour their particular issue. Their attitudes are consistent throughout training and very difficult to change. This is not to say they do not make good psychologists,

but they often miss the point of cultural competency training which can affect their work with clients.

This distinction raised an issue about the selection of students, with limited resources available to training programmes. Students who are receptive to cultural competency and understand their cultural position, can be energetic, ready for new information and readily seek further learning opportunities. Conversely, resistant students are difficult to engage, are likely to confront contentious issues with very little critical reasoning, and are likely to damage group moral. The attitudes of either group of students also influence the likelihood that training will transfer to the work setting.

Transfer of training

Transfer of training refers to the use of the new awareness, knowledge and skill (AKS) on the job. The retrospective questionnaire asked the participants if they had a Māori client since doing the workshop and whether they did anything with that client that was a result of the programme. Of the four participants who completed the retrospective survey, three described using Māori cultural concepts acquired from the programme such as: whakawhanaungātanga (offering to open the session in a particular way), offering karakia, and using pēpeha. Clients were also asked about the impact or influences of kaumatua, tūpuna, parents and extended whānau.

The participants demonstrated cultural knowledge and acceptance of different worldviews by discussing dreams, visions and the role of kaitiaki/guardians. They sought information from cultural advisors and cultural supervisors. They also offered clients the opportunity to see a cultural consultant or respected whānau wishes not to use cultural consultants.

The participants' responses show that they attempted to implement a range of Māori cultural concepts with their clients and were accepting of their client's perspectives including dreams, visions and kaitiaki/guardians. Their methods show that they were building relationships with clients by using whakawhānaungatanga, self-disclosure, pēpeha, and karakia.

Mas reported that he tried to offer a karakia to a client but this offer was rejected in no uncertain terms,

> A second client that I tried to engage in a similar manner remarked that I had no place trying to say a karakia and that I should stick to asking questions (Mas).

Mas did not provide any context about how he tried to offer the karakia or at what stage of the interview. In the workshop I discussed the likelihood that clients may not wish to have a karakia, or to have a Pākehā conducting a karakia. I expect that given Mas' presentation throughout training he would have respected the client's response and raised the issue during his cultural supervision meetings.

I also asked the following questions: *Q. 40. Since doing the workshop, what changes, if any have you made to your practice in relation to cultural competency? Q. 41. What difference has these changes made*? Megan said that using the cultural concepts made her feel more confident when working with Māori clients,

> In terms of the impact on my clients, it is probably too early to tell yet, but in the one instance I have changed my practice, I felt the family appreciated my acknowledgement of their cultural concerns (Megan).

Megan commented that she was more aware of how clients might perceive her and had a better understanding of consulting with Māori. Her increased understanding and awareness of her identity and her client's identity suggests that it more likely she will continue to implement Māori processes that benefit her client.

Mas' response to Q40-41 shows that he is developing confidence and a repertoire of skills that he uses with Māori clients. Despite the setback with his other client, he persevered and received good feedback. It is heartening to see Mas make an effort for his clients as it is not unusual for clients to be uncomfortable with a European psychologist. Their perception may be that an English psychologist would not take them seriously, or respect their worldviews. Mas also said,

Beginning with a pēpeha/karakia has helped to build rapport with clients – and I have had feedback from clients that, before arriving at the session, they weren't expecting to feel relaxed working with a European psychologist, as they didn't think I would take things that are important to them seriously.

Characteristics of the trainer

I chose not to focus too much on this section as the responses are similar to those in the pilot programme. Nine participants responded to this question. The expected outcome was that the trainer provided a learning environment that was safe, supportive and encouraged discussion of ideas. The relevance of this section is to highlight that the characteristics of the trainer can facilitate or impede a student's learning. A safe environment is critical to learning acquisition and retention and it is easily impacted by unkind, judgmental or harsh communication styles.

I found that participants easy to work with. They were initially shy and hesitant although polite and welcoming. The majority appeared sensitive and genuinely cared about working with Māori. However some participants were at times, challenging, obstructive, defensive and passive-aggressive. When that happened I remained calm and gently guided the discussion to material that provoked critical thinking.

Whether we agreed or not, my role was to be supportive and to encourage open and respectful discussion. The participants were asked: How did you find the trainer's style of teaching? Responses included:

Fantastic. Supportive and very enriching, (Tania, post-Q).

Excellent laid back, informative, easily approachable for questions, (Macy, post-Q)

Thank you for the opportunity to attend such an informative, thought-provoking, and spiritual learning experience, (Megan, retro-Q)

Very informative, non-judgmental, great facilitator (Tuts, retro-Q).

Also, having an opportunity to discuss concerns about whether or not I'm doing it properly in a non-threatening way (Mas, retro-Q).

The results suggest that as a trainer, I had an open and approachable style that was non-judgmental and thought-provoking.

Level Four: Results/Impact

Results refer to the impact of training on wider organisational goals. Results criteria include productive gains, good client outcomes, cost-saving, increased competence; improved confidence/morale, passing accreditation standards, or passing professional development standards. In this study there were two methods used to gather results-focused data: the retro-Q and the case report. I asked the participants to provide a copy of a case report of work with a Māori client. In the report, I expected to see components of the training programme in their cultural assessment and cultural formulation.

Case report

The purpose of the case report was to see if components of training were incorporated into the report, and specifically to ascertain the quality of the cultural case formulation. Only Mas, provided a case report. I can only speculate that this was because most participants did not see any Māori clients, they may have been too busy, they may not have included the cultural formulation in their report or, they did not have sufficient skills to write one.

Unfortunately, Mas' case report did not include a cultural formulation. When I read the report, I noted a series of protective factors for his client which Mas could have explored further. In hindsight, I should have given some feeback to Mas as it would have provided another training opportunity.

I have included an abridged report to show what Mas wrote. I add to this my view of where he could have included cultural factors.

Jane Johnston (pseudonym)

The preamble to Mas' report contained the following information,

> This report presents the case of Jane Johnston, a 40-year-old Māori woman who had been sentenced to 12 months supervision for a violent assault against her partner. Jane was referred to Psychological Service by her Probation Officer for assessment

regarding her offending, anger related difficulties, and propensity to use violence.

Presenting Problem

Ms Johnston had been convicted on the charges of Assault with Intent to Injure, Careless Driving Causing Injury, and Reckless Driving Causing Injury. The police summary of fact indicates that during the offence she first hit her partner with her motor vehicle and subsequently proceeded to physically assault him using her fists[33]. As a result of these convictions she was sentenced to a twelve-month period of Supervision and 150 hours of Community Work. Ms Johnston reported having difficulty controlling her anger and was experiencing problems in her current relationship. Alcohol abuse was also identified as a problem for Ms Johnston.

Background Information

Childhood

Ms Johnston reported that she was the eldest of three children. Her childhood was described as being physically, emotionally and verbally abusive, and was characterised by violence and neglect. The main perpetrator of this abuse was her father, whom Ms Johnston described as being a controlling and intimidating man. She reported that he would often "beat [her] with his hands" and other objects, often for minor childhood infractions.

During these beatings Ms Johnston described her mother as being unable to intervene for fear of being violently abused herself.

On one occasion Ms Johnston confided in a paternal uncle, seeking help regarding the abuse. Initially she felt safe going to her uncle, as he worked as a pastor in their church. However, the uncle informed her father of this, which led to more abuse as punishment. The uncle did nothing further and Ms Johnston did not seek help again.

Adolescence

---

[33] The case report also noted that the couple's 14 year-old son was present throughout the assault and intervened.

At the age of fifteen Ms Johnston reported experiencing a number of additional traumatic events: father had an extra marital affair, she became pregnant with her first child, the child's father abandoned her and that "he was no support". She had post-natal depression her parents had "taken my baby away from me" to raise the child without her.

She felt they kicked her out of home shortly after giving birth. She moved out of town and "lived on the streets" for approximately six months stealing and "having a lot of casual sex" drinking heavily and using "every drug you can imagine". When she was 31 her mother passed away. She reported that due to the ongoing conflict with her father, "he wouldn't let me come home" and was therefore unable to visit her mother before she died.

Case Formulation

Ms Johnston's early childhood was characterised by instability, inconsistent parenting and physical / emotional abuse. Within this environment, aggression was modelled as a means to resolve conflict, to maintain power and control, and to deal with negative affect. As a result, Ms Johnston may have developed a negative view of herself as powerless and vulnerable; learned to perceive others as malevolent; and to view the world as threatening and unpredictable.

In the context of long standing exposure to violence in an unsafe environment with limited support, guidance and protection, Ms Johnston learned that she had to be her own source of protection and would react violently when faced with difficult situations. Thus Ms Johnston's perceptions of the world, herself and others appear to have provided the catalyst for her emotional volatility and hostility.

Ms Johnston is likely to be sensitive to threats from her environment and biased towards labelling situations as hostile. In turn when she perceives that she is being threatened, ridiculed, or treated unfairly these maladaptive beliefs precipitate explosive aggressive outbursts.

Ms Johnston's early life experience also appears to have provided little modelling of appropriate mood regulation and conflict resolution. This is likely to have impeded the development of important affect regulation skills and led to the creation of dysfunctional coping mechanisms, including the abuse of alcohol and other substances. Her poor relationship skills and propensity for aggression and violence in situations of distress appear to have

been modelled and legitimised both at home and school throughout her formative years. This pattern of reacting with aggression and violence continued to be reinforced throughout Ms Johnston's adult relationships.

Factors likely to maintain Ms Johnston's offending in the future are; her cognitive attribution bias and over-sensitivity to perceiving and labelling situations as threatening; dysfunctional beliefs about relationships; poor ability to resolve interpersonal conflict and reduce personal distress; attribution of responsibility for escalating conflict to her partner; and minimising of the seriousness of her violent behaviour.

Protective factors include Ms Johnston's stated motivation and commitment to living an offence and alcohol free lifestyle, as well as her desire to maintain a cohesive family unit and to be an appropriate role model for her children. In addition, Ms Johnston is able to access a wide network of friends and family who are potential sources of support.

The possible reasons for Mas not including a cultural formulation are that: (a) he did not learn how to do a cultural formulation during training; (b) the limitations of writing reports for Psychological Services may have created a barrier to a lengthy detailed report; or (c) Mas did not have the skill to develop a sophisticated case formulation. To a novice, it is possible that no immediate indicators of Māori cultural issues were evident, that there may be a lack of confidence in hypothesising cultural factors, or Mas may have thought that he had included cultural features.

Mas could have asked Jane about how she saw herself as Māori. In the training programme we worked through a large section on Māori identity (including practice exercises and I provided a 'pat statement' that the participants could modify). Probing how Jane saw her identity could have provided insight into her past behaviour, and a means of preventing future offending behaviour. Jane also came from a small, parochial, rural town with a number of marae. The town is well-known for its links to a prominent tribal-group entity.

Mas missed the opportunity to explore socio-economic influences on Jane's presenting problem. The town in which she lived has a high rate of

unemployment and alcohol and drug-use and is known for its rugby culture, drinking and family violence.

Knowledge of socio-political features of Jane's hometown could have provided useful information. In previous years (and to a certain extent it still occurs) family and partner violence was overlooked by the community and sometimes whānau.   The police also had a history of not prosecuting perpetrators of partner violence. Racism towards Māori is common in Jane's home town and often acerbic. For example, in the 1960s, Māori and Pākehā had separate shopping days where Māori were not allowed in the town centre on the same days as Pākehā (Waitoki, 2000)[34].

Mas could also have explored the nature and quality of Jane's friendships and family support systems. She had a large network of friends and family and it is likely that she has had contact with marae. The nature and extent of any contact may have provided potential protective mechanisms. I also noted that Mas did not ask Jane about her parenting style or parenting practice to identify whether she perpetuated intergenerational violence towards her children. Jane said that she wanted to be a better-role model for her children; this could have been explored. There is also the issue of safety for her children as her son witnessed the attack on her partner.

The lack of a cultural formulation, while unfortunate for this research, was not unexpected as the skill required to create case formulation requires several training and practice sessions. I thought it highly unlikely that any of the students, other than Tuts, could have developed a cultural case formulation. Particularly, as noted previously, most interns have yet to develop that particular competency, let alone deal with cultural factors as well.

---

[34] I am talking about a long history spanning 50 years or more. In more recent years, the police are likely to make an arrest for partner violence. I lived in that town as a young mother for 10 years, my children have whakapapa connections to the town, and I conducted my Masters research there.

The report in my view constituted an N=1 evaluation, and I felt the need to whakamana (respect and empower) Mas for the effort in making it available to me. Although it did not show that he had learned to do a cultural formulation, it showed that he learned other components of training. The value of this case report is that it can be used as a training tool for future workshops. It also highlights the need to develop case conceptualisation early in training so that any difficulties are dealt with before students see clients.

Additional results-focused data

Some of the data from the transfer of training, and the AKS sections could be used to provide evidence of positive results (i.e., higher level of confidence, using whakawhānaungatanga). However the analysis should also include feedback, or some form of measurement obtained from the organisation and/or Māori clients. The only organisational result I have is that the clinical programme staff emailed their thanks to me and commented that the students enjoyed the programme.

In subsequent years, I was asked by the universities to run the programme again which is an indication that the staff thought the programme was useful. I expand on the implications of obtaining results-focussed data in the next chapter.

Summary

The results from study three were analysed according to Kirkpatrick's model (1994), with modifications made by Alliger et al. (1989). The model provided a structured way of evaluating whether training was successful by identifying the factors associated with training transfer (i.e., reaction, learning, behaviour and results). The results from the pre, post and retro questionnaires show that across three of those factors, the participants found the programme useful, they demonstrated that they learned some of the material, and they said they would incorporate the material in their work (some participants did use the material).

The finding for the results factor was disappointing as only one participant provided a case study. Mas' case report did not incorporate cultural factors the despite the presence of features of training which could have provided more information about treatment recommendation for his client. The omission could be related to Mas' inexperience with identifying cultural issues and managing a complex cognitive task.

As a participant in the workshop, Mas was positive, empathetic and he engaged with the material which showed his aptitude for learning. His feedback in the retro-Q about his work with Māori clients showed that he attempted to use the workshop material with them, albeit with mixed results. With extra training, and support it is possible that he could develop cultural case formulation skills.

Case formulation is a difficult cognitive skill to master; cultural case formulation is likely to be even harder as participants are required to integrate complex information in the context of competing personal values, and a lack of societal and organisational support for things Māori. However, because psychologists are expected to work with Māori, they should be able to demonstrate an ability to do a cultural case formulation in the same way it is required for clinical case formulation. Anything less must be considered unacceptable.

Another issue for this training programme relates to having sufficient time to work through the topics in order to maximise learning. The participants said

they gained from doing the programme but that more time was needed. These results are consistent with the pilot programme which is a matter I comment on in the final chapter.

In relation to trainee attributes, students, such as Mas and Tuts, demonstrated qualities that could be considered desirable for entry into clinical training programmes. Their attributes, in my view, make up the ideal student. My observations of the participants in this research and observations of students when I was a lecturer showed that some students are empathetic, non-judgmental, have critical analysis skills and are proactive in their attempts to work with Māori. Students who demonstrate defensive attributes have a tendency to blame others and fail to grasp critical thinking skills. I describe the relevance of these attributes in the next chapter.

Overall, the results from the final programme do not provide enough evidence to make conclusive statements. Although the participants provided information to show that they had learned the material and that at least some of them would use that information in their future practice, the numbers were too low to be consequential. The material in the workshop was also challenging personally and cognitively. Participants were asked to analyse long-held values and schemas about themselves, psychology, and Māori.

These inconclusive results are consistent with the pilot programme where students showed that although they learned the material and were willing to change their practice, they were limited by inexperience and a perceived lack of support from programme staff and their workplace. The concerns expressed show some of the organisational factors that have an impact on training transfer, in particular, staff apathy and a lack of support from colleagues (i.e., fellow students).

Lack of support can be taken a few ways: it undermines students' confidence in what is being taught; it suggests that staff do not consider cultural competency training necessary or useful; and it suggests that the students may not be supported in utilising what they have learned. There is also a possibility that a lack of support will also carry over to the workplace.

The following chapter discusses the findings and implications of this research.

CHAPTER 10: DISCUSSION

In this chapter I focus on two main themes: (1) the value of the training needs analysis with a particular focus on the cultural-clinical distinction and the possibility of an indigenous Māori psychology; and (2) the outcome of the training programme and its relevance to clinical training. In drawing my conclusions from this research, I describe their position within kaupapa Māori principles and suggest ways that transformation can occur.

Training needs analysis

The responsibility for providing quality and relevant training for students rests with tertiary institutions. However, I argue that this does not happen in a structured or meaningful way. The literature review showed that students need training to meet ethical standards, including Te Tiriti/The Treaty responsibilities, and in more recent years, to meet registration standards (Love & Waitoki, 2007; Nairn, 2007). The training development literature describes the importance of identifying firstly who needs training and the content of training before a programme is created. In this study, I used the training needs analysis in a structured way that incorporated a person analysis, task analysis and the critical incident technique (CIT).

Person analysis

The purpose of the person analysis is to determine whether training is necessary and who needs training. The data on the person analysis showed that the participants had limited prior bicultural training and needed training to meet minimum competency standards. At best, some of the participants had completed workshops on Te Tiriti/The Treaty, and Māori-focussed papers (either in psychology or another discipline), had cultural supervision (this was only in the internship year for a few students) and te reo/language papers, while others had no prior bicultural training, or had only completed a Tiriti/Treaty workshop.

The lack of bicultural experience is a theme consistently reported in the literature. A common problem with participants who lack previous training

or education is the need to provide basic information that should have been provided at years one and two of the Bachelor degree, or even at school level. Earlier training in basic aspects of cultural competency (such as Te Tiriti/The Treaty, discrimination, racism, prejudice, power, privilege and the limitations of Western psychology) would set the foundation for training and enable more complex discussions and learning about those topics to take place (I add to this issue in a later section). On that basis, I identified a need for students to undergo training.

Task analysis

The task analysis sought to identify the types of tasks that psychologists performed with Māori. Two main findings were evident: (1) that psychologists used Māori-cultural processes in their everyday practice; and (2) that the Māori-cultural processes could be distinguished from 'Western' psychological practice. When bicultural practice with Māori is viewed as every-day, typical practice, there is a greater likelihood that psychologists will be more relaxed and confident in their work. Another factor is that gaining experience to work with Māori also contributes to confidence levels. A common theme in the literature is that psychologists felt that a lack of training contributed to their lack of confidence to work with Māori (Love & Waitoki, 2007a; Sawrey, 1991). Some of the participants in the final programme stated how following training they felt more confident to work with Māori than they were previously.

Following on from the everyday nature of psychologists' tasks, it was also found that the tasks showed a combination of distinctly Māori-cultural practices, or distinctly general-cultural practices. Psychologists used Māori-cultural processes in typical, (i.e., everyday) fashion regardless of whether they were 'clinical' or Māori-cultural tasks. The use of Māori-cultural processes as typical tasks was unexpected until I considered those results in the context of the literature by Māori psychologists. The relevance of these findings is that cultural competency training needs to highlight that the material should be used as a part of everyday practice.

I noted previously that psychologists practiced with Māori in ways that were not taught to them in clinical training. This raises questions about where they learned to do those tasks, and whether they would be considered "safe" from a Western perspective. Alternatively, would their practice be considered safe from a Māori perspective?

Māori have traditional rules (tikanga) and monitoring processes to ensure that cultural practices are used by the appropriate people at the right time and context. It appears that Māori psychologists are aware of the lack of support within psychology for the use of distinct processes for Māori and attempts are regularly made to address that issue (Herbert, 1998; Hirini & Nairn, 1996; Lapsley, Nikora, & Black, 2002; Lawson Te Aho, 2002; Love & Waitoki, 2007a; Milne, 2005; Paewai, 1997; Palmer, 2004; Paterson, 1993). The presence of distinct forms of practice and the everyday aspect of psychologists' typical tasks suggest that a form of Māori psychology is present that should not go unnoticed.

Before I discuss this idea further, I would like to remind the reader of my earlier argument about the clinical-cultural distinction in psychology because the assumptions underlying the distinction create barriers to the possibility of a Māori psychology.

Clinical-cultural distinctions

The training needs analysis provided an opportunity to position the typical tasks that psychologists performed within their cultural context. As I identified in study two, Māori processes (e.g., whakawhanaungātanga, mihimihi, or karakia) and culturally-informed clinical processes (e.g., sharing power, conducting a standardised clinical interview or using psychometrics) were used with clients.

When I organised the tasks, I found that the Māori-cultural tasks were used to effect cognitive or behavioural change in clients. I argue that those processes are therapeutic psychological processes within a Māori framework of understanding and meaning and that they should be considered Māori psychological processes.

For example, karakia and te reo/Māori language were used to settle clients and whakawhanaungātanga was used to establish rapport and obtain information about clients' presenting problems.   These are psychological tasks. There is no reason for Māori-cultural processes to be viewed as non-psychological in preference for Western psychology as is often the case when distinctions are made between clinical and cultural.

Suaalii-Sauni and Samu, (2005) took a slightly different position on this issue. According to their view,

> Cultural skills and knowledges refer to those skills and knowledges that are relevant not only to understanding the ethno-cultural behaviours and beliefs of Pacific service users (and where necessary those of their Pacific families or community), but also to understanding those behaviours and beliefs associated with being part of a service, organisation, sector and/or profession.
>
> Clinical skills and knowledges, on the other hand, refer to those skills and knowledges that are relevant to understanding the diagnostic and treatment aspects of working with Pacific service users. This includes those diagnostic and treatment approaches specific to Pacific models of caring for MHA service users and those specific to mainstream (p. 32).

Suaalii-Sauni and Samu's definition of clinical is interesting as clinical skills and knowledge are defined on the basis of its relevance to working with Pacific groups. In this definition, cultural competency (as we understand it) is included in the term clinical and relates to diagnosis and treatment within Pasifika models of health. To be considered clinically skilled, one must be culturally skilled within Pasifika service users' cultural mores, beliefs, values and practices.

The writers say that the client's problem may be viewed with a clinical or cultural lens yet their definition of clinical competency is imbued with cultural dimensions. I was left wondering whether the undefined, default non-cultural position is the 'clinical' position. A limitation of not defining the supposedly non-cultural, clinical position is that Western cultural values continue unexamined.

Suaalii-Sauni and Samu (2005) perpetuate the assumption, as do others that the term clinical does not need to be defined because it is common, and taken for granted. They rightly argued that cultural competencies should be part of clinical competency, but they missed the opportunity to promote a Pacific psychology and possibly gave away their processes under their definition of clinical. Essentially, if clinical skills and knowledge rely on an understanding of cultural processes and Pacific caring models, then the resulting competencies and practices are a form of Pacific (or indigenous) psychology.

Similarly, I argue for a Māori psychology. This is a psychology in which distinctively Māori cultural practices can work independently, or work alongside other clinical practices which are not distinctively Māori (such as Western or Pasifika forms of psychology). The evidence for a distinct psychology for Māori was more apparent when I conducted the critical incident technique.

Critical incident technique

The CIT technique has evolved from being primarily task-oriented to being used as a qualitative, exploratory tool that is more focused on the incident and on capturing the thoughts, feelings and beliefs about what was done and its outcome. The crucial aspect is to ensure the entire content domain of the activity in question has been captured and described (Butterfield, 2005, p. 479). In this study, the focus of the CIT was on the beliefs and outcomes which provided an opportunity to identify what psychologists did in their work with Māori, and to break down those tasks to obtain training material for students.

The critical incident technique (CIT) has been used in other studies aimed at identifying psychological, medical, mental health and social work training needs but at the time of this research, it had not been used to identify cultural competency training needs. The model as a research tool appeared at a time when positivism was the dominant paradigm in scientific enquiry (Chell, cited in Schluter, p. 483). Flanagan (1954) was perhaps ahead of his time when he developed the qualitative aspect of the CIT within a quantitative framework.

The steps that Flanagan proposed the researcher follow are consistent with qualitative research characteristics (e.g., natural setting, researcher as key instrument, inductive data analysis, participants' meanings, emergent themes, theoretical lens, interpretive enquiry, and holistic account (Cresswell, 2009, p. 175-176; Schluter, 2009). A notable feature of the CIT methodology is the ability to create categories. When I followed Flanagan's analytical process I found that the categories I initially produced lacked context and decided to adopt a more in-depth, exploratory approach.

Schluter et al's., (2008) review of the CIT literature found that researchers employed qualitative research techniques such as content analysis, grounded theory, or descriptive phenomenological approaches. By using a thematic analysis I was able to identify categories that provided depth and meaning to the data which was helped by the richness of the stories that the psychologists provided.

The qualitative approach also enabled me to deviate from the standard CIT procedure in two ways: I positioned the psychologist as the authority on his/her stories; and I was explicit about the theoretical lens I used to analyse the data. The lens was particularly relevant as it provided training material and identified process issues related to conducting training. In particular, there was a need to manage the programme material to minimise the potential for cultural appropriation.

Subject-matter experts – collaborative research

In the training needs analysis (TNA) literature, subject-matter experts are used to provide the initial data about particular training needs, and a second group of subject-matter experts verify the findings obtained from the first group. There were a few issues in this study that limited the use of subject-matter experts that related to sampling (there were not enough psychologists to choose from) and the lack of credible experts who could judge the suitability of the results from the CIT.

As far as expert knowledge goes, it is not known how many psychologists are competent to work with Māori because the question has not been asked. The assumption is that most psychologists are not competent because

Universities do not provide the necessary training. From a kaupapa Māori perspective, there are systems in place that provide legitimacy for Māori cultural processes which I discuss further when I argue for a distinct Māori psychology.

In relation to the status of subject-matter experts, I relied on the psychologist to identify whether they were experienced, and to provide the most reliable accounts of what they thought was important for working with Māori. I valued their experiences and used their knowledge and my own to validate the outcome of the critical incident technique. The collaboration also helped to address the potential for me as a researcher to assume expert knowledge over the data as it was gathered (Bishop, 1999; Pitama et al., 2007).

I chose to utilise the experience of the psychologists in this study by asking them to determine and judge the importance of the AKSs in their scenarios. In this way I capitalised on their status as subject-matter experts and as active research participants, to provide descriptions of how to work with Māori. I positioned the psychologist as the expert on his/her behaviour so they could clarify and expand on the scenarios in their words, and so that they could see the complexities of their work with Māori. As experts they helped to minimise the potential for any biases I hold to negatively influence data interpretation.

With regards to judgment and decision making I omitted the step of asking a second group of subject-matter experts to validate the tasks and training objectives. I did this because there were very few credible subject-matter experts who could act as judges and because of resistance within psychology to biculturalism and Māori processes. There were potential risks in asking a group of randomly-assigned experts to rate the importance, or not, of the tasks that were generated from the CIT.

There is sufficient evidence in the literature to suggest that if I followed that process I risked having the data invalidated by those who may not recognise the importance of Māori processes. It was also likely that the Māori processes that might have been validated would be those that posed no

challenge to the dominant clinical model, or that provided only ceremonial value to Pākehā (Durie, 2004).

To avoid some of the pervasive influence of monocultural psychology and society on this research, I incorporated the judgments of the participant-psychologists as subject-matter experts, (as I described earlier). I also used my own knowledge about psychology and Māori culture and the literature provided by Māori writers in the field. A further layer of validation came from the theoretical lens that I followed.

The theoretical lens

Although I followed a Western model in developing the training programme, I deviated from the method by incorporating a kaupapa Māori theoretical lens in how I collected and analysed the data. Kaupapa Māori methods of validation are equally relevant as they align with the aims of the study and the practice standards of the psychologists. Inherent in the kaupapa Māori approach is a challenge to the dominant discourse that privileges Western ways of knowing that is intrinsically linked to imperialism and colonialism (Bishop & Glynn, 1999).

The theoretical lens incorporated a kaupapa Māori perspective that sought transformation and emancipation for Māori; and education and change of practice for Pākehā (Bishop, 1999; Bishop & Glynn, 1999; Pihama, 2001; G. Smith, 2003; L. Smith, 2000). To achieve those goals, the research was designed within a social, historical and political framework that took into account the relationship that Māori have with the dominant Pākehā group and my worldviews as a Māori, female, researcher. An understanding of personal dynamics is central to my position as a researcher and also underpins the effectiveness of cultural competency training and practice.

The CIT as a qualitative, phenomenological tool has different requirements for validity to those necessary in quantitative approaches (Butterfield, et al. 2005). Although I deviated from the standard procedure, the validity of the data collection and analysis was not compromised because I triangulated the results with the literature review and the psychologists who consistently reported similar awareness, knowledge and skill competencies. In doing so, I

attempted to reflect an understanding of how my expectations shaped the research process. Chells, argued,

> Therefore it is critically important that the researcher examines his/her own assumptions (and predilections), considers very carefully the nature of the research problem to be investigated, and thinks through *how* the technique may most appropriately be applied in the particular researchable case (Chells, cited in Butterfield, et, al. 2005, p. 483).

The process of determining *how* the technique might be applied was formed in conjunction with the values underpinning the theoretical lens. The critical incident technique methodology analysis asked a very simple question: what awareness, knowledge and skill do you think a student needs to do what you did with your client? In using the theoretical analysis process, I obtained a large amount of information from seemingly small tasks through to complicated and difficult tasks. For example, Jean described what looked like a simple task when she talked about how she attempted to pronounce her client's name correctly.

In her description of the scenario, Jean said she noticed that the multidisciplinary team made no effort to make the client feel comfortable and that he was unsettled in their presence. The awareness, knowledge and skills obtained from Jean's scenario showed that rote learning alone did not take into account the socio-political experiences of Māori and language use. When considering the multiple influences on language needed to do that particular task (correct pronunciation), the necessary AKSs go beyond superficial competencies to addressing systemic processes that preclude or support using correct language in the first place.

Examples of systemic processes relate to deliberately or unknowingly discriminating against Māori by not being cognisant of their specific needs. The discrimination shown towards Jean's client was evident when the multidisciplinary team ignored him and made no attempt to engage with him, or pronounce his name correctly. For some people it is relatively simple on a physical level to pronounce a person's name correctly. Despite this, in monolingual Aotearoa/New Zealand, mispronunciations are common due to

an inability to form the tongue around certain sounds or resistance to correct pronunciation. An everyday micro-aggression for Māori is often centered on language and how it is controlled and used by the dominant group. The results from study two highlighted the need to focus training on this issue.

Cultural competency, social justice and kaupapa Māori principles draw attention to the social and political implications of accurate and inaccurate pronunciation and the power of language to marginalize or empower groups. There is evidence of the unpleasant reaction by some members of Aotearoa/New Zealand society when it is suggested that original Māori place names are reinstated, or when Māori language is spoken on mainstream television during Māori Language Week.

The theoretical lens was applied to each level of analysis which I believe is a more accurate reflection of the necessary awareness, knowledge and skills underpinning the tasks that the psychologists performed. In relation to the development of training needs, the critical incident technique provided results that were consistent with the literature on cultural competency education. Those results were made explicit when their relevance was clearly defined and linked to outcomes. The importance of those linkages was seen following the analysis of the scenarios and the development of the awareness, knowledge and skill (AKS) categories, the themes and the competency statements.

When the critical incident question highlighted more complex scenarios, diverse competencies were identified that foreshadowed the difficulties of teaching students Māori processes. Some of the scenarios produced complex awareness, knowledge and skill training needs that created ethical dilemmas for this study. For this reason I argue the importance of making strategic decisions to not include some material in the teaching content.

The theoretical lens lays the foundation for how the data was analysed and also how it should be used in a culturally appropriate manner. My view is that research conducted for Māori should benefit Māori and be controlled by Māori unless the research partners or recipients of that research are able to work within a Tiriti/Treaty framework (Smith, Bishop & Glynn, 1999;

1999b). As I argued earlier, my decision was influenced by the risk of cultural appropriation and my status as a cultural novice.

Cultural appropriation of research results

The mix of science, cultural arrogance and political power continues to present a serious threat to indigenous peoples (Smith, 1997, p. 99).

The dangers of cultural appropriation became evident in the CIT analysis phase and the teaching phase, and related to: (1) my lack of experience in working with complex Māori processes; (2) the problem of following a research methodology without knowledge of the benefits, or wider consequences for Māori; and (3) whether it was appropriate to teach students about complex or tapu Māori processes.

Smith (1997) argued that due to the structure of Māori society, its unique world view, and its strong oral tradition, Māori knowledge was "never held to be universally available" (p. 172). Knowledge could not simply be handed over without considering the merits of the potential recipient. Manihera (1975) was unequivocal in his belief that some forms of knowledge were tapu and that by giving it away it would be commercialised and made common. He added that "knowledge that is profane has lost its life, lost its tapu" (p. 9). The reality for Māori is that a great deal of their knowledge has become common, and has lost its life.

Although I could have analysed all the complex scenarios and produced a range of AKSs, I considered that I would do what Māori elders (Manihera, 1975) feared would happen to Māori knowledge. I would be handing over knowledge that I do not really understand to people who do not value it. I had a real concern that some of the work the psychologists did was beyond the abilities of students, or mainstream universities to manage appropriately. Māori knowledge is often misused by non-Māori and by Māori and for that reason there must be safeguards in place to minimise any risk to Māori and students.

I was concerned about the potential issues that may arise if I analysed all the data, and if I did, how the results might be used. I was a cultural novice looking to obtain bicultural training material for students within a mainstream institution, in a limited timeframe.

When I did further analyses, I found that some of the AKSs were too complex for me to describe easily and I did not proceed any further. The principles underpinning the kaupapa Māori theoretical lens provide a framework for considering the ethics of conducting research that may not benefit Māori (Smith, 2003; Bishop & Glynn, 1999). In doing so I recognised my limitations in working with esoteric Māori processes and acknowledge that such knowledge should be handled carefully.

Although not all the tasks were complex, they still warranted risk management. Seemingly basic tasks took on complex dimensions that could have an impact on clients when they are performed by others. For example, scenario 55 below highlights the importance of recognising the depth of analysis that was required when I/we went through what the psychologist did.

> Scenario Using Whakatauki/Karakia to Explore Māori Identity Situation 55: Male psychologist, Māori, (aged 33).
>
> Outcome: Client liked the metaphor of bookends and agreed to clinician finishing the session with a whakatauki. At the next session the client commented that she appreciated this process and that after she left the session she felt "really good" which was not usually the case after she had been discussing this kind of material. She requested that whakatauki and karakia be used at every session. This also became an avenue through which the client began to explore and acknowledge her Māori identity more strongly.

The layers that unfolded in this scenario show that what initially started as a mechanism to soothe and settle the client's distress soon became a tool to explore her Māori identity. The psychologist skilfully negotiated with her to use Māori processes despite her earlier reluctance, and showed how karakia and whakatauki can be used in multiple ways. With regards to training outcomes, how much 'buy-in' does a psychologist need when they perform pēpeha, mihimihi, or karakia? If emancipation for Māori is to occur,

psychologists need to understand the complexities that underlie Māori processes.

My concern is focussed on the likelihood that the Māori processes would be used in a naive or careless manner. The lens that Western psychology uses to understand the meaning and purpose of Māori processes may not produce accurate representations and meaningful outcomes. A student may know a karakia, but they should also understand a Māori worldview of karakia, and the role that religion may have in the lives of their clients.

I chose to leave the complex training needs that emerged from the data because I do not have the experience to unpack their full meaning. I could also have gone to a cultural advisor, or kaumatua, but that would place me at risk of criticism and disapproval. Māori who train in mainstream universities already face condemnation for being indoctrinated (Milne, 2004) and I would be seen in the same light. I was apprehensive about how psychology processes Māori knowledge and I did not wish to jeopardize the integrity of that knowledge by teaching it without approval or appropriate support (Glynn, 2007).

As a cultural novice, Māori esoteric processes, spiritual encounters and many levels of Māori knowledge are beyond my experience or comprehension. As I outlined in my positioning statement, I was not exposed to Māori language, Māori whānau, or Māori protocols in my formative years. Since learning to speak Māori, and raising children who speak Māori, I know now that Māori knowledge about language, spirituality, arts, healing, lore and law, marae, hapu, iwi, and whānau are gifts that should be cherished. My status as a cultural novice increased the risk that I would misuse this research to the detriment of Māori. Pewhairangi exposes the dangers involved in disseminating Māori knowledge to Pākehā:

> When you learn anything Māori, it has to be taken seriously. It involves the laws of tapu…Tapu is something that teaches you how to respect the whole of nature, because Māori things involve the whole of nature (Pewhairangi, in King, 1992, p. 10–11)

I do not propose that Māori versions of reality and behaviour are more real than Pākehā versions. What I argue is that Māori have a version of reality that is no less real than Pākehā versions. I recognise that Māori knowledge is precious not only because of esoteric forces, whakapapa and whānau values, but because Pākehā have an imperial history of appropriation to further their economic and political position.

I chose to teach the material from the CIT that aligned with the established literature on bicultural training, and the cultural competency literature. In doing so, I safeguarded my integrity and I limited the exposure of Māori knowledge and practices to avoid misuse. Bishop and Glynn, (1999) argue that Māori knowledge and practices are redefined and commodified by Pākehā at the expense of Māori. They posited that Māori have the right to define what they consider taonga,

> those things that explain and make sense of their world, which the world gives to nurture and protect them and which give spiritual or artistic expression to their sense of being' (Jackson, cited in Bishop & Glynn, 1999, p. 26).

The right to define what is taonga in relation to the development of a Māori psychology is described later.

Summary

Although the task analysis formed a small part of the study and provided only contextual information, the intention was to identify the typical tasks psychologists performed with Māori clients and to link those tasks to the awareness, knowledge and skill competencies. I found that psychologists worked differently with Māori clients which provided the rationale for the development of a training programme that reflected the diversity of that work. In order for Māori-cultural processes to be recognised as a form of psychology, it was necessary to distinguish between 'clinical' tasks (which I have called Western-cultural) and Māori-cultural tasks.

The critical incident technique provided the basis for identifying exactly what psychologists did with Māori clients that worked, or did not work so that

specific training needs could be identified. The findings from that study support my premise that training programmes need to do more than implement ad-hoc bicultural content if students are to be adequately prepared to work with Māori. Another finding was that the Māori-cultural processes were used in ways that support the evidence for a distinct Māori psychology. If Māori are to attain autonomy and respect for their knowledge forms, they need to be recognised as equal contributors to psychological education and practice.

The structure of training is also a major factor that I discuss in the next section.

Evaluation

Evaluation Framework

I argued earlier that clinical programmes need to develop ways of identifying whether they prepare students to work with Māori. In this section I discuss the usefulness of the evaluation framework, the influences on training transfer, the relevance of cultural case conceptualisation ability, the characteristics of the students as learners and the ideal programme. I proposed that evaluation during training and assessment of cultural case conceptualisation ability were useful ways of measuring competency. I identified whether the participants acquired the core components of the workshop through observation of their performance during training and an analysis of the pre, post and retro questionnaires within Kirkpatrick's (1987) and Alliger, et al's, (1997) evaluation framework.

Clinical programmes lack a comprehensive system of identifying whether teaching methodologies are effective for teaching cultural competency. Despite the limitations of this study (especially the small number of participants) the evaluation framework that I used provided a way of teasing out the components of learning acquisition that could be used in clinical training. The framework was helpful in organizing the data from the questionnaires and for this research that was where I saw its value. The framework focused the participants' responses so that I could make

judgments about their meaning in relation to training outcomes, in particular, training transfer.

In considering this framework, I note that I am looking to sift through the layers to identify if the levels (reaction, learning, behaviour and results) can be used to show whether students can work appropriately with Māori. From a practical perspective the framework's potential lies in identifying the interrelationship between each of the levels. For example, did the participants value what they learned in the workshop, has that learning transferred to the workplace, and has the new behaviour had an impact on results in the workplace?

Wexley (2002) maintained that utility reactions are more closely linked to training transfer than affective reactions. The reactions level allowed me to identify what participants thought about training such as whether students believed that the material was useful for them and for clients. I found that students who were positive about the benefits of training engaged more quickly with the material, while those who disagreed with, or disliked certain aspects, were more resistant and wanted training to suit them. The results from the latter group of participants were consistent throughout the workshop and indicate a cognitive style that I believe influences the extent to which their learning is shaped and used.

In relation to learning and behaviour levels, most of the participants showed that they had learned the material and were able to demonstrate that learning during the workshop. I watched some of them show that they had learned to critically analyse key issues that affected Māori and to integrate the information with mixed results into a cultural formulation.

From my observations during the workshop I noted that the participants completed the exercise successfully at the time, but there was no guarantee that they would transfer that learning to the workplace. It is an interesting irony; without the learning experience they would have nothing new to carry over into the workplace and are more likely to use their standard clinical training. As I showed in the literature review, experienced psychologists

defaulted to using clinical training instead of using cultural competency training (Downing-Hansen et al., 2006).

As I noted earlier, evaluation researchers agree that learning and behaviour are linked, but they do not agree that learning is a prerequisite for training transfer (Tannebaum & Yukl, cited in Winfred, et al., 2003, p. 235). It is also recognised that behaviour is subject to environmental influences (Salas & Cannon-Bowers, 2001). The participants were likely to have been influenced by the training environment including my presence as the trainer, peer relationships, the programme staff and concerns about negative feedback.

Training transfer

The evaluation framework allowed me to make judgments about where learning occurred in relation to the central issue: did the training transfer and what were the results? When I speculated on the variables that determine whether students will transfer their learning to the workplace I agree that the levels in Kirkpatrick and Alliger's frameworks help to identify whether training transfer will occur. On the other hand, in cultural competency training, reactions and organisational support play a greater role than previously assumed.

One of the determining features of training transfer is that the organisation must support the trainee to implement what they have learned in training. The evaluation literature has not fully discussed the effects of institutional racism on training transfer, but I suspect that the influences are similar to what is seen in psychology departments: apathy, resistance, timing constraints, philosophical differences and lack of resources. The degree of belief in the effectiveness of a culturally-focused training programme is also likely to influence transfer.

When an organisation implicitly and explicitly privileges one worldview over another, students are sent a very clear message about whether they will be supported in training. In the questionnaires, I touched on the organisational factors that may have an impact on training transfer when I asked the participants to describe what would support them using their learning. All of the participants commented that they needed support from academic staff

and support from their supervisors in the workplace. They also commented that they viewed their status as inexperienced juniors as a barrier to their ability to advocate for cultural competency.

Students need support when using Māori cultural processes and practices during clinical training and the workplace. The extent to which they will become proficient is influenced by their level of confidence and their belief that they will be mentored and guided in their learning. This is true for any part of clinical training. However the difference lies in the content of that training as it is fair to say that when it comes to Western clinical training, there is almost no resistance to learning and considerable support for training transfer. When Māori content is used, resistance and reluctance appears in a variety of forms.

As a lecturer and psychologist I found that students had little difficulty transferring Western psychology to their workplace. However, there was no guarantee that the bicultural content they learned in class would also transfer. Students still used Western material despite being taught about Māori processes. This may be due to their status as novices and a lack confidence, or because they may not believe that the material will be useful to them.

There can be little doubt that monocultural Pākehā values are infused in training to the extent that Western psychological knowledge is taken for granted while Māori knowledge is viewed with suspicion and doubt. The suggestion here is that Western psychological knowledge is imparted and supported in such a way that students readily believe in its effectiveness.

The training evaluation literature is also silent on how to minimise the personal harm that is caused by colleagues and seniors who fail to engage with the training programme. One of the participants, Tuts, was deeply offended that her student colleagues did not participate in the training programme. In her opinion, their lack of interest and the programme's inability to take a stand on their training was evidence of racism and incompetence. Tuts described her position as Māori in the context of a Pākehā institution with predominately Pākehā colleagues as culturally

alienating and depersonalizing. She mirrored the experiences of many other Māori psychology students who endure clinical training because they genuinely believe that in the end, they can help their people.

The framework does not stand alone as a measure of learning. I observed the participants during the training programme and I was able to add another level of analysis based on their responses on the questionnaires. I can say very little about the value of the framework for assessing whether training was effective because of the lack of data. I do not think that the evaluation framework told me anything new about whether a particular student had acquired the necessary awareness, knowledge and skills to work with Māori.

Cultural case conceptualisation

The case conceptualisation component from study three provided limited information from which to draw conclusions. Despite the drawbacks, there is still value in discussing case conceptualisation as a part of cultural competency training evaluation. In my hypothesis I argued that ability to conceptualise a client's problem using cultural variables was an indicator of cultural competency. Case conceptualisation as a general psychological task is difficult to learn because of the complexities involved in integrating variables and making judgments.

The case formulation is dependent on professional judgment which is subject to personal and academic bias (Garb, 2005). Cultural case conceptualisation requires meta-judgment, integration of facts and hypothesis, and critical thinking about a client's problems and goals within the cultural worldview of the client. For those reasons, it is important to spend time dealing with the biases that participants may hold as those biases influence whether students are receptive to learning and whether they will carry that learning into the workplace.

The participants needed more time to process personal values and assumptions about Māori and Pākehā relations in Aotearoa/New Zealand so that they were flexible in their thinking about the issues that are relevant to Māori. These findings are consistent with Evans and Paewai (1999) who commented that everyday knowledge of how people function and specific

cultural knowledge are the hardest elements to incorporate into a functional analysis.

Collie and Ward (2007) recommended that case conceptualisation is structured so that errors of judgment are minimised. I provided the participants with two templates for developing a case conceptualisation – the *culturally informed functional assessment* (Tanaka-Matsumi, Seiden, & Lam, 1996) and the checklist from the functional assessment developed by Evans and Paewai (1999). We also used Rebecca's case study and the training material to practice writing a case conceptualisation for her problem.

By using Rebecca as an example, I inadvertently developed a framework for writing a case conceptualisation that was easier to use than the ones described above. I did not write the framework down, and it was not part of the planned content. The participants commented that they understood the relevance of the training material when it was described within the context of Rebecca's story. The framework seemed to develop naturally from the structure of the workshop as I worked through the topics and summarised the material in relation to Rebecca's case. There is potential for this framework to be used in future research.

In relation to the case conceptualisation skill, the participants appeared to grasp the theory of what was required, but they lacked the practical skill. I suspect that the cultural case formulation was too difficult for participants to learn in a two-day workshop, particularly, as a number of topics were covered. Without a doubt, there is a real need for students to learn cultural formulation over an extended period, with a variety of opportunities to practice.

After conducting this study, I have come to the conclusion that training programmes benefit some students, while others require more time and different experiences to help shift long-standing assumptions. The change process for the later group requires a lot more than a one-off, two-day programme. For some, personal exposure to racism as experienced by ethnically different family or friends may be the catalyst needed to see how privilege and injustices operate in society. The participants in study one and

three displayed characteristics that I believe influenced their learning and the learning of others.

The psychology of students as bicultural learners

Due to the nature and content of cultural competency training most students present in certain ways that give a fairly good indication of their suitability to work with Māori. Perhaps it is human nature that cannot be easily explained but when certain topics are raised, some students react in ways that indicate rigid cognitive assumptions.

The pilot and the final programme provided insight into a range of possible qualities of students who may be more amenable to cultural competency training. In recent years, clinical programmes have modified their selection criteria to screen students, but more could be done to ensure that they are already engaged with biculturalism.

One of the tasks I undertook as a former lecturer was the selection of students who were receptive to bicultural training. In my teaching experience, there is usually a protagonist and an antagonist who debate and argue the validity of biculturalism. The learning opportunities are there for both parties. Given the scarce resources and the high possibility that the antagonist will retain his or her views, early identification of who might benefit from training is important.

I have noted that there are three types of student learners; some students were open and flexible about bicultural material (the protagonist) and others were defensive, closed-minded and disruptive (the antagonist). The third group "sits on the fence" and does not offer any opinions.

Students who are open-minded benefit from defensive students as they provide additional training for real-life encounters with clients who may present the same way. Similarly, defensive students are exposed to careful, critical thinking that challenges their assumptions and at times their views are changed. The third group inadvertently maintains the dominant monocultural discourse by remaining silent during critical discussions.

In training and selection, defensive students can be the most difficult to educate about cultural competency training. They appear unconcerned about their learning style, are self-focused and unaware that they alienate or hurt their peers. In study two I described the importance of identifying whether training was necessary and for whom. Students should be able to demonstrate that they engage with the training material, they should critically analyse difficult and challenging material, and their learning should evolve.

I argue that training transfer is influenced by cognitive learning styles and that some students are harder to teach than others because they come to training with a set of assumptions and values that, depending on the level of entrenchment, can be difficult to shift, in particular, when it comes to cultural issues.

In this study, I found that students who were open-minded were able to build on the knowledge and skills they acquired and use it as the programme developed. Students who exhibited a passive and defensive style struggled with the material and asked typical (or standard) questions about the relevance of Te Tiriti/The Treaty, (e.g., why there are scholarships for Māori and not for Pākehā, and why Māori do not put the past behind them). As I noted earlier, if these issues were dealt with in undergraduate training, I would have had time to discuss more complex issues.

Having said that, I have taught at undergraduate level and some students can be defensive when they perceive they have been unfairly treated compared to Māori. I do not think there is an easy answer to this situation as students are affected by the opportunities they have had in their lives. Sometimes a structured, flexible teaching approach is the first step to assist defensive students to shift in their thinking. The shift may occur during training or at a later time, much in the same way that clients benefit from therapy several years after therapy has concluded. Timing may be the key to cultural competency training.

The path to cultural competency begins with attitude, not knowledge or skills. Although, knowledge influences attitudes, knowing about something

does not mean that the learner will have positive attitudes. The antagonist, more often than not, cannot help making unhelpful remarks that show their views about Māori and Pākehā relations. In contrast, participants who have positive attitudes, an open-mind and show willingness to learn about new cultures may be better prepared to embark on the journey towards cultural competency.

Research Implications

In chapter four I described my basic understanding of kaupapa Māori theory. I use the term basic because I did not fully comprehend the depth and breadth of the theories generated by Māori academics primarily located in the discipline of education. In that respect, I recognise that I must first liberate myself and consider whether this thesis contributes to liberation for Māori and shared responsibility for Pākehā, or whether it maintains the status quo.

My perception of kaupapa Māori, while well-intentioned, lacked a deep understanding of tikanga Māori and a framework from which to position Māori worldviews. I humbly acknowledged that I viewed clinical psychology as valid for Māori albeit with some modifications. Since conducting this research I have come to view the current position of psychology as antithetical to Māori aspirations.

To facilitate my understanding of the implications of this research, I chose to position the conclusions within a kaupapa Māori framework from which to describe the relevance of this research to clinical training programmes and ultimately to Māori. The framework provides a mechanism that when followed limit the potential for cultural appropriation, or marginalisation of Māori knowledge. The framework also ensures the needs of Māori are met and protected in the spirit of Te Tiriti o Waitangi/Te Tiriti.

The kaupapa Māori principle of 'self-determination and autonomy' is relevant for this discussion because any cultural competency training programme that seeks to advance Māori participation in psychology needs to recognise the role of Māori. Māori self-determination is related to 'being Māori'; is

connected to Māori philosophy and principles; takes for granted the legitimacy of Māori; and the importance of Māori language and culture. Self-determination is also concerned with the struggle for autonomy over our own cultural well being (Smith, G, cited in Smith, 1999, p, 185). By focussing on Māori autonomy I ensure that Māori process are not grafted onto Western processes without recognising their origins and to create space for an indigenous psychology.

My contribution to the psychological literature is to ensure that Māori aspirations of self-determination are characterised throughout future uses of this research. Although the training programme could be used as it is, Māori involvement will be limited to the add-on position. In this respect, I propose that the programme could be strengthened by recognising the contribution of Māori worldviews to psychology and by extending the amount of time allocated to run the programme.

Some of the limitations of this research are the result of timing constraints, and the small sample size. The participants had no choice in the amount of time allocated for training as that decision was made by the clinical programme staff. In relation to sample size, at the time this research was conducted there were seven clinical programmes. Of that number, two formed the pilot programme, two were the test programme, I taught at one and the other was too far away. I considered having a control group but none of the remaining universities wanted that role.

Another limitation was the lack of consumer input into the cultural competencies. If I were to take this research further I would focus the evaluation on triangulating with clients, psychologist and supervisor. Another limiting factor was that interns were not seeing Māori clients. In regards to triangulation, there is increasing research that uses clients to verify the effectiveness of treatment and the competencies of psychologists. This is a non-threatening way to ask clients to comment on elements of therapy without placing them in a difficult situation of having to manage their wellness and potential concerns about the effect of commenting on their psychologist. I consider that consumers were involved in a small way via the

scenarios and the literature review; in actuality their absence leaves a gap in the research.

A unique Māori psychology

As I worked through the data it occurred to me that the material on Māori cultural processes needed to be recognised as a viable Māori-centered psychology. I found compelling reasons to create space for Māori within the academy by defining and claiming Māori processes.

The idea of a distinct Māori psychology arises from the view that Māori aspirations and self-determination are critical to achieving a better position for Māori in society and to ensure that Māori are competitive players in the psychological arena. Durie (2003) commented that the development of Māori-centered approaches to therapy is in part due to dissatisfaction with the principles underlying mainstream models. It is apparent from the literature that Māori are not entirely happy with mainstream models of therapy.

The contribution of the training needs analysis to a Māori-centered psychology can be seen in the psychologists' descriptions of the typical tasks they performed with Māori and the nature of those tasks. I identified that Māori psychologists used non-Western psychological processes in their work with Māori. Those psychologists appeared to have struck a balance between the two competing worldviews and cultural practices. They also challenged Milne's (2005) research findings about Māori who go into University and come out thinking like Pākehā.

Building on my challenge to the distinction between cultural and clinical, I argue that many of the cultural tasks that the psychologists performed, and the associated awareness, knowledge, and skills required to achieve those tasks, were based on processes that can be viewed as psychological. I organised the typical tasks that psychologists described involving any aspect of Māori-cultural practice into a separate category and presented those tasks as *Māori-cultural processes*. The separation from Western-cultural processes enabled me to identify Māori knowledge and processes in a psychological setting.

The distinction is important as it is not known whether the psychologists might have been successful if they did not use Māori-cultural practices. An opportunity exists to highlight where Māori-cultural psychological processes occur (or can occur) in the therapeutic relationship to build on an indigenous knowledge base. Smith (2003) argued that indigenous theorizing is needed to transform Māori from the position of oppressed to self-autonomous, and to challenge the "grip of hegemony" (p. 3). The notion that Māori psychology exists as a viable addition or alternative to mainstream psychology requires acceptance that Māori theorizing and practice can be defined by Māori.

The broader principles that underpinned some of the Māori cultural processes occur across many cultures, (e.g., manaakitanga/hospitality, karakia/prayer) but they are not typically seen in standard clinical practice. The psychologists in this study used a range of Māori-cultural processes with their clients including: whakawhanaungātanga and assessing identity, iwi, hapū, whānau links. They also used te reo/using language, pēpeha, mihimihi, karakia, pōwhiri, poroporoaki, whakatau and waiata. These processes were used to heal clients and their whānau.

The psychologists also used established Māori models of health and therapy to guide their practice: Te Whare Tapa-Wha (Durie, 1994), Te Paiheretia (Durie, 2003), Te Pae Māhutonga (Durie, 2003), Te Wheke (Pere, 1994) as well Māori mythology and folklore. The literature review showed that whakawhanaungātanga or aspects of the whānau concept was commonly employed to establish trust and build relationships (Bennett, 2009; Herbert, 2001b; Huriwai, Robertson, Armstrong, Kingi, & Huata, 2001; Macfarlane, 2008; Paewai, 1997). Additional processes such as tangihanga, whakamōmori and poroporoaki are also used to help clients.

Herbert (2001b) showed the applicability of Māori concepts by incorporating aspects of whakapapa, whānaungatanga and āwhinatanga with standard cognitive-behavioural models to produce a culturally adapted parenting programme for Māori parents. Māori psychologists in this research also used processes with their clients that originated in a Māori worldview. The concept of whakawhānaungatanga was particularly common.

Durie's Te Paiheretia (2003) model uses tangihanga and pōwhiri as a healing encounter for Māori who are seeking to establish their cultural links. Tangihanga used as a healing method "can be catalytic, evoking images, thoughts and emotions which have hitherto been suppressed" (p. 53). Durie added,

> the fact that the whole process (tangihanga and pōwhiri) are based on Māori language, philosophy and social organisation supports a positive cultural identity and adds to the emotional and spiritual experiences (p. 53).

Not all tangi are positive and uplifting experiences for Māori but neither are some Western psychological therapies. I highlight here what Durie and others argue, that Māori therapeutic processes exist and they can heal Māori clients. A further example, can be seen with Māori researchers at the University of Waikato who have been exploring the use of tangihanga as a therapeutic process in times of grief (Nikora & Te Awekotuku, 2009).

In relation to theory building, the Māori concepts identified in this research have the potential to contribute to psychological knowledge because they were used regularly to modify and influence the behaviour and cognitions of clients. Western rules about how theories are generated and scrutinised are less important as I attempt to build my theory from a value system from a Māori perspective.

Smith (1997) argued that the Western academy constructs the rules about theorising and has silenced the voice of the indigenous scholar. Smith (2003) believed that transformation has to be won on at least two broad fronts; a confrontation with the colonizer, and a confrontation with `ourselves'. For Māori to gain space in the academy while adhering to aspirations of emancipation, they must overcome the influence of the 'captive-mind' and 'brain-washing' and position themselves as legitimate researchers.

The theorising journey for indigenous researchers begins by seeking to have unique Māori knowledge and practices recognised, and the need to prove that Māori knowledge is legitimate, authentic and should belong to Māori. Smith (2003) argued that the critical elements of useful theory and theorizing

are that the theory needs to be useful and it must be viewed as a 'tool' that is useful in the right hands and destructive in the wrong hands.

Theorising also needs to be transformative for Māori; it needs to be adaptable to multiple transforming strategies, and it needs to be accountable to the community (Smith, 2003, p, 5). In keeping with Smith's views about theory as a useful or destructive tool, I have made it clear that I sought to protect portions of the data from misuse. There is place for that unused data in the academy, but it must be managed and controlled by Māori.

I do not advocate a total rejection of Western psychology. Smith (1999) commented that "the general impact of Western research on Māori attitudes towards theory and academic knowledge resulted in some Māori rejecting *all* theory and *all* research" (p. 183). I retained my view that Western psychology can benefit Māori, as long as Māori have the opportunity to influence psychological education and practice. Ted Glynn (2007) described his journey as a Pākehā educator and researcher and made the observation that,

> My journey has taught me that if we want to design effective, professional, development for psychologists who will work with Māori, then we need to look beyond Western-European knowledge bases and cultural practices, and look into those found within Māori worldviews (p. 14).

There is sufficient evidence in the existing literature that psychologists use distinct Māori psychological processes in their work with clients. The task analysis contributed to that literature base by distinguishing where Māori processes were used and the critical incident technique enhanced that evidence by showing how psychologists used those processes with clients and their outcomes.

I consider that this thesis is intended to be transformative for the benefit of Māori communities. Smith (2003) contended that in order to benefit indigenous communities, transformative theory must have the capacity to sustain itself in a context of unequal power relationships, the theories must be sustainable in the face of challenge from colonizing imperatives and from

internal (indigenous) hegemonic forces, and the theories must be owned by, and make sense to indigenous communities.

The ideal programme

An autonomous Māori-centered approach to delivering training programmes locates Māori aspirations, preferences and practices at the center of the exercise, and involves Māori in the design, delivery, pedagogy, management and monitoring of educational initiatives and developments (Smith, 2003). Whānau, hapu, iwi and marae support and validation are also key features of autonomy (Smith, 1993; Durie, 1999). Autonomy/tino rangatiratanga/self determination captures a sense of Māori ownership and active control over the future by planning for the needs of future generations (Durie, 1995, 1999).

Is it possible to have a Māori-centered approach to training that is added-on? Durie (2003) argued that there are multiple pathways to Māori educational achievement and that no one pathway is better than the other. Māori-added pathways need a critical mass, adequate space and sufficient curriculum time to be successful (p. 209). Following my analysis of study two and three, I decided that principles of autonomy are necessary for this programme to be successful in achieving emancipation for Māori.

As I noted in the literature review, the social, political, institutional and personal factors that contribute to and maintain monocultural dominance are resistant to change. Bishop and Glynn (1999) pointed out that where the dominant policy-makers continue to address the challenge of cultural diversity from a monocultural position, they will fail to understand, let alone address, the aspirations of all groups (p. 73).

I have not been trained to deal with Māori-cultural processes, and I do not believe that there is sufficient time allocated in psychology to teach anyone to learn basic, let alone complex Māori processes. Furthermore, I question whether it is in the best interest of Māori to teach students about complex material that is beyond the competencies of the trainer or the institution. The situation creates a dilemma where I argue that while this thesis

contributes to the bicultural training literature, if misused, Māori will be the first to suffer.

When I reflected on the ethics of this research I also considered the value systems of knowledgeable kaumatua and peers who said that knowledge should not be available to everyone just because it exists. I also examined the possibility that Māori cultural knowledge should be earned through Māori defined systems and not 'added-on' to training within a monocultural Pākehā system. I argue that for students to develop a proficient level of cultural competency to work with Māori, they must be taught Māori cultural processes in incremental stages at a tertiary institution.

Western psychological knowledge is deemed important and difficult to comprehend and must be delivered in a staged fashion culminating in a recognised degree. A staged system of learning recognises the complexities of Māori cultural knowledge and practices and positions the learner within a process that values long-term and sustained learning. A staged system could also contribute to Māori aspirations of claiming space in academia and provide a viable alternative to Western psychology.

A cultural training programme could not realistically be taught as a workshop or stand-alone paper. It needs to be infused in all parts of the psychology curriculum so that there is a developmental learning process. Such a process ensures that sufficient time is allocated to teach students to work with bicultural material and provides space for them to work through difficult cognitive and emotional reactions. While there are bicultural courses (or there have been) taught in clinical programmes, they only form part of what is needed for graduates to be culturally competent. The courses could be longer, and they could deal with more complex issues.

Training in Māori therapies could reach degree status in the future. Moeke-Pickering, (2010) reviewed a diploma course in Māori counselling and recommended that the course be located in the Māori Studies department and that the content should reflect: the impact of colonisation, the role of the Treaty of Waitangi, traditional knowledge, and cultural values. She added that the programme should eventually evolve into a bachelor's degree

programme. A Māori-focussed psychology could have the same expectations. Moe Milne's (2005) paper was written to canvass the possibility of developing a kaupapa Māori scope of practice for psychologists. Once students were trained, they could specialise as kaupapa Māori psychologists.

The outcome of cultural competency training is very important from the perspectives of clinical course educators, regulatory authorities, and students. The training needs analysis clearly showed that training goals needed to be matched with content. Clinical programme staff should seriously consider what is needed in their coursework to produce students that would meet the standards of cultural competency set out by the New Zealand Psychologists Board (2007). A quick perusal of the accreditation standards document is all that is needed to highlight the discrepancies between what is taught and what is expected.

Summary

Cultural competency and cultural safety theories and practice have developed over the past 30-40 years to address the disparities between minority and majority groups in the United States, and between Māori and Pākehā in Aotearoa/New Zealand. These theories and practices challenge the relevance of applying Western-based psychology to all cultural groups. Clinical psychology as a target of that challenge has been asked repeatedly to include more cultural diversity in education and practice.

The main proponents of that challenge have been indigenous and ethnically diverse peoples who are not members of the dominant Pākehā, or White ethnic group. Clinical psychology has failed to rise to that challenge in the spirit of genuine power-sharing and respect for diversity. The underpinnings of that failure reside in the value system of the dominant White or Pākehā group who determines legitimate psychological methodology, education and practice.

The literature on the development of clinical psychology shows that the Boulder model, that is, the scientist-practitioner model, was controversial and difficult to implement. Opponents of the model argued that clinical

psychology privileged the worldviews of White, middle class males and the psychiatric or medical model of health. Despite the evidence collected over previous decades, clinical psychology continues to maintain its dominance in mental health even though clinical training methodologies do not always produce clinically competent or culturally competent psychologists (Belar et al., 2003; Evans & Fitzgerald, 2007; Love & Waitoki, 2007).

Allowances are made for clinical psychology that is not given to indigenous theorists although the discipline cannot seem to agree on how clinical training should be conducted. There is little research that has looked at the design of clinical training programmes in relation to bicultural content. We know from the literature that there should be some bicultural content, but we know little about what that should look like, whether that content is relevant or whether students have been trained appropriately.

I think I achieved my goal of developing and evaluating a cultural competency programme by using training and evaluation principles that have an established history. Although the programme evaluation was not as robust as I would have liked, the results suggest that a way forward is possible. The principles I used to develop the workshop material were derived from a kaupapa Māori worldview. In using that worldview I affirm my belief that Western-cultural processes have some value for Māori. I also highlight the opportunity for Pākehā to share space with Māori when developing and evaluating training programmes.

The part of this research that I am most proud of is study two. The material obtained for the training programme showed me how rich and diverse Māori culture is although I only touched upon the surface. While a large amount of training material was developed, the difficulties inherent in monocultural institutions increase the likelihood they not be considered useful. The critical incident technique and task analysis literature made no mention of conducting research within the context of institutional and societal racism.

The crux of the issue appears to be that Western psychology exists as a dominant force because it is accepted without in-depth questioning or self-reflection. Society explicitly and implicitly espouses values of Pākehā

cultural dominance and student psychologists may carry those values with them when they enter tertiary education.

On reflection I was not that different. I initially thought that I could develop the programme by using the existing Western literature on multicultural competencies with cultural safety principles and Te Tiriti o Waitangi/The Treaty of Waitangi. My captive-mind ignored the monocultural underpinnings of my thinking. Although I did not realise it at time, this research contained elements of a kaupapa Māori approach in the way I progressed through the stages of developing the training programme. By including perspectives on how psychologists worked with Māori, I moved away from relying on literature outside of Aotearoa/New Zealand.

As I worked through this study, I considered the goals of the student, teacher, and institution in light of the overall purpose of bicultural training programmes. If we are serious about addressing the unequal position of Māori in psychology, fundamental changes to the many systems within psychological education, practice and regulation need to happen.

References

Abbott, M., & Durie, M. (1987). A whiter shade of pale: Taha Māori and professional psychology training. *New Zealand Journal of Psychology, 16*, 58-71.

Abreu, J. M., Chung, R. H. G., & Atkinson, D. R. (2000). Multicultural counseling training. *The Counseling Psychologist, 28*(5), 641-656.

Aguinis, H., & Kraiger, K. (2009). Benefits of training and development for individuals and teams, organizations and society. *Annual Review of Psychology, 60*, 451-474.

Alatas. (1972). "The captive mind in development studies". *International Social Science Journal, 26 (4)*.

Alatas, S. H. (1996). *The study of the social sciences in developing societies: Towards an adequate conceptualization of relevance*. Paper presented at the Asia Pacific Regional Conference of Sociology (APRCS).

Alatas, S. H. (2002). The development of an autonomous social science tradition in Asia: Problems and prospects. *Asia Journal of Social Science, 30*(1), 151-157.

Albee, G. (2000). The Boulder Model's fatal flaw. *American Psychologist, 55, 2*, 247-248.

Alliger, G., Tannenbaum, S., Bennett, W, Jr., Traver, H., Shotland, A. (1997). A meta-analysis of the relations among training criteria. *Personnel Psychology, 50*, 341-358.

Allison, K., Crawford., Echemendia, R., Robinson, L., & Knepp, D. (1994). Human diversity and professional competence: Training in counseling psychology revisited *American Psychologist, 49*(792-796).

Allison, K., Echemendia, R. J., Crawford, I., & Robinson, W. L. (1996). Predicting cultural competence: Implications for practice and training. *Professional Psychology: Research and Practice, 276*(4), 386-393.

American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic and culturally diverse populations. *American Psychologist, 48*(1), 45-48.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*(5), 377-402.

Barnes, H. M. (2000). Kaupapa Māori: Explaining the ordinary. *Pacific Health Dialog, 7*.

Barnett, H. (2004). *A feminist critique of clinical psychology training programmes in Aotearoa New Zealand.* Victoria University, Wellington, New Zealand.

Baxter, J. (2008). Māori mental health needs profile: A review of the evidence: Te Rau Matatini.

Baxter, J., Kingi, T. K., Tapsell, T., Durie, M., & McGee, M. (2006). Prevalence of mental disorders among Māori in Te Rau Hinengaro: The New Zealand mental health survey. *Australian and New Zealand Journal of Psychiatry 2006, 40*(914-923).

Bedi, R., Davis, M., & Williams, M. (2005). Critical incidents in the formation of the therapeutic alliance from the client's perspective. *Psychotherapy: Theory, Research, Practice, Training., 42*(3), 311-323.

Belar, C. D., Nelson, P. D., & Wasik, B. H. (2003). Rethinking education in psychology and psychology in education. *American Psychologist, 58*(8), 678-684.

Belich, J. (2001). *Making Peoples.* NZ: The Penguin Press.

Bennett, S. (2009). *Te huanga o te ao Māori: Cognitive Behavioural Therapy for Māori clients with depression: development and evaluation of a culturally adapted treatment programme.* Unpublished PhD, Massey, Palmerston North.

Bernal, G., Jimenez-Chafey, M., & Rodriquez, M. (2009). Cultural adaptations of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology, Research and Practice, 40*(4), 361-368.

Bernal, M. E., & Castro, F. (1994). Are clinical psychologists prepared for service and research with ethnic minorities? Report of a decade of progress. *American Psychologist, 49*(9), 797-805.

Bertanees, C., & Thornley, C. (2004). Negotiating colonial structures: Challenging the views of Pākehā student teachers. *Asia-Pacific Journal of Teacher Education, 32*, 81-93.

Bishop, R. (1999). *Kaupapa Māori research. An indigenous approach to creating knowledge.* Paper presented at the Māori and Psychology: Research and Practice, Hamilton: University of Waikato.

Bishop, R., & Glynn, T. (1999). *Culture Counts: Changing Power Relations Education.* Palmerston North, NZ: Dunmore Press Ltd.

Black, J. S., & Mendenhall, M. (1990). Cross-cultural training effectiveness: A review and a framework for future research. *Academy of Management Review, 15*(1), 113-136.

Black, R., & Huygens, I. (2007). Pakeha culture and psychology. In I. Evans, M. O'Driscoll & J. Ruckledge. (Eds.), *Professional Practice of Psychology in Aotearoa*. Wellington: New Zealand Psychological Society.

Boyatzis, R. (1998). *Transforming Qualitative Information: Thematic Analysis and Code Development*. London: Sage.

Brady, E. (1992). Cross-cultural issues in clinical psychology training programmes. *New Zealand Journal of Psychology, 21*, 56-61.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Burke, A., & Hutchins, H. (2008). A study of best practices in training transfer and proposed model of transfer. *Human Resource Development Quarterly, 19*(2), 107-127.

Butterfield, L., Borgen, W., Amundsen, N., & Maglio, A. (2005). Fifty years of the critical incident technique: 1954-2004 and beyond. *Qualitative Research, 5*(4), 475-497.

Cargo, T. (2008). Māori Experiences of Delivering the Incredible Years Parenting Programme (Reflections): The Werry Center for Child and Adolescent Mental Health.

Castro, F. G. (1998). Cultural competence training in clinical psychology: Assessment, clinical intervention and research. In A. Bellack, M. Hersen (Ed.), *Comprehensive Clinical Psychology* (pp. 127-140): Elsevier Science Ltd.

Cherrington, L. (2003). *The use of Māori myths in clinical settings: Training issues and needs.* Paper presented at the National Māori Graduates of Psychology Symposium: Making a difference, Waikato University, Hamilton, New Zealand.

Chipps, J., Simpson, M., & Brysiewicz, P. (2008). The effectiveness of cultural-competence training for health professional in community-based rehabilitation: A systematic review of the literature. *Worldviews on Evidence-Based Nursing, 5*(85-94).

Christensen, T. M. (2000). A qualitative investigation of the process of group supervision with group counselors. *Journal for Specialists in Group Work., 25*(4), 376-393.

Coleman, H. L. (1997). Portfolio assessment of multicultural counseling competence. In D. Pope-Davis, Coleman, H. (Ed.), *Multicultural Counseling Competencies: Assessment, Education and Training, and Supervision* (pp. 43-59). Thousand Oaks, California: Sage Publications, Inc.

Collie, R. M., & Ward, T. (2007). Professional judgment and decision making. In I. Evans, J. Ruckledge & M. P. O'Driscoll (Eds.), *Professional Practice of Psychology in Aotearoa New Zealand* (pp. 301-315). Wellington: The New Zealand Psychological Society.

Constantine, M. (1998). Developing competence in multicultural assessment: Implications for counseling psychology training and practice. *The Counseling Psychologist, 26*(6), 922-929.

Constantine, M. (2001a). Independent and interdependent self-construals as predictors of multicultural case conceptualisations ability in counsellor trainees. *Counseling Psychology Quarterly, 14*(1), 33-42.

Constantine, M. (2001b). Multicultural training, theoretical orientation, empathy, and multicultural case conceptualisation ability in counselors. *Journal of Mental Health Counseling, 23*(4), 537-372.

Constantine, M., & Gushue, G. V. (2003). School counselors ethnic tolerance attitudes and racism attitudes as predictors of their multicultural case conceptualisation of an immigrant student. *Journal of Counseling and Development, 81*(Spring), 185-190.

Constantine, M. G., & Ladany, N. (2000). Self-report multicultural counseling competence scales: Their relation to social desirability attitudes and multicultural case conceptualisation ability *Journal of Counseling Psychology, 47*, 155-164.

Cooper, E., Rickard, S., & Waitoki, W. (2011). Māori psychology and the law: Considerations for bicultural practice. In F. Seymour, S. Blackwell & J. Thornburn (Eds.), *Psychology and the Law in Aotearoa New Zealand* (pp. 35-62). Wellington: The New Zealand Psychological Society, Te Roopu Mātai Hinengaro.

D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling and Development, 70*, 143-150.

Department of Economic and Social Affairs. (2004). The Concept of Indigenous Peoples. New York: United Nations.

Department of Social Welfare. (1985). Puao-te-Atatu, *The Report of the Ministerial Advisory Committe on a Maori Perspective for the Department of Social Welfare*. Wellington.

Dickson, G. L., Jepsen, D. A., & Barbee, P. W. (2008). Exploring the relationships among multicultural training experiences and attitudes toward diversity among counseling students. *Journal of Multicultural Counseling & Development, 36*(2), 113-126.

Dow, D. (2001). 'Pruned of its dangers': The Tohunga Suppression Act, 1907. *Health and History, 3*, 41-46.

Downing-Hansen, N., Pepitone-Arreola-Rockwell, F., & Greene, A. F. (2000). Multicultural competence: Criteria and case examples. *Professional Psychology: Research and Practice, 31*(6), 652-660.

Downing-Hansen, N., Randazzo, K., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., et al. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice, 37*(1), 66-74.

Ducker, D., Christopher, D. (2001). The reliability and validity of a multicultural assessment instrument developed for a graduate training programme. *Professional Psychology: Research and Practice., 32*(4), 425-432.

Dueck, A., Sing-Kiat, T., & Cutiongco, R. (2007). Constantine, Babel, and Yankee Doodling: Whose indigeneity? Whose psychology? *Pastoral Psychology, 56*, 55-72.

Duirs, A. (2005). National Standing Committee on Bicultural Issues (NSCBI): A brief history. *The Bulletin, 105*, 12.

Durie, M. (1989). The Treaty of Waitangi and health care. *The New Zealand Medical Journal, 102*, 283-285.

Durie, M. (1997). Identity, nationhood and implications for practice in New Zealand. *New Zealand Journal of Psychology, 26*(2), 32-38.

Durie, M. (1998). Tirohanga Māori. In *Whaiora* (2 ed., pp. 66-80). Auckland: New Zealand: Oxford.

Durie, M. (1999a). Mental health and Māori development. *Australian and New Zealand Journal of Psychiatry, 33*, 5-12.

Durie, M. (1999b). Te Pae Mahutonga: a model for Maori health promotion. *Health Promotion Forum of New Zealand Newsletter* 2-5 December 1999.

Durie, M. (2003). *Ngā Kāhui Pou: Launching Māori Futures*. Wellington: Huia.

Durie, M. (2004). *Te Mana, Te Kawanatanga: The Politics of Maori Self-Determination*. Melbourne, Australia: Oxford University Press.

Durie, M. H. (1994). *Whaiora*. Auckland: Oxford.

Dyall, L., Bridgman, G., Bidois, A., Gurney, H., Hawira, J., Tangitu, P., et al. (1999). Māori outcomes: Expectations of mental health services. *Social Policy Journal of New Zealand, 12*, 71-90.

Edmondson, A. (1999). Psychological safety and learning behavior in work teams *Administrative Science Quarterly, 44*(2), 350-383.

Eketone, A. (2008). Theoretical underpinnings of kaupapa Māori directed practice. *MAI Review, 1*.

Essandoh, P. K. (1998). Perspectives from Sub-Saharan Africa. In A. Bellack, M. Hersen (Ed.), *Comprehensive Clinical Psychology* (pp. 357-364): Elsevier Science Ltd.

Evans, I. E. (2008). Steering by matariki and the southern cross: Plotting clinical psychology's course in New Zealand. *New Zealand Journal of Psychology, 37, 3*, 5-14.

Evans, I. M., & Fitzgerald, J. (2007). Integrating research and practice in professional psychology: Models and paradigms. In I. Evans, J. Ruckledge. & M. P. O'Driscoll (Eds.), *Professional Practice of Psychology in Aotearoa/New Zealand.* (pp. 283-300). Wellington: New Zealand Psychological Society, Te Roopu Matai Hinengaro o Aotearoa.

Evans, I. M., & Paewai, M. K. (1999). Functional analysis in a bicultural context. *Behaviour Change, 16*(1), 20-36.

Eysenck, H. (1949). Training in clinical psychology: An English point of view. *The American Psychologist, 4(6)*, 173-176.

Ferguson, S., Collings, S., Blakely, T., & Allan, A. (2005). Suicide rates in New Zealand: Exploring associations with social and economic factors. Wellington: Ministry of Health.

Flanagan, J. C. (1954). The critical incident technique. *Psychological Bulletin, 51*(4), 327-358.

Fly, B., van Bark, W., Weinman, L., Strohm-Kitchener, K., & Lang, P. (1997). Ethical transgression of psychology graduate students: Critical incidents with implications for training. *Professional Psychology: Research and Practice, 28*(5), 492-495.

Fouad, N. A. (2006). Multicultural guidelines: Implementation in an urban counseling psychology program. *Professional Psychology: Research and Practice, 37*(1), 6-13.

Freire, P. (1972). *Pedagogy of the Oppressed*: Harmondsworth: Penguin.

Gaines, B., Buckingham, A., Eagar, K., Burgess, P., & Green, J. (2003). New Zealand Mental Health Classification and Outcomes Study: Final Report. Auckland: Health Research Council of New Zealand.

Garb, H. (2005). Clinical judgment and decision making. *Annual review of psychology, 1*, 67-89.

Garvey, D. C. (2007). *Indigenous Identity in Contemporary Psychology: Dilemmas, Developments, Directions.* Sydney: Thomson.

Gasser, M., & Tan, R. (1999). Cultural tolerance: measurement and latent structure of attitiudes toward the cultural practices of others. *Educational and Psychological Measurement, 59*(1), 111-126.

Gavala, J., & Taitimu, M. (2007). Training and supporting a Māori workforce. In I. Evans, Ruckledge, J., O'Driscoll, M (Ed.), *Professional Practice for Psychologists in Aotearoa/New Zealand* (pp. 229-244). Wellington: The New Zealand Psychological Society.

Gergen, K., Gulerce, A., Lock, A., & Misra, G. (1996). Psychological science in cultural context. *American Psychologist, 51*(5).

Glover, M., & Robertson, P. (1997). Facilitating development of kaupapa Māori psychology. In H. L. W. Whittaker (Ed.), *Practice Issues for Clinical and Applied Psychologists in New Zealand*. Wellington: New Zealand: Government Print.

Goldsbury, S. (2003). *Service Users Experience of Non-Maori Clinical Psychologists.* Unpublished Masters thesis, Waikato, Hamilton.

Hammerton, H. (1998). Cultural Safety Workshop. Hamilton: Department of Psychology, University of Waikato.

Hare-Mustin, R. T., Marecek, J. (1997). Abnormal and Clinical psychology: The politics of madness. In D. Fox & I. Prilleltensky (Eds.), *Critical Psychology: An Introduction*: London Sage.

Haynes, S. N., Lench, H. C. (2003). Incremental validity of new clinical assessment measures. *Psychological Assessment, 15*(4), 456-466.

Helms, J. E. (1997). How "multiculturalism" obscures race and culture as differential aspects of counseling competency. In D. B. Pope-Davis & H. L. Coleman. (Eds.), *Multicultural Counseling Competencies: Assessment, Education and Training, and Supervision* (pp. 59-79). Thousand Oaks, California: Sage Publications, Inc.

Helms, J. E., & Carter, R. T. (2001). Development of the white racial identity inventory. In J. E. Helms (Ed.), *Black and White Racial Identity: Theory, Research, and Practice* (pp. 67-80). Westport, CT: Greenwood.

Henry, E., & Pene, H. (2001). Kaupapa Māori: Locating indigenous ontology, epistemology and methodology in the Academy. *Organisation: Speaking Out, 8*, 234-424.

Herbert, A. (1998). The Treaty of Waitangi in clinical psychology training at the University of Waikato. *The Bulletin, 93*, 12-14.

Herbert, A. (2001a). *Māori centred research and clinical training programmes in Aotearoa/New Zealand.* Paper presented at the Annual Conference of the NZ Psychological Society, University of Waikato.

Herbert, A. (2001b). *Whanau Whakapakari: A Maori-Centered Approach to Child Rearing and Parent-Training Programmes.* Unpublished PhD, Waikato, Hamilton.

Herbert, A. (2002). Bicultural partnerships in clinical training and practice in Aotearoa/New Zealand. *New Zealand Journal of Psychology, 31*(2), 110-116.

Herbert, A., Evans, I., & Phipps, A. (2001). *Bicultural partnerships in clinical training and practice in Aotearoa/New Zealand.* Paper presented at the World Congress of Behavioral and Cognitive Therapies, Vancouver.

Hertzsprung, E., & Dobson, K. (1998). Diversity training: Conceptual issues and practices for Canadian clinical psychology programmes. *Canadian Psychology, 41*(3), 184-191.

Hill, R. S., & Bonisch-Brednich, B. (2007). Reparations Processes in New Zealand Politicizing the Past: Indigenous Scholarship and Crown— Maori. *Social and Legal Studies, 16*(163-181).

Hirini, P. R., & Nairn, R. G. (1996). Psychological practice for the NZ context. *The Bulletin, 89*(August 1996), 6-7.

Hohepa, P. (2010). *Keynote address.* Paper presented at the Manu Ao, Doctoral Writing Retreat.

Huriwai, T., Robertson, P., Armstrong, D., Kingi, J., & Huata, P. (2001). A process in the treatment of Māori with alcohol and drug use related problems. *Substance Abuse and Misuse, 8*, 1017-1035.

Ihimaera, L. (2007). Whakarato Whānau ora - Whanau Wellbeing is Cntral to Māori Wellbeing. Palmerston North: Te Rau Matatini.

Ihimaera, L., & Tassell, N. (2004). Clinical Placement Guidelines for Māori Psychology Students. Palmerston North: Te Rau Matatini.

Iwamasa, G. Y. (1996). Introduction to the special series: Ethnic and cultural diveristy in cognitive and behavioral practice. *Cognitive and Behavioral Practice, 3*, 209-213.

Johnstone, K., & Read, J. (2000). Psychiatrists' recommendations for improving bicultural training and Māori mental health services: a New Zealand survey. *Australian and New Zealand Journal of Psychiatry, 34*(1), 135-145.

Jones, I. (1998). The scientist-practitioner model: A critical examination. *Australian Psychologist, 33, 1*, 24-30.

Kais, S. M. (2010). *Fifty years of Bangladesh sociology: Towards a "hybrid sociology"?* Paper presented at the Facing an Unequal World: Challenges for a Global Sociology, Asia.

Kaufman, R., Keller, J., & Watkins, R. (1995). What works and what doesn't: Evaluation beyond Kirkpatrick. *Personnel and Industrial* (November-December), 8-12.

Keatinge, D. (2002). Versatility and flexibility: Attributes of the critical incident technique in nursing research. *Nursing and Health Sciences, 4*, 33-39.

King, M. (2003). *The Penguin History of New Zealand*. NZ: Penguin.

Kingi-'Ulu'ave, D., Faleafa, M., & Brown, T. (2007). A Pasifika perspective of psychology in Aotearoa. In I. Evans, Ruckledge, J., O'Driscoll, M (Ed.), *Professional Practice of Psychology in Aotearoa New Zealand* (pp. 67-83). Wellington: The New Zealand Psychological Society.

Kirkpatrick, D. L. (1987). Evaluation of training. In R. L. Craig (Ed.), *Training and development handbook: A guide to human resource development* (2 ed., pp. 18-27). New York: McGraw-Hill.

Kirkpatrick, D. L. (1994). *Evaluating Training Programs: The Four Levels*. San Francisco: Berrett-Koehler.

Kiro, C. (2000). *Kimihia mo te hauora Māori: Māori health policy and practice.* Unpublished Doctor of Philosophy, Massey University, Albany.

Kiselica, M. (1998). Preparing anglos for the challenges and joys of multiculturalism. *The Counseling Psychologist., 26*(1), 5-21.

Kiselica, M., & Maben, P. (1999). Do multicultural education and diversity appreciation training reduce prejudice among counseling students. *Journal of Mental Health Counseling, 21*(3), 240.

Kraiger, K. J., Ford, K., & Salas, E. (1993). Application of cognitive, skill-based and affective theories of learning outcomes to new methods of training evaluation. *Journal of Applied Psychology, 1993*(78), 2.

LaFromboise, T. D., Coleman, H. L. K., Hernandez, A. (1991). Development and factor structure of the cross-cultural counseling inventory-revised. *Professional Psychology: research and Practice, 22*(5), 380-388.

Lange, R. (1999). *May the People Live: A History of Māori Health Development 1900-1920*. Auckland.

Lange, R. (2009). The Provision of Health Services to East Coast Māori: Crown Forestry Rental Trust.

Lapsley, H., Nikora, L., & Black, R. (2002). "Kia Mauri Tau!" Narratives of Recovery From Disabling Mental Health Problems. Hamilton, New Zealand: University of Waikato.

Lawson-Te Aho, K. (1993). The socially constructed nature of psychology and the abnormalisation of Māori. *New Zealand Psychological Society Bulletin, 76*, 25-30.

Lawson Te-Aho, K. (1994). *The Master's Tools: Māori Development Inside Pākehā Psychology.* Unpublished Master of Social Science, Hamilton: University of Waikato.

Lawson Te Aho, K. (2002). Cultural Safety in the Practice and Teaching of Psychology in Aotearoa: A Discussion Document. New Zealand Psychologist's Board.

Leong, F. T., & Kim, H. H. (1991). Going beyond cultural sensitivity on the road to multiculturalism: Using the intercultural sensitizer as a counselor training tool. *Journal of Counseling and Development, 70*, 112-118.

Levy, M. (2002). *Barriers and incentives to Māori participation in the profession of psychology.* Wellington, New Zealand: New Zealand Psychologists Boardo. Document Number)

Levy, M. (2007). *Indigenous Psychology in Aotearoa: Realising Māori Aspirations.* Unpublished Doctor of Philosophy, Waikato, Hamilton.

Linehan, M. (1993). *Cognitive Behavioural Treatment of Borderline Personality Disorder*. New York: Guilford.

Love, C. (1999). *Māori voices in the construction of indigenous models of counselling theory and practice* Unpublished PhD dissertation, Massey, Palmerston North, New Zealand.

Love, C. (2002). Keynote Address. In L. Nikora, M., Levy, M., Masters, B., Waitoki, M., Te Awekotuku, N. Etheredge, R. (Ed.), *Making Spaces: The Proceedings of the National Maori Graduates of Psychology Symposium* (pp. 13-18). Waikato University: Hamilton.

Love, C., & Waitoki, W. (2007a). Multicultural competence in bicultural Aotearoa. In I. Evans, M. O'Driscoll & J. Ruckledge. (Eds.), *Professional Practice of Psychology in Aotearoa* (pp. 265-280). Wellington: New Zealand Psychological Society.

Love, C., & Waitoki, W. (2007b). Multicultural competencies in bicultural Aotearoa. In I. Evans, Ruckledge, J., O'Driscoll, M (Ed.), *Professional Practice of Psychology in Aotearoa New Zealand* (pp. 265-280). Wellington: The New Zealand Psychological Society.

Ludy, B. T. (2005). A history of clinical psychology as a profession in America (and a glimpse at its future). *Annual review of psychology, 1*, 1-30.

Macfarlane, A. (2008). Kia hiwa rā! Listen to culture: a counter narrative to standard assessment practices in psychology. *The Bulletin*, 30-36.

Magyar-Moe, J., Pedrotti, J., Edwards, L., Ford, A., Petersen, S., Rasmussen, H., et al. (2005). Perceptions of multicultural training in predoctoral internship programs: A survey of interns and training directors. *Professional Psychology: Research and Practice, 36*(4), 446-450.

Mahuika, J. (2008). Kaupapa Māori theory is critical and anti-colonial. *MAI Review, 3*.

Mancall, P., Robertson, P., & Huriwai, T. (2000). Māori and alcohol: a reconsidered history. *Australian New Zealand Journal of Psychiatry*, 129-134.

Manihera, T. U. (1975). Learning and tapu. In M. King (Ed.), *Te Ao Hurihuri: Aspects of Maoritanga* (pp. 9). Auckland: Reed Books.

Manna, L. (2002). *Biculturalism in practice, "Te Pounamu": Integration of a Maori model with traditional clinical assessment processes.* Paper presented at the National Maori Graduates of Psychology Symposium 2002: Making a Difference, Waikato University.

Marie, D., & Haig, B. (2006). Is kaupapa Māori research methodology credible. *New Zealand Skeptic, 81*.

Maton, K., Kohout, J., Wicherski, M., Leary, G., & Vinokurov, A. (2006). Minority students of color and the psychology graduate pipeline: Disquieting and encouraging trends, 1989-2003. *American Psychologist, 61*(2).

McCan, D. (2001). *Whatiwhatihoe: The Waikato raupatu claims*. Wellington, New Zealand: Huia.

McCreanor, T. (1993). Pakeha psychology and its resistance to the Maori challenge. *New Zealand Psychological Society, Psychological Bulletin*, 23-27.

McDonald, J. D., & Chaney, J. M. (2003). Resistance to multiculturalism: The "Indian problem". In J. S. Mio & G. Iwamasa (Eds.), *Culturally Diverse Mental Health: The Challenges of Reseach and Resistance*. New York: Brunner-Routledge.

McFall, R. (2005). Doctoral training in clinical psychology. *Annual Review of Clinical Psychology, 2*, 9.1-9.27.

McIntosh, P. (1988). White Privilege and Male Privilege: A Personal Account of Coming To See Correspondences through Work in Women's Studies

Working Paper 189. Wellesley MA: Wellesley College Center for Research on Women.

McReynolds, P. (1987). Lightner Witmer: Little-known founder of clinical psychology. *American Psychologist, 42, 9*, 849-858.

Merrit, M. (2003). Māori experiences in clinical psychology training. Palmerston North: Te Rau Whakamaru.

Metge, J. (1978). *Talking past each other: Problems of cross-cultural communication*. Wellington.

Milne, M. (2001). Ngā tikanga tōtika mo te oranga hinengaro, oranga wairua: hui report: Best practice guidelines for kaupapa Māori mental health services. Unpublished Report. Ministry of Health.

Milne, M. (2005). Māori perspectives on kaupapa Māori and psychology: A discussion document. Wellington, NZ: New Zealand Psychologists Board.

Ministry of Social Development. (2009). The Social Report/Te Purongo Oranga Tangata. Wellington: Ministry of Social Development.

Moeke-Pickering, T. M. (2010). *Decolonisation as a social change framework and its impact on the development of indigenous-based curricula for helping professionals in mainstream tertiary education organisations.* Unpublished PhD, Waikato, Hamilton.

Moghaddam, F., & Studer, C. (1997). Cross-cultural psychology: The frustrated Gadfly's promises, potentialities and failures. In D. Fox & I. Prilleltensky (Eds.), *Critical Psychology: An Introduction*. London Sage.

Nairn, R. (1997). Cultural justice and ethic in psychological practice. In Love. H. & W. Whittaker (Eds.), *Practice Issues for Clinical and Applied Psychologists in New Zealand.* (pp. 127-135). Wellington: Government Print.

Nairn, R. (2007). Ethical principles and cultural justice in psychological practice. In I. Evans, Ruckledge, J., O'Driscoll, M (Ed.), *Professional Practice of Psychology in Aotearoa/New Zealand* (pp. 19-34). Wellington: The New Zealand Psychological Society.

Nathan, P. (1997). Discursive psychology. In D. Fox & I. Prilleltensky (Eds.), *Critical Psychology: An Introduction*: London Sage.

Nathan, S. B. (1999). Tikanga Māori in Aotearoa/New Zealand clinical psychology training programmes: A follow-up of Abbott and Durie's (1987) study. Unpublished Master's thesis. Victoria University, Wellington, New Zealand.

New Zealand Health Information Service. (2003). Psychology Workforce: Health Workforce Annual Survey. Wellington: NZ Health Information Service.

New Zealand Psychological Society. (2002). The code of ethics for psychologists working in Aotearoa/New Zealand. Wellington: New Zealand Psychological Society.

New Zealand Psychologists Board. (2006a). Cultural Competencies for Pychologists Registered under the Health Practitioners Competence Assurance Act 2003. Wellington: New Zealand Psychologists Board.

New Zealand Psychologists Board. (2006b). Standards and Procedures for the Accreditation of Qualifications Leading to Registration as a Psychologist in New Zealand. Wellington: New Zealand Psychologists Board.

Nezu, A., Nezu, C., Peacock, M., Girdwood, C. (2004). Case formulation and cognitive-behavior therapy. In M. Hersen, S. Hayes & E. Heiby (Eds.), *Behavioral Assessment. Vol. 3 of the Comprehensive Handbook of Psychological Assessment*. New York: Wiley.

Nikora, L. (1993). *Cultural Justice and Ethics*. Hamilton: Psychology Department, Waikato University.

Nikora, L. (1995). *Cultural Justice and Ethics in Psychological Practice*, Wellington.

Nikora, L., Levy, M., Masters, B., & Waitoki, W. (2004). Indigenous psychologies globally: A perspective from Aotearoa/New Zealand.

Nikora, L., & Te Awekotuku, N. (2009). 2010, from http://www.waikato.ac.nz/wfass/subjects/psychology/mpru/tangihanga/index.shtml

Nursing Council of New Zealand. (2005). Guidelines for Cultural Safety, The Treaty of Waitangi, and Māori Health in Nursing Practice and Education.

O'Driscoll, M., & Cooper, C. (1996). A critical incident analysis of stress-coping behaviours at work. *Stress Medicine, 12*, 123-128.

Older, J. (1978). *The Pākehā Papers*. Dunedin: John McIndoe Limited.

Orange, C. (1996). *The Treaty of Waitangi*: Bridget Williams Books.

Ottavi, B., & Thomas, M. (1994). Examining the association between self-reported multicultural counseling competencies and demographic variables among counselors. *Journal of Counseling and Development, 72*(6), 651-659.

Paewai, M. (1997). *Cultural Safety Within Clinical Psychology: A Māori Perspective* Unpublished Master's Thesis, Massey, Palmerston North.

Palmer, S. (2004). Homai te waiora ki ahau: A tool for the measurement of wellbeing amond Māori - the evidence of construct validity. *New Zealand Journal of Psychology, 33*(2), 50-58.

Parker, I. (1994). Reflexive research and the grounding of analysis: Social psychology and the psy-complex. *Journal of Community & Applied Social Psychology, 4, 1*, 239-252.

Paterson, K. (1993, 23 August 1993). *Life in a Clinical Diploma Course.* Paper presented at the Cultural Justice and Ethics, University of Victoria, Wellington.

Patterson, C. H. (2004). Do we need multicultural counseling competencies? *Journal of Mental Health Counseling, 26*(1), 67-73.

Pedersen, P. (Ed.). (1999). *Multiculturalism as a Fourth Force*. New York: Brunner/Mazel.

Pere, R. (1994). Te Wheke - A Celebration of Infinite Wisdom. Gisborne, New Zealand: Ako Global Learning.

Petti, P. (2008). The use of a structured case presentation examination to evaulate clinical competencies of psychology doctoral students. *Training and Education in Professional Psychology, 2*(3), 145-150.

Pewhairangi, N. (1975). Learning and tapu. In M. King (Ed.), *Te Ao Hurihuri: Aspects of Maoritanga* (pp. 9). Auckland: Reed Books.

Phelan, S., & Shearer, F. (2009). 'The "radical", the "activist" and the hegemonic newspaper articulation of the Aotearoa New Zealand foreshore and seabed conflict' *Journalism Studies, 102*(220-237).

Phillips, P., & Phillips, J. (2001). Symposium of the evaluation of training. *International Journal of Training and Development, 5*(4), 240-247.

Pihama, L. (2001). *'Tihei Mauri Ora: Honouring Our Voices. Mana Wahine as a Kaupapa Maori Theoretical Framework'* Unpublished PhD, University of Auckland.

Pilgrim, D., & Treacher, A. (1992). *Clinical Psychology Observed*. London: Routledge.

Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T., & Dallas-Katoa, W. (2007). Meihana model: A clinical assessment framework. *New Zealand Journal of Psychology, 36, 3*, 118-125.

Ponterotto, J. (1997). Multicultural counseling training: A competency model a national survey. In H. L. C. Donald Pope-Davis. (Ed.), *Multicultural*

Counseling Competencies: Assessment, Education, and Training, and Supervision (Vol. 7, pp. 111-130). California: SAGE Publications.

Ponterotto, J., & Mallinckrodt, B. (2007). Introduction to the special section on racial and ethnic identity in counseling psychology: Conceptual and methodological challenges and proposed solutions. *Journal of Counseling Psychology, 54*(3), 219-223.

Ponterotto, J., Rieger, B., Barrett, A., & Sparks, R. (1994). Assessing multicultural counseling competence: A review of instrumentation. *Journal of Counseling and Development, 72*, 316-322.

Prilleltensky, I., Fox, D. (1997). Introducing Critical Psychology: Values, Assumptions and the Status Quo. In D. Fox. & I. Prilleltensky (Eds.), *Critical Psychology: An Introduction*. London: Sage.

Quintana, S. M., & Bernal, M. E. (1995). Ethnic minority training in counseling psychology: Comparisons with clinical psychology. *The Counseling Psychologist, 23*(102-121).

Raimy, V. (1950). *Training in Clinical Psychology*. New York: Prentice Hall.

Ramirez, S. Z., Wassef, A., Paniagua, F. A., & Linskey, A. (1996). Mental health providers' perceptions of cultural variables in evaluating ethnically diverse clients. *Professional Psychology: Research and Practice, 27*(3), 284-288.

Ramsden, I. (1996). The Treaty of Waitangi and cultural safety: The role of the Treaty in nursing and midwifery education in Aotearoa, *Guidelines for Cultural Safety in Nursing and Midwifery Education*. Wellington: New Zealand Council of Nurses.

Ramsden, I. (1997). Cultural Safety: Implementing the concept. The social force of nursing and midwifey. In P. Te Whaiti, M. McCarthy & A. Durie. (Eds.), *Mai i Rāngiatea: Māori Wellbeing and Development*. Auckland: Auckland University Press.

Ramsden, I. M. (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu.* Victoria University of Wellington, Wellington.

Rangihau, J. (1975). Being Māori. In M. King (Ed.), *Te Ao Hurihuri: Aspects of Maoritanga* (pp. 183-190). Auckland: Reed Books.

Rata, E. (2006). The political strategies of ethnic and indigenous elites. In E. Rata & R. Openshaw (Eds.), *Public Policy and Ethnicity: The Politics of Ethnic Boundary Making* (pp. 40-55). New York: Palgrave Macmillian.

Reed, J., & Vakola, M. (2006). What role can a training needs analysis play in organisational change? *Journal of Organizational Change Management, 19*(3), 393-407.

Reynolds, A. L. (2001). Multidimensional cultural competence: Providing tools for transforming psychology. *The Counseling Psychologist, 29*(6), 832-841.

Ridley, C., Baker, D., Hill, C. (2001). Critical issues concerning competence. *The Counseling Psychologist, 29*, 822-832.

Ridley, C., Espelage, D., & Rubinstein, K. (1997). Course development in multicultural counseling. In D. B. Pope-Davis, Coleman, H. L. (Ed.), *Multicultural Counseling Competencies: Assessment, Education and Training, and Supervision* (pp. 131-158). Thousand Oaks, California: Sage Publications, Inc.

Ridley, C., Li, L., & Hill, C. (1998). Multicultural assessment: Reexamination, reconceptualization, and practical application. *The Counseling Psychologist, 26*(6), 827-910.

Roberson, L., Kulil, C., & Pepper, M. (2001). Designing effective diversity training: Influence of group composition and trainee experience. *Journal of Organizational Behavior, 22*, 871-885.

Robertson, P. J., Collier, A. F., Sellman, J. D., Adamson, S., Todd, F., Deering, D., et al. (2001). Clinician beliefs and practices related to increasing responsivity to the needs of Māori with alcohol and drug problems. *Substance Abuse and Misuse, 36*, 999-1016.

Ross, R., & Altmaier, E. (1990). Job analysis of internships in counseling centers. *Journal of Counseling Psychology, 37*(4), 459-464.

Roysicar, G. (2005). Culturally sensitive assessment, diagnosis and guidelines. In M. Constantine & G. Sue (Eds.), *Strategies for Building Multicultural Competence in Mental Health Settings* (pp. 19-38). New Jersey: John Wiley & Sons.

Rubin, J., Bebeau, M., Leigh, I., Lichtenberg, J., Nelson, P., Sanford, P., et al. (2007). The competency movement within psychology: An historical perspective. *Professional Psychology, Research and Practice, 38*(5).

Ryan, E. (1996). Seven years on: Psychiatric inquiry 1988, a Maori health worker's perspective. In W. Brookbanks (Ed.), *Psychiatry and the Law* (pp. 137-146). Wellington: Brooker's Ltd.

Salas, E., & Cannon-Bowers, J. A. (2001). The science of training: A decade of progress. *Annual Review of Psychology., 52*, 471-500.

Sammons, C. C., & Speight, S. (2008). A qualitative investigation of graduate-student changes associated with multicultural counseling courses. *The Counseling Psychologist, 36*(6), 814-838.

Sanchez-Jankowski, M. (2002). Representation, responsibility and reliability in participant-observation. In T. May (Ed.), *Qualitative Research in Action* (pp. 146-160). London: Sage.

Sawrey, R. (1991). *A Survey of Psychologists' Opinions and Behaviour on Aspects of Māori Health.* Unpublished Master's Thesis, Victoria, University, Wellington.

Schluter, J., Seaton, P., & Chaboyer, W. (2008). Critical incident technique: A user's guide for nurse researchers. *Journal of Advanced Nursing, 61*(1), 107-114.

Seymour, F. (2007). The foundation for practice. In I. Evans, Ruckledge, J., O'Driscoll, M (Ed.), *Professional Practice of Psychology in Aotearoa New Zealand* (pp. 5-15). Wellington: The New Zealand Psychological Society.

Sharoff, L. (2008). Critique of the critical incident technique. *Journal of Research in Nursing., 13*(4), 301-309.

Shippman, J., Ash, R., Battista, M., Carr, L., Eyde, L., Hesketh, B., et al. (2000). The practice of competency modeling. *Personnel Psychology, 53*, 703-738.

Shouksmith, G. (1990). New Zealand. In G. Shouksmith & E. Shouksmith (Eds.), *Psychology in Asia and the Pacific: Status reports on teaching and research in eleven countries* (pp. 443-458). Bangkok, Thailand: UNESCO.

Siegel, H. (2002). Multiculturalism, universalism and science education: In search of common ground. *Culture and Comparative Studies.*

Silber, C., Novielli, K., Paskin, D., Brigham, T., Kairys, J., Kane, G., et al. (2006). Use of critical incidents to develop a rating form for resident evaluation of faculty teaching. *Medical Education, 40*, 1201-1208.

Silva, N. K. (2000). He kānāwai e ho'opau i na hula kuolo Hawai'i: The political economy of banning the hula. *The Hawaiian Journal of History, 34*, 29-49.

Skogstad, P., Skogstad, I., & Britt, E. (2005). Taha Māori and Aotearoa/New Zealand clinical psychology: Developments at the University of Canterbury, New Zealand. *Journal of Psychology, 34*, 58-63.

Smith, G. (2003). *Kaupapa Māori Symposium.* Paper presented at the Kaupapa Māori Theory: Theorizing Indigenous Transformation of Education & Schooling, Hyatt Hotel, Auckland NZ.

Smith, L. (1992). On being culturally sensitive: The art of gathering and eating kina without pricking yourself on the finger. *Monograph, 9.*

Smith, L. (1999a). *Decolonizing Methodologies: Research and Indigenous Peoples*. Dunedin: University of Otago Press.

Smith, L. T. (1999b). *Decolonizing Methodologies: Research and Indigenous Peoples*. Dunedin: University of Otago Press.

Smith, L. T. (2000). Māori Research and Development: Kaupapa Māori Principles and Practices a Literature Review (pp. 58). Auckland: International Research Institute for Māori and Indigenous Education (IRI), University of Auckland, Te Rōpū Rangahau Hauora a Eru Pōmare, Wellington School of Medicine, University of Otago.

Smith, L. T. (2006). Researching in the margins: Issues for Māori researchers - a discussion paper. *AlterNative. An International Journal Indigenous Peoples, 2*, 1.

Smith, T., Constantine, M., Dunn, T., Dinehart, J., & Montoya, J. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology, 53*(1), 132-145.

Sodowsky, G., Kuo-Jackson, P., & Loya, G. (1997). Outcome of training in the philosophy of assessment: Multicultural counseling competencies. In D. Pope-Davis, Coleman, H. (Ed.), *Multicultural Counseling Competencies: Assessment, Education and Training, and Supervision* (pp. 3-42). Thousand Oaks, California: Sage Publications, Inc.

Sodowsky, G., Taffe, R., Gutkin, T., & Wise, S. L. (1994). Development of the multicultural counseling inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41*(2), 137-148.

Spanierman, L., Oh, E., Poteat, V., McClair, V., Beer, A., Clarke, A. (2008). White University students' responses to societal racism. *The Counseling Psychologist, 36*(6), 839-870.

Speight, S., Myers, L., Cox, C., & Highlen, P. (1991). A redefinition of multicultural counseling. *Journal of Counseling and Development, 70*, 29-36.

Sprangers, M., & Hoogstraten, J. (1989). Pretesting effects in retrospective pretest-posttest designs. *Journal of Applied Psychology, 74*(2), 265-272.

Spruill, J., Rozensky, R., Stigall, T., Vasquez, M., Bingham, R., & De Vaney Olvey, C. (2004). Becoming a competent clinician: Basic competencies in intervention. *Journal of Clinical Psychology, 60*(7), 731-754.

Stanley, P. (1993). *The power, the glory and the great white hunter.* Paper presented at the Psychological Services Hui on Bicultural Issues, Auckland New Zealand.

Stanley, P. (2002, 2003). *Nobody knows me even though I'm always there: Why Maori men Do exist in all the wrong places.* Paper presented at the National Maori Graduates of Psychology Symposium 2002: Making a difference, Hamilton, New Zealand.

Steward, R. J., & Morales, P. (1998). The multicuturally responsive versus the multiculturally reactive: A study of perceptions of counselor trainees. *Journal of Multicultural Counseling and Development., 26*(1), 13-25.

Stewart, G. (2007). *Kaupapa Māori Science.* Unpublished PhD, University of Waikato, Hamilton, New Zealand.

Stewart, T. (1997). Historical interfaces between Māori and psychology. In P. Te Whaiti, M. McCarthy & A. Durie. (Eds.), *Mai i Rāngiatea: Māori Wellbeing and Development* (Vol. 75-95). Auckland: Auckland University Press.

Stiles, W. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13*, 593-618.

Stricker, G. (2005). The scientist-practitioner model: Ghandi was right again. *American Psychologist, 55*(2), 253-254.

Stricker, G., Trierweiler, S. (2006). The local clinical scientist: A bridge between science and practice.

Stuart, R. B. (2004). Twelve Practical Suggestions for Achieving Multicultural Competence. *Professional Psychology: Research and Practice, 35*(1), 3-9.

Suaalii-Sauni, T., & Samu, K. (2005). Exploring Cultural Competency: An Exploratory Study of Cultural Competency in Pacific Mental Health: Pacific Mental Health, Waitemata District Health Board.

Sue, D., Bernier, J., Durran, A., Feinberg, L., Pederson, P., Smith, E., et al. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*, 45-52.

Sue, D. W. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology, 34*(2), 237-245.

Sue, D. W., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, 477-486.

Sue, S. (1998). In search of multicultural competence in psychotherapy and counseling. *American Psychologist, 53*(4), 440-448.

Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist*, 964-970.

Sue, S., Zane, N., Nagayama-Hall, G., & Berger, L. (2008). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology.*(60), 525-548.

Suzuki, L. A., McRae, M. B., & Short, E. L. (2001). The facets of cultural competence: Searching outside the box. *The Counseling Psychologist, 29*(6), 842-849.

Tanaka-Matsumi, J., Seiden, D. Y., & Lam, K. (1996). The culturally informed functional assessment (CIFA) interview: A strategy for cross-cultural behavioral practice. *Cognitive and Behavioural Practice, 3*, 215-233.

Tannenbaum, S., & Yukl, G. (1992). Training and development in work organizations. *Annual review of psychology, 43*, 399-441.

Tau, T. M. (2008). The discovery of islands and the stories of settlement. *Thesis Eleven 92*, 11-28.

Taylor, P. (2002). Training. In M. Warner (Ed.), *International Encyclopedia of Business & Management* (2nd ed., pp. 6535-6545). London: Thomson Learning.

Taylor, P., Russ-Eft, D., & Taylor, H. (2009). Transfer of management training from alternative perspectives. *Journal of Applied Psychology, 94*(1), 104-121.

Taylor, P. J., O'Driscoll, M. P., & Binning, J. F. (1998). A new integrated framework for training needs analysis. *Human Resource Management, 8*(2), 29-50.

Thomas, D. R. (1993). What are bicultural psychological services? *The Bulletin, 76*(31-36).

Tohunga Suppression Act, (1907).

Trickett, E. (2009). Community psychology: Individuals and interventions in community context. *Annual Review of Psychology, 60*, 395-419.

Trimble, J. E. (2007). Prolegomena for the connotation of construct use in the measurement of ethnic and racial identity. *Journal of Counseling Psychology, 54*(3), 247-258.

Voyce, M. (1989). Māori Health in New Zealand: The Tohunga Suppression Act 1907. *Oceania, 60*, 99-124.

Waitangi Tribunal. (1999). The Wananga Capital Establishment Report (Wai 718). Wellington.

Waitoki, M. (2000). *Cultural Diversity and Parenting.* Unpublished Masters, Waikato, Hamilton.

Waldegrave, T. (1996). *Developing a More Bicultural Psychology: Academic Discourses of Resistance.* Unpublished Master's thesis, Massey, Palmerston North.

Walker, R. (1975). The relevance of myth and tradition. In M. King (Ed.), *Te Ao Hurihuri: Aspects of Māoritanga* (pp. 171-184). Auckland: Reed Books.

Walker, R. (2002). Maori news is bad news. In J. McGregor & M. Comrie (Eds.), *What's news? Reclaiming journalism in New Zealand.* Palmerston North: Dunmore Press.

Walker, R. (2004). *Ka Whawhai Tonu Matou: Struggle Without End*: Penguin.

Weinrach, S., & Thomas, K. (2004a). The AMCD multicultural counseling competencies: A civil debate. *Journal of Mental Health Counseling, 261*(1), 41-43.

Weinrach, S., & Thomas, K. (2004b). The AMCD multicultural counseling competencies: A critically flawed initiative. *Journal of Mental Health Counseling, 261*(1), 81-94.

Wexley, K. N. (1984). Personnel training. *Annual review of psychology*, 519-551.

Wexley, K. N., & Latham, G. P. (2002). *Developing and training human resources in organizations* (3 ed.). NJ: Prentice Hall.

Wharewera-Mika. (2007, 23-24 November). *Mental health inpatient services: Improving our understanding of the needs of Māori when acutely unwell.* Paper presented at the "Claiming Spaces" Proceedings of the 2007 National Māori and Pacific Psychologies Symposium, Hamilton.

Winfred, A., Bennett, W. Jr, Edens, P., Bell, S. (2003). Effectiveness of training in organisations: A meta-analysis of design and evaluation features. *Journal of Applied Psychology, 88*(2), 234-245.

Worthington, R., Mobley, M., Franks, R., & Tan, J. (2000). Multicultural counseling competencies: Verbal content, counselor attributions and social desirability. *Journal of Counseling Psychology, 47*, 460-468.

Wrenn, G. (1962). The culturally encapsulated counselor. *Harvard Educational Review, 32*(444-449).

Young, A. (2010, Wednesday April 21). Bitter outbursts follow backing for UN move. *The New Zealand Herald*, from http://www.nzherald.co.nz/politics/news/article.cfm?c_id=280&objectid=10639755

Yutrzenka, B. (1995). Making a case for training in ethnic and cultural diversity in increasing treatment efficacy. *Journal of Consulting and Clinical Psychology, 63*, 197-206.

Appendices

Appendix A   *Letter to Programme Directors*

Director of Clinical Training
Department of Psychology
Address line 1
Suburb
City

18 September 2012

Dear Sir/Madam,

Re: Phd Research - Bicultural competency: transferring the multicultural competency literature into a bicultural context

Thank you for considering your participation in this research and your involvement to date. Further to our initial contact, this letter is a formal request to proceed with the research study. I have received ethical approval from Waikato University Psychology Department's Ethics Committee.

I propose that the research be conducted with students in either the 2nd or 3rd (Internship) years of training. This is to ensure that participants have some clinical experience and the opportunity to utilise the skills taught in the workshop. The workshop will be conducted over two-days. The students may leave at any point and may also withdraw their information at any time, without penalty.

I also ask that the clinical tutor contact the supervisors of the students (participants) to obtain their (the supervisor's) permission to participate in the research. I will provide my contact details for the supervisor and they can contact me. Alternatively, if they provide their contact details, I will contact them.

I have included copies of the programme outline, letter to participants, and consent form.

If you have any questions, please do not hesitate to contact me at the email or phone address above.

Noho ora mai,

Waikaremoana Waitoki
PhD Candidate
Registered Psychologist

Appendix B   *Information Letter for Participants – Workshop*

Information Sheet for Participants
Bicultural Competency: Transferring the Multicultural Competency Literature into a
Bicultural Context

Kia ora,

Thank you for taking part in this programme. I understand how valuable your time is, so I appreciate the effort that you have made in taking part in this research. There is a consent form for you to sign outlining that you understand the research topic, that you are free to withdraw at anytime, and that your information is confidential. If you have any questions, please feel free to contact me.

Research Rationale

The purpose of this study is to determine whether international studies on multi cultural competency training can be applied in a bicultural New-Zealand-Aotearoa context. The programme will be used to develop culturally appropriate service techniques for clinical psychology students working with Māori and non-Māori in a clinical setting.   The programme has been developed from the international and the national literature on cultural safety and treaty training and bicultural competency training.

Core domains to be included in the programme are awareness of bi-cultural issues, sensitivity to diversity, increasing awareness of biases and stereotypes; increasing cultural-clinical knowledge; and cultural-clinical skills. The development of critical analysis skills when dealing with cultural issues in assessment, treatment and supervision will be included.

How the programme will run

The programme will run over two days from 9:00am - 3:00pm. The format consists of didactic teaching, group work, role-plays, and caucus groups. The primary teaching method is group work and feedback to the wider group. At times, you will be separated on the basis of self-identified ethnicity (i.e., Māori or non-Māori). This is to ensure that issues relevant to each group are addressed and discussed. Morning tea and lunch will be provided each day.

Confidentiality

All the information that collected is confidential. The information will not be available to anyone else. You are free to withdraw at anytime, for whatever reason, no questions asked. However, if there are any problems with either the group, or me please contact me after the discussion. The clinical staff has also agreed to be available if you have concerns that you do not wish to raise with me directly.

Safety issues

The nature of cultural awareness-raising can be difficult and provoke feelings of guilt, anger, shame, or sadness in some people. This is due to exposure to issues such as power, privilege, and identity awareness. These processes are normal and typical in this type of programme. However, should you feel uncomfortable at any time and wish to take a break, or withdraw all together, please let me know. It would however be helpful if you could discuss your concerns before deciding to withdraw, as these feelings are typical and often discussing these feelings either individually or in a group setting can help to prevent any further difficulties.

Participant support services

Should you require additional support, you may benefit from either talking with a clinical staff member, or talking with a student counselor. Your university has student support services available to you.

Additional information issues

The outcomes of this programme will be published and or presented at conferences in the near future. No identifying information will be divulged, unless requested by you.

Confidentiality

Your details will be kept confidential. You may read any information about you if requested. The information gathered over the course of this study will not be made available to the clinical programme staff.

Consent

A consent form will be provided during the workshop.

Thank You for Your Time and Effort

Contact Details Waikaremoana Waitoki Department of Psychology University of Waikato 07-856-2889 ext. 8403 m.waitoki@waikato.ac.nz

Supervisor Contact Dr Averil Herbert
Māori Counsellor, Psychologist
Directorate for Māori Advancement Waiariki Institute of Technology Private Bag 3028 ROTORUA

Dr Bernard Guerin
Associate Professor of Psychology University of Waikato
Private Bag, Hamilton University of Waikato 07-856-2889 ext. 8293
b.guerin@waikato.ac.nz

Programme Timetable

Day One

Time	Format	Facilitator	Topic
9:00			Course welcome/introduction/mihimihi
10:00			Rationale for kaupapa Māori focus & theories of cultural competency
10:30			Morning Tea
11:00			Social Justice Part 1: Treaty of Waitangi
12:00			Social Justice Part 2: The impact of Treaty breaches and legislation on Māori
12:30			Lunch
1:00			Cultural awareness: Part 1
2:30			Cultural awareness: Part 2
3:00			Finish

Day Two

Time	Format	Facilitator	Topic
9:00am			Cultural knowledge: Part 1
10:30am			Cultural knowledge: Part 2 Cultural skills Part 1: Assessment
11:00am			Morning Tea
1l:30am			Cultural skills Part 2: Bicultural Case Conceptualisation
12:00			Bicultural case conceptualisation (cont.)
12:30pm			Lunch
1:00pm			Treatment planning
2:30pm			Wrap-up & consolidating awareness, knowledge and skills
3:30pm			

Appendix C   *Consent Form*

University of Waikato

Psychology Department

CONSENT FORM

PARTICIPANT'S COPY

Research Project: Cultural Competency Training in Aotearoa: Transferring Multicultural Training into a Bicultural Context

Name of Researcher: Moana Waitoki_____

Name of Supervisor (if applicable): Dr Bernard Guerin & Dr Averil Herbert_____

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee.

Participant's Name:_____Signature:_____Date:_____

===

University of Waikato
Psychology Department

CONSENT FORM

RESEARCHER'S COPY

Research Project: Cultural Competency Training in Aotearoa: Transferring Multicultural Training into a Bicultural Context

Name of Researcher: Moana Waitoki_____

Name of Supervisor (if applicable): Dr Bernard Guerin & Dr Averil Herbert_____

I have received an information sheet about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee.

Participant's   Name: _____Signature:_____
Date:_____

Appendix D   *Demographic Form, Pilot Programme*

Demographic Sheet

This information is to ensure that relevant information is gathered that adequately describes your background

Name:_____

Age:_____   Source of Income:_____

What year are you in (the Clinical Programme)_____

What training or study have you had/done in relation to working with Māori, or diverse groups?

_____

_____

_____

_____

_____

_____

Iwi links:_____

Church Links:_____

Sexual Orientation:_____

Did you grow up in your own iwi area? Yes / No / N/a

Children: Yes / No

Age: F / M:

Thank you for participating
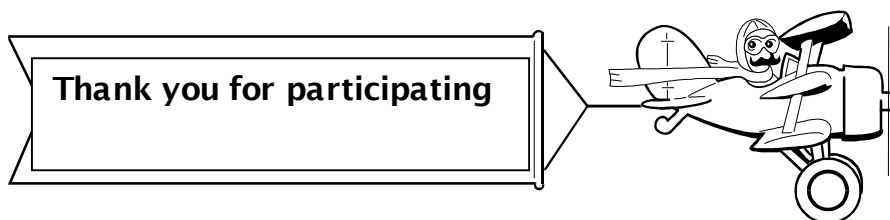
Appendix E   *Pre Workshop Questionnaire, Pilot Programme*

For each statement, indicate the response that most closely identifies your beliefs and attitudes. Use the following code:

5 = I strongly agree with this statement 4 = I agree with this statement

3 = I am undecided about this statement 2 = I disagree with this statement

1 = I strongly disagree with this statement

_1. Well-trained, sensitive, and aware therapists who do not impose their own values on clients are better qualified to work with diverse cultural groups

_2. To practice effectively, I must be of the same ethnic group as my client

_3. Psychological interventions are multicultural because the underpinning theories are value-free

_4. I must challenge cultural stereotypes when they become obvious in therapeutic situations

_5. Contemporary psychological theories can be applied to all ethnic and cultural groups

_6. I will be able to examine my behaviour and attitudes to determine the degree to which potential cultural biases might influence assessment, formulation and intervention directions

_7. I am able to critically analyse my therapeutic style to ensure that the client receives the best possible cultural service

_8. Special guidelines are needed for therapy with members of different ethnic and cultural groups

_9. I must take into account the ethnic and cultural difference between myself and my clients

_10. I have an ethical responsibility to ensure that I am familiar with the value systems of diverse cultural groups

_11. I would have no trouble working with Māori clients

_12. Māori and New Zealanders are more alike than different

_13. Breaches of the Treaty have no bearing on the state of Māori health

_14. Client resistance in therapy is more about not wanting to change, than differences between the therapist and the client

_15. As a condition for registration, or practice, all therapists should have specialised training and supervised experience in relation to ethnicity, gender, sexual orientation, age, religion, disability, or socioeconomic status

_16. At this point in my training, I feel well prepared to work with clients from different ethnic groups

_17. The Treaty of Waitangi provides a useful framework when working with Māori

_18. The Treaty of Waitangi provides a useful framework when working with other ethnic groups

_19. I am knowledgeable about racial identity development

_20. My ethnicity does not impact on my client's treatment outcomes

_21. The client's ethnicity does not impact on my decision-making

_22. The client's worldviews should always been considered

_23. I am aware of my own worldview and how it impacts on clients

_24. I am aware of how negative beliefs and stereotypes can impact on treatment outcomes

_25. I feel confident incorporating indigenous helping practices into my client's treatment plan

_26. My socioeconomic status does not impact on how I relate to clients

_27. Behavioural models are relevant across all cultures because of empirical testing

_28. Cognitive models are relevant across all cultures because of empirical testing

_29. Using formulation models I am able to accurately conceptualise cultural factors into a client's presenting problems

_30. Even without careful investigation of cultural factors, a good functional analysis will enable me to accurately describe problem behaviour

_31. I should know about socio-political events that may impact on my clients

_32. Psychometric testing is value and culture free

_33. Psychometric tests done properly are still applicable to non-normed populations

_34. Land alienation, acculturation and oppression can account for minority mental health problems

_35. Openness and sensitivity alone are the fundamental characteristics needed when working with diverse clients

_36. I am able to recognise the limits of my competency in relation to diversity

_37. "Referring on" should only be done after I have made every attempt to develop my awareness, knowledge and skills when working with diverse clients

_38. I am aware of how my communication style might impact on clients

_39. Clients should converse in English alone in therapy

_40. I am able to work with clients different religious beliefs

_41. I know that psychometric tests are biased towards many ethnic groups and can adjust test results accordingly

_42. I am comfortable intervening with other professionals or institutions on behalf of my client when issues of discrimination occur

_43. I know that barriers exist for minority clients when accessing therapeutic services

_44. I know that ethnic/culturally diverse clients experience discrimination in ways that I have not, or will not experience

_45. I understand the importance of acquiring verbal and nonverbal culture-specific communication styles

_46. There is too much unnecessary emphasis on Treaty training and cultural safety

_47. I am able to use a language with which my client is familiar to describe the therapeutic process

_48. I am aware of the impact of western psychology on my clients

_49. I feel comfortable assessing Māori cultural identity

_50. I am able to design and implement treatment plans for diverse client groups

_51. I know that clients from different cultures experience psychiatric illness differently from DSM-IV categories

_52. I know that psychological theory is embedded in a western framework that may be irrelevant to Māori, and other cultural groups

The following questions are designed to obtain qualitative information about how you see cultural competency training programmes.

1. How can cultural competency training affect clinical practice?

2. What do you hope to gain from undertaking cultural competency training?

Appendix F   *Post Workshop Questionnaire, Pilot Programme*

The post workshop questionnaire is a repeat of the Pre-Q with the addition of these questions:

The following question should be answered after you have completed the workshop

1. How can cultural competency training affect clinical practice

2. Have your goals in Q2 been met?

Yes

No

If yes, how have your goals been met

If no, what was missing?

Appendix G   *Retrospective Questionnaire, Pilot Programme*

This is a retrospective questionnaire that is designed to elicit additional information that was not asked after the Cultural Competency Workshop. The information you provide will assist in redesigning the workshop.

Please read through the notes from the Cultural Competency Workshop. This will help remind you of the content of the programme and will help you to answer the questions below.

	Before Training	After Training
	1 – not that important 2 – somewhat important 3 – important 4 – very important 5 – extremely important	1 – not that important 2 – somewhat important 3 – important 4 – very important 5 – extremely important
1. How important was it to you to have undertaken the Cultural Competency (CC) workshop?	1 2 3 4 5	1 2 3 4 5
2. How important do you now think CC workshop is for students and psychologists	1 2 3 4 5	1 2 3 4 5
This section should be answered as yes no, and open-ended.		
3. Why do you think the CC workshop is important or not for psychologists and students?		
4. Has your understanding of how to work with Māori improved as a result of the CC workshop? If so, in what way?		
5. If not, what do you think would improve your understanding?		
6. What aspects of the CC workshop did you find most useful? a) trainer style b) workshop format c) manual		

d) workshop content	
7. What aspects of the CC workshop did you find least useful?	
8. What do you think would help you generalise the training programme content into your practice?	
9. What would make it difficult for you to generalise the training content into your practice?	

This section focuses on the importance of certain contents of the Cultural Competency training. It is organised according to your thoughts before and after the training workshop. For example, consider what you thought about ethnic identity before training, and what you thought after training.

	Before Training	After Training
	1 – Did not think about it 2 – somewhat important 3 – important 4 – very important 5 – extremely important	1 – Did not think about it 2 – somewhat important 3 – important 4 – very important 5 – extremely important
10. How important is it to include assessment of Māori ethnic identity?	1 2 3 4 5	1 2 3 4 5
11. How important do you believe it is for you to be aware of cultural factors in therapy?	1 2 3 4 5	1 2 3 4 5
12. How important is it for you to be skilled in applying different techniques for Māori clients?	1 2 3 4 5	1 2 3 4 5
13. How important is it for you to be aware of Treaty issues?	1 2 3 4 5	1 2 3 4 5

	Before Training	After Training
14. How important is it for you to be skilled at addressing the impact of socio-political variables on Māori?	1 2 3 4 5	1 2 3 4 5
15. How important is it for you to be aware of how acculturation can impact on Māori clients?	1 2 3 4 5	1 2 3 4 5
	Before Training	After Training
	1 – Did not think about it 2 – somewhat important 3 – important 4 – very important 5 – extremely important	1 – Did not think about it 2 – somewhat important 3 – important 4 – very important 5 – extremely important
16. How important is it for you to be aware of privilege and how it can impact on therapy?	1 2 3 4 5	1 2 3 4 5
17. How important do you think it is for you to know about Māori identity and its impact on psychological wellbeing?	1 2 3 4 5	1 2 3 4 5
18. How important is it for you to be aware of stereotypes and how they can impact on therapy?	1 2 3 4 5	1 2 3 4 5
19. How confident do you feel in your ability to work with Māori clients? (before and after training) Questions a-f:	1 no confidence at all 2 some confidence 3 confident 4 pretty confident 5 highly confident	1 no confidence at all 2 some confidence 3 confident 4 pretty confident 5 highly confident
a. Acculturation b. Māori identity c. Cultural variables d. Stereotypes e. Sociopolitical issues f. Cultural case conceptualisation	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
This section focuses on behavioural outcomes of training, and should be thought of in relation to post-training behaviour (i.e., what have you done since the CC workshop)		
20. Have you had a Māori client since you did the training programme?	Yes	No

21. If so, did you do anything with this client that you think was a result of CC training? What did you do?		
22. How would you rate the effectiveness of what you did (following on from Q. 21)?	1 not at all effective 2 somewhat effective 3 effective 4 very effective 5 extremely effective	1 2 3 4 5
23. What, if anything, would you do differently with a Māori client that you would not have done before the CC workshop?		
Any other comments you would like to add:		
Thank you very much for your time		

Appendix H *CIT Information Letter: Study Two*

Multicultural Competency Training in a Bicultural Context

Information Sheet: Critical Incident Technique

Waikaremoana Waitoki
Psychology Department
University of Waikato
HAMILTON   20/05/06

Kia ora ra koutou katoa

Tuatahi he mihi kau noa atu ki a koe mo tau whakaaro ki te noho ki taku taha hei awhina i taku mahi i tenei wa. He paku korero tenei kia whakamarama atu ki a koe i te kaupapa o taku mahi, te ahua o nga patai, me te ahua o te haora kei mua i a tatou.

Purpose of the research

This phase, the critical analysis technique forms part of a PhD research based on developing a cultural competency programme for clinical psychology students. The purpose of this phase is to discuss critical incidents with practitioners who have extensive experience working with Māori clients, or who have supervised others who have worked with Māori clients.

Critical incidents are reports or descriptions of things people in the studied population report having done or have been observed by others as having done. These reports are classified as effective or ineffective in achieving the desired job results (of working with Māori clients). These descriptions can take the form of stories, anecdotes, reports, or observations related by peers, supervisors, or managers.

The typical method of obtaining critical incidents is to interview practitioners. I have chosen to interview people who have extensive experience working with Māori clients. The interview should take approximately 50 minutes and will be quite detailed. Please feel free to ask for clarity at any stage, or if you would rather terminate the discussion, just let me know. The data gathered from this phase and two completed pilot programmes will form the content of a revised cultural competency training programme that will be trialed with clinical psychology students.

There are two forms to fill out. One is a demographic form which asks questions about your work role and training experience. The other form is the standard University of Waikato consent form. If you have any questions or concerns please do not hesitate to discuss these with me, email, or call.

Noho ora mai,

Waikaremoana Waitoki
m.waitoki@waikato.ac.nz

Appendix I   *Critical Incident Technique Interview Schedule*

1) **Job title of target job**.
What specific clinical psychology job is this information in reference to?
Assessment, diagnosis, treatment, etc.,
Relate this information to broad categories of clinical jobs

How many years have you practiced?_____

Highest qualification achieved_____

What is your ethnicity?_____

Where do you
work?_____

_____

Current position _____

Contact details_____

Typical tasks that you perform as a psychologist when working with Māori

2) **Relationship of respondent to target job.**
Is the respondent: a supervisor __ an incumbent __ a client __ a cultural advisor __

3) **Specific tasks performed as a psychologist.**
Identify the key tasks performed in the job. Brainstorm the AKSs for these tasks (brainstorm the aks based on tasks performed)
Identify the critical tasks

Follow-up questions
This "tasks then AKSs" approach also allows you to use follow-up questions when respondents provide vague AKSs. "For which of the tasks you mentioned earlier is cultural background important?" "Taking the first task you mentioned of 'performing an initial client interview with a Māori client', what specific knowledge of cultural background knowledge is important? Why is that knowledge important for this particular task?"

4) **Greater specificity in AKSs.** More specific details about the specific AKSs that are important, for example, when a respondent says a broad category of knowledge, such as when Respondent # 1 says "Treaty of Waitangi" as the first knowledge requirement, you need to follow up to find out what specific knowledge of the Treaty they believe clinicians need to have.

5) **Specific and multiple critical incidents.** You need to use follow-up questions to obtain more specific critical incidents from your respondents. Ask the respondent to provide a specific example of when they recall a clinician doing this, describing the

the situation the clinician faced,

their *or the other's behavior*

outcomes what happened?

Below is an example of an ineffective critical incident

Situation: An older Māori man, (Jehovah Witness), (dark-skinned) from Ngati Pikiao was referred to a mental health service for anger-management.

Behaviour: The psychologist engaged in a therapeutic alliance building process of whakawhanaungatanga. He described his own whakapapa to the client at which point the client laughed derisively. The psychologist had assumed that the client was open to a formal whanaungatanga process because of his obvious ethnicity and geographical background.

Outcome: The psychologist was able to use the incident to discuss issues around culture and the client's referral problem.

Example of an effective incident

Situation: A young boy was referred to a mental health service following the death of his girlfriend.

Behaviour: A young man (Tuhi) was referred following the death of his girlfriend. As part of the whakawhānaungatanga process the clinician talked about her Māori ethnicity, and whakapapa of Ngā Puhi. Tuhi was from Kai Tahu. His grandmother, from Kai Tahu rang the service in a distressed state and questioned the receptionist about the clinician's whakapapa and said that she "didn't want someone messing with her boy's head, who wasn't friendly".

Outcome: This process enabled the mother to 'save face' (by talking with the receptionist) and to learn that there was a safe iwi link between her son and the practitioner.
From these incidents I then identity the knowledge, skills, and attitudes a psychologist needs to do the same thing, (or not).

3. Start by describing a critical incident (either effective or ineffective) in which a psychologist (yourself, a peer, or a supervisee) was involved.

(1) Critical incident
Situation

Behaviour

Outcome

(2) Critical incident (effective or ineffective):

Situation

Behaviour

Outcome

What knowledge, skills, or attitudes do you think a psychologist should possess to have done what you did with your client? Please be as specific as possible (i.e., rather than 'knowledge of Māori culture (generally)' – knowledge of iwi and hapu history and any historic animosity between different tribes. Nga Puhi geographical knowledge, customs, practices). (The incident above highlights the importance of knowing tribal histories and provides clear evidence of how not knowing this history could have undermined the therapeutic relationship).

Knowledge

Skill

Ability

Thank you for taking the time to participate

Appendix J   *Consent Form Critical Incident Technique*

University of Waikato Psychology Department

CONSENT FORM

PARTICIPANT'S COPY

Research Project: Cultural Competency Training in Aotearoa: Developing a Cultural Competency Training Programme

Name of Researcher: Waikaremoana Waitoki_____

Name of Supervisor (if applicable): Professor Paul Taylor and Bernard Guerin

I have received information about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Research and Ethics Committee.

Participant's Name:_____Signature:_____

Date:_____

==

University of Waikato Psychology Department

CONSENT FORM

RESEARCHER'S COPY

Research Project: Cultural Competency Training in Aotearoa: Developing a Cultural Competency Training Programme

Name of Researcher: Waikaremoana Waitoki_____

Name of Supervisor (if applicable): Professor Paul Taylor and Bernard Guerin

I have received information about this research project or the researcher has explained the study to me. I have had the chance to ask any questions and discuss my participation with other people. Any questions have been answered to my satisfaction.

Participant's Name:_____Signature:_____
Date:_____
Director of Clinical Training
Department of Psychology

Appendix K   *Letter for Clinical Programme Director – Study*
Three

Address line 1
Address line 2
Suburb
City

Date

Dear Sir/Madam,

Re: Phd Research -   Bicultural competency: transferring the multicultural competency literature into a bicultural context

Thank you for considering your participation in this research and your involvement to date. Further to our initial contact, this letter is a formal request to proceed with the research study. I have received ethical approval from Waikato University Psychology Department's Ethics Committee.

I propose that the research be conducted with students in either the 2nd or 3rd (Internship) years of training. This is to ensure that participants have some clinical experience and the opportunity to utilise the skills taught in the workshop. The workshop will be conducted over two-days. The students may leave at any point and may also withdraw their information at any time, without penalty.

I also ask that the clinical tutor contact the supervisors of the students (participants) to obtain their (the supervisor's) permission to participate in the research. I will provide my contact details for the supervisor and they can contact me. Alternatively, if they provide their contact details, I will contact them.

I have included copies of the programme outline, evaluation outline, and consent forms. If you have any questions, please do not hesitate to contact me at the email or phone address above.

Noho ora mai,

Waikaremoana Waitoki
PhD Candidate
Registered Psychologist

Appendix L   *Workshop Outline: Study Three*

Cultural Competency Training Workshop

Waikaremoana Waitoki - 2006

This workshop focuses on developing cultural competency skills to enhance the effectiveness of participants when working with clients who are culturally diverse. The workshop is based on bicultural models of practice, with a particular emphasis on the Treaty of Waitangi. The emphasis is on understanding the implications of culture and ethnicity on the therapeutic relationship (for example: a non-Māori psychologist with a Māori client, or a Māori psychologist with a non-Māori client.

❑ A recent trend in the competency literature has been to focus on developing a culturally aware, culturally knowledgeable, and culturally skilled practitioner
❑ Psychologists must be culturally sensitive and culturally competent when working with clients from a different cultural background
❑ Training is regarded as an essential tool for trainee psychologists to gain core clinical and cultural competency for Māori, and the development of the trainee

Workshop Format

The workshop teaching methodology is a combination of didactic teaching, role-play (RP), group discussion (GD) and working in pairs.

Day One

9:00am – **Welcome and karakia***:* Spiritual acknowledgment and blessing of workshop. Housekeeping. *Mihimihi:* Greetings and whakawhānaungatanga: establishing links through people, shared professional identity, discussion of expectations of workshop participation.
Workshop rationale – discussion of current models of training and their cultural and ethical limitations; issues in training, practice and service delivery.

Foundations of Cultural Competency - Discussion of the principles of cultural competencies with regard to the following: Cultural awareness, cultural knowledge, and cultural skills. Discussion of issues in multicultural competencies.

10:30am – *Kai – Whakanoa:* Morning tea break

11:00am – **Cultural awareness** - Developing a personal understanding of cultural competency - Social justice, privilege, power differences, biases and assumptions that impact on clinical judgment.

12:00pm – Kai a te rānui - lunch

12:45pm – Participants will be encouraged to identify and challenge their own biases and stereotypes and its potential impact on clients. These exercise serve as a model for developing these competencies in trainees.

Cultural knowledge – Knowledge acquisition (i.e., what knowledge do we need to acquire) in cultural competency. 3:00pm - Finish

Day Two

9:00am – **Cultural knowledge** – Knowledge acquisition (i.e., what knowledge do we need to acquire) in cultural competency; identity, therapists and client characteristics that impact on therapy. Review of cultural formulation models.

10:30 – Morning tea

11:00 – **Cultural skill** – Building competencies to work with Māori; developing skills to build a therapeutic alliance; working with specific Māori processes; raising the issue of culture in the relationship; whakatau and powhiri processes. Building a cultural formulation.

12:00pm – Kai a te rānui - lunch

12:45pm – **Cultural skill (cont)** Issues in culturally-ethically appropriate assessment and treatment; engaging the client and whänau. Building a cultural functional analysis and cultural formulation Examples from the facilitator will be utilised for discussion. Developing culturally appropriate case formulations.

3:00pm – Summary and feedback

Poroporoaki – farewell.

Appendix M   *Pre-Workshop Questionnaire (pre-Q)*

Name:	Date:	Position:
	18 – Dec – 06	

Circle a response that best matches what you currently think				
1 = none	2 = a little	3 = average	4 = above average	5 = high

1. Rate your level of awareness of cultural competency	1 2 3 4 5
2. Rate your level of confidence to work with Māori	1 2 3 4 5
3. Rate your level of awareness of how your identity and culture can affect how you perceive others	1 2 3 4 5
4. Rate your level of awareness of how your identity and culture can affect how others perceive you	1 2 3 4 5
5. Rate your level of awareness of the impact of stereotypes and discrimination	1 2 3 4 5
6. Rate your level of awareness of how culture can affect judgment	1 2 3 4 5
7. Rate your level of knowledge of cultural competency	1 2 3 4 5
8. Rate your level of knowledge of cultural formulation models	1 2 3 4 5
9. Rate your level of knowledge of the impact of institutional racism	1 2 3 4 5
10. Rate your level of knowledge about privilege and its impact on therapy	1 2 3 4 5
11. Rate your level of knowledge about power and its impact on therapy	1 2 3 4 5
12. Rate your level of knowledge of Treaty issues	1 2 3 4 5
13. Rate your level of knowledge of the impact of western psychology on Māori	1 2 3 4 5
14. Rate your level of knowledge of the history of oppression and discrimination of Māori	1 2 3 4 5
15. Rate your level of knowledge of acculturation issues for Māori clients	1 2 3 4 5
16. Rate your level of knowledge of the monocultural nature of psychological theory	1 2 3 4 5
17. Rate your level of knowledge of Māori identity	1 2 3 4 5
18. Rate your level of knowledge of different Māori views of psychological illness	1 2 3 4 5

19. Rate your level of knowledge of Māori psychological helping techniques	1 2 3 4 5
20. Rate your level of knowledge of Māori family structures	1 2 3 4 5
21. Rate your level of knowledge of the impact of worldviews on behaviour	1 2 3 4 5
22. Rate your level of knowledge of the process involved in doing a whakatau	1 2 3 4 5
23. Rate your level of knowledge of the purpose of mihimihi	1 2 3 4 5
24. Rate your level of knowledge of the purpose of waiata	1 2 3 4 5
25. Rate your level of knowledge of pepeha	1 2 3 4 5
26. Rate your level of knowledge of the powhiri process	1 2 3 4 5
27. Rate your level of knowledge of how to develop a cultural formulation for Māori	1 2 3 4 5
28. Rate your ability to participate in a whakatau	1 2 3 4 5
29. Rate your ability to participate in a powhiri	1 2 3 4 5
30. Rate your ability to say a pepeha	1 2 3 4 5
31. Rate your ability to participate in waiata	1 2 3 4 5
32. Rate your ability to challenge others about racism and discriminatory practices	1 2 3 4 5
33. Rate your ability to modify therapy techniques for Māori	1 2 3 4 5
34. Rate your ability to understand a Māori worldview	1 2 3 4 5
35. Rate your ability to do a functional analysis using cultural variables for Māori	1 2 3 4 5
36. Rate your ability to identify your level of cultural competency	1 2 3 4 5
37. Rate your ability to raise the issue of ethnicity with Māori	1 2 3 4 5
38. Rate your ability to develop rapport with Māori	1 2 3 4 5
39. Rate your ability to convey empathy in culturally sensitive ways	1 2 3 4 5

No reira, i runga i te rangimarie, me te aroha, kia ora rawa atu mo te tautoko mai i tenei kauapapa whakahirahira taku.

Thank you very much for participating in this research project.

Appendix N   *Post-Workshop Questionnaire (post-Q)*

The table below was added to the pre-Q above.

This section focuses on the format and content of the programme
40. What do you think has been the most useful component of the workshop for you?
41. What do you think has been the least useful component of the workshop for you?
42. How did you find the trainer's style of teaching?
Any other comments you would like to add:

Appendix O   *Retrospective Questionnaire (retro-Q)*

Name:	Date: 18 – Dec – 06	Position:
This questionnaire focuses on the importance of certain contents of the Cultural Competency training. It is organised according to your thoughts before and after the workshop. For example, consider what you thought about ethnic identity before training, and what you thought after training. Circle a response that best matches what you currently think		

1 = none	2 = a little	3 = average	4 = above average	5 = high

1. Rate your level of awareness of cultural competency	1 2 3 4 5
2. Rate your level of confidence to work with Māori	1 2 3 4 5
3. Rate your level of awareness of how your identity and culture can affect how you perceive others	1 2 3 4 5
4. Rate your level of awareness of how your identity and culture can affect how others perceive you	1 2 3 4 5
5. Rate your level of awareness of the impact of stereotypes and discrimination	1 2 3 4 5
6. Rate your level of awareness of how culture can affect judgment	1 2 3 4 5
7. Rate your level of knowledge of cultural competency	1 2 3 4 5
8. Rate your level of knowledge of cultural formulation models	1 2 3 4 5
9. Rate your level of knowledge of the impact of institutional racism	1 2 3 4 5
10. Rate your level of knowledge about privilege and its impact on therapy	1 2 3 4 5
11. Rate your level of knowledge about power and its impact on therapy	1 2 3 4 5
12. Rate your level of knowledge of Treaty issues	1 2 3 4 5
13. Rate your level of knowledge of the impact of western psychology on Māori	1 2 3 4 5
14. Rate your level of knowledge of the history of oppression and discrimination of Māori	1 2 3 4 5
15. Rate your level of knowledge of acculturation issues for Māori clients	1 2 3 4 5
16. Rate your level of knowledge of the monocultural nature of psychological theory	1 2 3 4 5

17. Rate your level of knowledge of Māori identity	1 2 3 4 5
18. Rate your level of knowledge of different Māori views of psychological illness	1 2 3 4 5
19. Rate your level of knowledge of Māori psychological helping techniques	1 2 3 4 5
20. Rate your level of knowledge of Māori family structures	1 2 3 4 5
21. Rate your level of knowledge of the impact of worldviews on behaviour	1 2 3 4 5
22. Rate your level of knowledge of the process involved in doing a whakatau	1 2 3 4 5
23. Rate your level of knowledge of the purpose of mihimihi	1 2 3 4 5
24. Rate your level of knowledge of the purpose of waiata	1 2 3 4 5
25. Rate your level of knowledge of pepeha	1 2 3 4 5
26. Rate your level of knowledge of the powhiri process	1 2 3 4 5
27. Rate your level of knowledge of how to develop a cultural formulation for Māori	1 2 3 4 5
28. Rate your ability to participate in a whakatau	1 2 3 4 5
29. Rate your ability to participate in a powhiri	1 2 3 4 5
30. Rate your ability to say a pepeha	1 2 3 4 5
31. Rate your ability to participate in waiata	1 2 3 4 5
32. Rate your ability to challenge others about racism and discriminatory practices	1 2 3 4 5
33. Rate your ability to modify therapy techniques for Māori	1 2 3 4 5
34. Rate your ability to understand a Māori worldview	1 2 3 4 5
35. Rate your ability to do a functional analysis using cultural variables for Māori	1 2 3 4 5
36. Rate your ability to identify your level of cultural competency	1 2 3 4 5
37. Rate your ability to raise the issue of ethnicity with Māori	1 2 3 4 5
38. Rate your ability to develop rapport with Māori	1 2 3 4 5
39. Rate your ability to convey empathy in culturally sensitive ways	1 2 3 4 5

This section focuses on the format and content of the programme and your practice since doing the workshop.

40. Since doing the workshop, what changes, if any, have you made to your practice in relation to cultural competency?
41. What difference have these changes made?
42. Have you had a Māori client since you did the training programme?   If so, what did you do with this client that was a result of the workshop?
43. How would you rate the effectiveness of what you did with your client?   1. Very ineffective   2. Somewhat ineffective   3. Effective   4. Very effective   5. Highly Effective
44. What do you do with a Māori client that was a result of the workshop that did not work so well?
45. What do you think has been the most useful component of the workshop for you?
46. What do you think has been the least useful component of the workshop for you?
47. Since doing the workshop, what changes, if any have you made to your practice in relation to cultural competency?
48. What do you think should have been included in the workshop?
Any other comments you would like to add:

No reira, i runga i te rangimarie, me te aroha, kia ora rawa atu mo te tautoko mai i tenei kauapapa whakahirahira taku.

Thank you very much for participating in this research project.

Appendix P   *Scenarios, AKS and Competency Statements*

<u>Māori Cultural Themes as Training Needs</u>

The competencies listed are interrelated and rely on each other for meaning, context, and proficient use. The competencies do not stand alone and all would be meaningless if taught as discrete parts. As I said in chapter nine, I included a few of the scenarios in that section to provide evidence for the development of the themes. The remaining scenarios are presented below together with a portion of the scenarios from chapter nine (I also included the psychologists' nom de plumes to help remind the reader). The scenarios are organised under their themes, followed by the AKS(s) and then the competency statements.

Theme 1: Incorporating whakawhānaungatanga

Table 10: Scenario Relationship Building: Personal Disclosure

> **Situation   57:**   Female   psychologist,   Māori   34   (Erena) whakawhānaungatanga/and use of Māori concepts. A nine-year old Māori boy was referred to the CAF service for assessment following a suicide attempt. The boy had a long referral history to the service. He had attended Te Kōhanga Reo, and Te Kura Kaupapa (Maori preschool and a total immersion Maori school). The clinician thought through the referral information and wondered what had happened to this boy and questioned in her mind "why wasn't anything working?"

Table 11: Scenario Using Hongi to Close a Relationship

> **Situation 37:** Male psychologist, Pākehā (Quinn). [35]Closing a relationship – Hongi and writing a report on client after hongi. Male – 34 years old. Safety issues with violence and sex offending. Said he was "not into that Māori stuff". Did not want Bicultural Treatment Model (BTM). He was aggressive and threatening. Beat up people a lot. Threatened to beat me up. Did not like praise.

---

[35] This scenario could be used for a number of themes. It is in this theme because the client wanted to establish a connection with the psychologist, even though it occurred at the conclusion of therapy.

Table 12: Scenario Using Karakia and Te Reo to Establish Rapport

Situation 25: Female psychologist, British, (aged 28). 20 year old male. Assessment to identify what contributed to client's offending. Client was suspicious, made no eye-contact and was ashamed of offending. He was raised traditionally with Māori grandparents until 10. He was returned to the parental home where he was physically abused by father. When he returned to grandparents some years later, he distanced himself from Māori tikanga and processes.
Behaviour: I offered karakia, made attempts to speak Māori correctly, offered a cultural assessment.
Outcome: Was able to develop a relationship with him, and he talked about his offending patterns. He also engaged with Māori tikanga offered as part of the prison programme.

Table 13: Scenario Using Patience to Gain Trust

Situation 26: Female psychologists, Chinese (mid 20s). Male client, 20 years old. Referred for parole assessment. Responses were yes/no, unresponsive, consistently demonstrated lack of interest. Previously assessed by two psychologists. He appeared detached, and uninterested in treatment. I attempted to make a connection but nothing was working.
Behaviour: I decided to try a direct approach and told him that "we have a scheduled hour and I'll sit here anyway and shut-up and wait to hear what he says.
Outcome: After 30-odd minutes started to talk about what he was there for. Psych was able to identify that he was anxious in groups and did not trust others. I offered to do individual treatment.

Table 14: Scenario Looking For Connections to Establish a Relationship

[36]**Situation 52:** Male psychologist, Scottish (late 40s). Client, male, late 40s. Ten minutes into the session he said he didn't like Pākehā. He said, not you though, you go beyond true (his term for trustworthy). He was part-Māori. He wanted to explore his identity. He self-identified as Māori but was identified by others as Pākehā – he didn't want that. A background exploration revealed that he rejected aspects of Māori self-determination, such as, land claims and Treaty issues.
Behaviour: Rapport building - Both human beings. I know what it feels like

---

[36] This scenario was also used for Themes 3 and 5

to be angry – it's a good platform. If there is a connection you can pick it - there is a space between you if there is no connection. If there is space, I try a karakia".

Outcome: Openness to begin exploring cultural identity and then work on other psychological processes affecting offending behaviour.

Table 15: AKS: Whakawhānaungatanga/Relationship Building

Knowledge: Family roles: grandparents, parents, brothers, sisters, eldest, youngest, mokopuna; colonisation history of NZ; own history (which might not be in NZ) history of client – possible historical linkages; cultural mores, behaviours, worldview and beliefs.

That there could be emotional reactions to what is disclosed and being able to manage those reactions; that some clients will not want to establish links to their ethnic/cultural group; of different communication styles: body language and its meaning, eye contact, language, hugging, kissing cheeks, hongi. Iwi and hapu histories that might impact on psychologist and client; know the purpose of pēpeha, knows the relevance of maunga, awa and marae; karakia and opening processes; that you need to clarify your role early in the relationship.

That whakawhanaungatanga (a connection) can occur at any time in the relationship.

Skill: Making initial contact by phone and letter; having a core set of questions that you ask of yourself when you have a client from a different background; comfort with knowing that psychologist may have little cultural experience and being able to discuss that with the client; looking for things in the client's environment, or paying attention to what the client considers important that could be used to connect; being comfortable sharing information such as age, schooling, family structures; displaying a genuine attempt to connect; confidence using a non-clinical method to engage.

Being able to manage emotions: as anger, sadness, guilt, and shame to build an alliance and achieve goals; being open and respectful of clients probing to identify connections; being able to discuss a clients cultural background and gain real understanding from the information.

Demonstrate willingness to stay on client's level; using empathy and confidence when talking about client's problems, identifying verbal and non-verbal cues that someone is uncomfortable. Being able to connect a client to an advisor, kaumatua, marae, or community group.

Awareness: Of limitations of university psychological training in how to establish relationships with Māori and how that may impact on psychologists' worldview; body language and communication styles. The impact that whakapapa, iwi and hapu connections have on therapy; culturally

appropriate levels of relationship building (boundaries); that connections can lead to expectations; that a connection can occur on any level.

Competency statements Whakawhanaungatanga

 iv. Psychologists recognise that Māori may present with emotional reactions and worldviews based on a culture of discrimination and colonial oppression and have considered the impact of their position in the relationship

 v. Psychologists are prepared to build the relationship at a pace that meets the needs of client

 vi. Psychologists understand the western origins of psychological processes of engagement and use processes that recognise Māori worldviews

 vii. Psychologists who have a shared whakapapa with a client are able to manage conflicts and potential expectations that clients may have of them[37]

 viii. Psychologists understand the value that Māori assign to cultural practices and considers the impact on their worldview

 ix. Psychologists understand that whakawhanaungatanga can occur at any time, or place.

Theme 1a: Recognising whānau influences

Table 16: Scenario Māori Client's Worldview on Whānau

Situation 44: Male Psychologist, Pākehā, aged 48 (Paulo). Māori worldview on whānau. Ineffective. Client came in to see me with problems he was having a work.

---

[37] Tauutuutu described earlier is a considerable ethical dilemma for Māori psychologists. I do not propose an answer to this situation, but consideration must be given to which worldview prevails.

Behaviour: The psychologist asked "what was the impact of a particular event on his life?"The client said "well that is an interesting question: In order for me to tell you what I think about this. I have to think about what my mother thinks, what my father thinks and in fact what my extended whānau think too – then I can tell you what I think."

Table 17: Scenario Checking Credentials: Client and Whanau

Situation 63: Male psychologist, Māori (mid 40s). A whanau brought their son in for consultation. They were emotionally charged.
Behaviour: I had made prior contact with the whanau, I was well informed about the case file, I knew about the community. I was physically confident, happy to be submissive to restore equilibrium. The whanau asked if I was the right person for the job and that they wanted the best. I was not defensive. I was able to spot mana and to show reciprocity – tauututu.
Outcome: The whanau were comfortable with sending their son to the service and that I should be his psychologist.

Table 18: Scenario Using Manaakitanga/Hospitality

Situation 18: Female psychologist, Pākehā (mid 30s) reintegrate client back into whānau post release.
Behaviour: I contacted the whānau initially to discuss the process, talked about my role, who I was, what I was doing and any expectations. Basic manaaki – tea, coffee, refreshments and place to rest for a brief time. Facilitate whānau hui.
Outcome: It enabled the whānau to ask questions before the hui so that nothing was a shock to them, and to rest and refresh so that they weren't tired from the trip. Made the process a lot less confrontational and helped with the power dynamics associated with psychologist and whānau/client.

Table 19: Scenario Using Knowledge of Whānau Resolve Grief

Situation 45: Male psychologist, Pākehā (early 50s). A Maori woman was grieving over her son who had suicided [sic] some years previously.
Behaviour: I connected with the woman in terms of people I knew from her area. I had met members of her family. She was dealing with a number of issues and she was particularly grieving and feeling guilty about the suiciding [sic] of her son. I asked her to think about someone who had supported her

and given her encouragement when she was younger – it was her nanny – I then asked her: "If your nanny was listening to this conversation, what would she say to you right now, what words of encouragement would she have for you about X's death".

Outcome: The woman felt relieved and no longer experienced such strong feelings of guilt. She felt "released" from the burden of her boys death.

Table 20: AKS: Recognising Whānau Influences

Knowledge: About the concept of whānau and how it relates to self, hapū, iwi, tribe, river, maunga, and rohe; that whānau may be well-known in the community (confidentiality, or safety issues); socio-political history and effects of government, educational and welfare policies designed to reshape and isolate whānau; legislation related to adoption and whāngai; that children are viewed as taonga; the high rate of childhood abuse in Māori families.

Māori concepts of identity development, and child and whānau development; the validity or otherwise of psychometric tests for non-normed populations; that Māori mistrust government agencies; history of Māori interactions with Social Welfare/CYFS (Child Youth and Family Services)/health and education officers.

When meeting with whānau: knowing group dynamics – who is involved, how far they have travelled, what their needs may be; provision of refreshments; whānau may have questions prior to the hui – being available to answer questions; knowing who is going to start and who is going to finish; how a family functions together, or apart; what roles people will play; that it is not often the spokesperson with the mana; that the psychologist is selling the client a product; of different community and cultural groups that impact on the whānau.

The influence of cultural commitments (poukai, marae hui, tangihanga, unveilings) on whānau resources; that making the whanau comfortable is as important as gathering information; manaakitanga; that you are selling them a product; that you have to understand your client and they have to understand you; concepts of tuturu/honesty; knowing who is going to start, and who is going to finish; power differences; the importance of establishing linkages with communities.

Skill: Using karakia, mihimihi, and whakawhānaungatanga (when appropriate) or a process that conveys your trustworthiness; demonstrating an interest in the group and their cultural needs; being flexible and adaptable with time; not to rush the process; checking body language and verbal cues to

see who whānau defer to; being able to establish your integrity; collaborating with and trusting non-psychological experts; being confident to be in a room with whānau.

Being able to use the tapa wha model; noticing how clients interact with their whānau; making the whanau feel comfortable; offering hospitality – tea, refreshments; mihimihi – introducing oneself; establishing integrity – your right to ask the client questions[38]; got to be able to 'spot mana' – who is in charge; not be defensive, being able to pick the spokesperson.

Awareness: Being aware of who is "pulling the strings"; who do they defer to? Body language, last person speaking might be the one with mana; not be threatened (power difference); understand the process of reciprocity; client process and aware that it was appropriate; where communities are located; possible mistrust of the profession; of the inherent power imbalance that exists between the psychologist and the whānau.

That Māori whānau may be deeply mistrustful, afraid, anxious, angry, confused; or conversely, that whānau may be highly competent; of whānau role in whānau wellbeing; limitations and strengths in western models of psychological theory; family roles and structures differ from non-Māori; of the different socio-political context of Māori whānau including micro-aggressions (school, WINZ (Work and Income New Zealand), housing, hospitals).

Competency Statements: Recognising whanau influences

    a. Psychologists know the socio-political history of government policies designed to break-down whānau groups (i.e., promoting nuclear-family configurations, pepper-pot housing practices, and Social Welfare practices placing Māori children in foster care)

    b. Psychologists understand the concept of whakapapa/genealogy that is centered in a Māori worldview including (whāngai/Māori adoption) concepts

---

[38] See also Theme 4a sharing power

c. Psychologists know Māori values related to whānau, individualism and collectivism

d. Psychologists understand that Māori carry intergenerational grievances about Te Tiriti/Treaty breaches

e. Psychologists know the roles of individual whānau members

f. Psychologist are appropriately prepared to meet with whānau groups[39]

g. Psychologists have developed whakawhānaungatanga skills or seek appropriate assistance to develop those skills

h. Psychologists are comfortable with meeting whānau on a marae[40], in their home, or in a place of their choosing

i. Psychologists can engage with and show interest in whānau members including kaumatua, parents, teens, children and whānau support persons

j. Psychologists appear confident and can convey mana without forcing his or her authority.

Theme 1b: Comfort with using self-disclosure/sharing stories

Table 21: Scenario Self-Disclosure: Sharing Stories

Situation14: Female psychologist, Pākehā 35, (Jade). Male 36, The client was suspicious, gang member/ rapport was difficult to establish. He wouldn't make eye contact and there was a hint of irritation. He sat facing away from me.

---

[39] Flexibility requires a calm state of mind. Psychologists who are inexperienced or lacking in confidence are inflexible and may not be able to monitor the direction of the session

[40] This happens with some regularity depending on the recovery goals of the client, or mauhere.

Table 22: Scenario Sharing Stores Relationships with Grandparents

Situation 1: Female psychologist, Pākehā/Samoan. Client was female from Tuhoe. Assessment of offending cycle and treatment goals. Client was reserved and unwilling to disclose information. Difficult establishing relationship with client. Client presented as psychologically disturbed – rocked, no eye-contact withdrawn. Client had panic attacks.
Behaviour: I disclosed personal information. I told her that I was born on the same day as her in the context of gathering background information, and that I was also raised by her grandmother until she died. I also asked the client "if she would like to begin with a karakia or other ritual specific to you". I also demonstrated as much as possible, empathy and concern for her wellbeing. Conducted a timeline in one of the sessions to describe historical events that were significant to offending history.
Outcome: Client disclosed an event in her life and her feelings towards the event. The event was a precipitating factor in her lifestyle of offending. She had not told anyone else previously.

Table 23: Scenario Self Disclosure Commonalities and Differences

Situation 39: Male psychologist, Pākehā. Prisoner, long-term sentence Tuhoe, gang-affiliated.
Behaviour: I try to engage the offender by talking about where I come from, any issues that arise because of my ethnicity, language, pronunciation and I talk about my family. I also invited the offender to ask me anything they would like to know. Client did a tauparapara then translated it for me.
Outcome: Client agreed to continue working with me.

Table 24: AKS: Self Disclosure/Sharing Stories

Knowledge: Knowing when to back-off from the relationship- when you are not the best person for the job; that a connection can occur on any level; process issues related to boundaries; code of ethics; that not sharing information could be seen as unethical (i.e., reciprocity dynamics).
Skill: Ability to let a process proceed without knowing what is going on; to

trust in others; picking the right time to disclose; seek out educational, consultative, and training experience to improve understanding and effectiveness in working with culturally different populations; to facilitate/manage a group of diverse peoples; management of emotions such as anger, sadness, guilt, shame, letting other take charge to achieve a process.

Being able to consult when client engages in a cultural practice that is unknown to the psychologist; confidence to make decisions that might be considered culturally inappropriate; being able to suspend judgment; being able to talk about and use Maori concepts in a culturally metaphoric way; non-patronising way; not to come across as the cultural expert.

Awareness: That clients are expected to disclose information while the psychologist can give no personal information in return; issues of shame and guilt for historical and current discrimination towards Māori; power issues between client and therapist due to professional differences, ethnicity, gender, age, religion; of the impact of belief structure and worldview on the relationship; reciprocity - understanding the nature of give and take; not to make assumptions that the psychologist holds all the knowledge and the client has nothing to offer.

Competency statements: Comfort with using self-disclosure: sharing stories

a. Psychologists demonstrate interpersonal skills: ability to listen and be empathetic with others; shows respect for others' cultures, experiences, values, points of view, goals and desires, fears

b. Psychologists recognise that while western psychological training does not condone the use of self-disclosure with clients he or she is comfortable with providing personal information using reciprocity to establish trust[41]

c. Psychologists know that boundary issues occur in therapy and taking cues from the situation, can adjust where appropriate

---

[41] Self-disclosure refers to providing information such as geographical links, schooling, iwi, hapu, shared experiences, or values. The psychologist must recognise that self disclosure should not be a form of personal counselling

d. Psychologists understand the potential for miscommunication and can confidently discuss this with clients

e. Psychologists keep records of their disclosures to discuss with their supervisors when necessary

f. Psychologists consider their personal strengths and weaknesses, and can recognise their cognitive, emotional and behavioural reactions to clients

g. Psychologists recognise and act to minimise harm that may be caused by cultural misunderstandings

h. Psychologists demonstrate cognitive skills: problem solving ability, critical thinking, organized reasoning, intellectual curiosity and flexibility

i. Psychologists demonstrate affective skills: affect tolerance (of clients and own emotions); tolerance/understanding of interpersonal conflict; tolerance of ambiguity and uncertainty

j. Psychologists demonstrate the desire to help others; openness to new ideas; honesty/integrity/valuing of ethical behaviour; personal courage.

k. Psychologists recognise multiple methods of communicating ideas, feelings and information in verbal, non-verbal and written forms

l. Psychologists demonstrate reflective skills: critical thinking, ability to examine and consider one's motives, transference and counter-transference issues, attitudes, behaviours and one's effect on others

m. Ability to work effectively with other modes of communication in assessment, treatment and consultation.

Theme 1c: Recognising and engaging with pōwhiri, whakatau and mihimihi

The practice of [42]pōwhiri and whakatau does not sit easily with many non-Maori. Equally so, many Maori are also uncomfortable, unskilled and unfamiliar with these processes. The pōwhiri and whakatau processes are described separately, but the competencies are outlined together unless I refer to distinctively separate parts.

Table 25: Scenario Use of Mihimihi to Establish Connection

Situation 5: Psychologist Male, Pākehā, Mihi whakatau/use of te reo (Stephen). Group session with prisoners: I had not been able to attend the residential service pōwhiri and so had not been introduced to the current residents prior to my first Case Management (weekly progress review) session with them. **Behaviour:** The Programme Manager recommended a whakatau process with residents and asked that I mihi to them in Maori.
Outcome: After the whakatau and during whakawhānaungatanga, several of the Maori residents reported to me that they appreciated the effort I had made to learn some Maori. Another individual later said that this encouraged him (in a good way) to learn more himself because he wanted to catch up on the reo compared to my effort to date.

Table 26: Scenario Marae-based Reintegration Hui

Situation 38: Male psychologist, Pākehā (Josh). Participated in a reintegration hui on a marae. Needed to reintegrate client (offender - rapist) back into the marae community. He had denied his offending. The victim lived in the same location. The purpose of the hui on a marae was for the offender to admit his offence publicly.
Behaviour: We arranged for a cultural advisor to accompany us to the marae and be welcomed formally. There was a formal pōwhiri with waiata, and afterwards there were more waiata, and speeches. It appeared to be a happy occasion. There was no opportunity for the victim to speak.
Outcome: The offender told everyone on the marae that he had raped a whānau member. He was received back into the marae community. A negative outcome

---

[42] See page for fuller discussion of pōwhiri and whakatau and how it is used by psychologist and viewed by Pakeha and tauiwi.

of this hui was that he was welcomed back with banners in the dining room. It looked as though "he was the star". It appeared to minimise the impact on the victim. It could also have turned out the other way, where he was rejected by his community yet it was a foregone conclusion that he was to be accepted and welcomed back.

Table 27: Scenario Use of Mihimihi to Establish Connection

Situation 9: Female psychologist, aged-35 (Ashlee). Use of clinically trained introduction. Ineffective ACC client, Māori woman. I began the session by offering refreshments. I also asked her how she would like to start. She said "you start". I talked about my background training, and where I was from. Overall this was ineffective. The client took charge of the session and I was unable to regain control.
Behaviour: Although the client had taken charge, she came back for another session, which was unexpected. In this session I talked about her cultural identity (from information disclosed the previous week). We discussed her marae affiliation and that her children were at kōhanga reo, and her whānau. Although I felt that I had lost control, I was able to gain her trust and obtain a lot of information from her.
Outcome: I used this information in the next session.

Table 28: AKS: Pōwhiri, Whakatau and Mihimihi

Knowledge: Kaumatua who may assist with the pōwhiri; roles within and across families on the marae; of Māori worldview of whakapapa/genealogy; disclosure of personal information may occur on the marae; community, hapū or iwi organisation in the area; the role of marae; understanding of the pōwhiri process: karanga, mihimihi, waiata, pēpeha; whaikōrero; tauparapara, koha, tapu, noa, relevance of food.   Māori beliefs about death; role of religion; Māori spirituality; manuwhiri and tāngata whenua roles; the purpose of cultural advisors and the importance of a reciprocal relationship; the physical spaces on the marae (including tapu spaces); of poroporoaki; Māori understandings of violations of tapu, mana and ira tangata.   Purpose and history of the hongi; kissing the cheek is viewed by some Maori as a reminder of colonisation and that a hongi is preferred; when to help prepare food or help clean up a dining room, or wharenui.   Knowing that principles of reciprocity are compromised in a clinical

relationship.[43]Socio-political history of the marae, iwi and or hapū; whether there are ongoing Waitangi Tribunal claims, or Crown involvement; iwi and hapu information about the client and other clients or professionals in contact with the client.

If the psychologist is Māori, knowing how their own iwi and hapu connections might impact on a client; not assuming that clients will want to use mihimihi to establish a connection. Acculturation and deculturation theories and its impact on clients and also the psychologist.

Skill: Being able to confidently play an active, or passive role in another process; te reo language skill, comfort with public singing or speaking; being able to see through a process without being in control; being able to reverse power dynamics; seeking cultural advice when there are gaps in understanding.; building a reciprocal relationship with cultural advisor or cultural supervisor, iwi, hāpu and community groups so that requests for help are not sudden; basic through to competent te reo/language use.

Comfort with working on a marae, having established relationships with marae (i.e., sponsoring of marae, sport or school activities); being able to kiss, hug, or hongi strangers; being able to sleep in a large space with others; doing the dishes; cleaning up; helping to prepare or serve food; comfort with serving clients refreshments;

Being actively involved with Māori outside of the therapeutic setting (community events, social, educational, recreational and political functions, celebrations, friendships, neighbourhood groups).

Comfort and skill in disclosing personal information; listening skills; ability to find connections based on what client has disclosed; checking iwi and hapu geographical information; having a list of self-reflection questions - am I the right person? What do I need to know? What do I need to do to prepare myself?

Importance of being overt about the need for cultural sensitivity; managing levels of disclosure; checking personal comfort of the client; being able to spot who is in charge – checking that stereotypes held do not lead to assumptions about what the client may do, or may need; an ability to

---

[43]The socio-political experiences of hapu and iwi relate to confiscation of marae lands. The expectation is that psychologists know that marae, hapu and iwi committees or trusts are often engaged in 'negotiation with The Crown". Negotiation with The Crown is a term used by The Crown, but in fact has no real resemblance to the partnership principles that typically underpin a process of negotiation. The Crown does what it wants and consults only for the purpose of achieving a settlement that suits their purposes.

> empower clients.

> **Awareness:** Of personal biases and stereotypes about pōwhiri or whakatau; the power differential when non-Maori attempt to control the process to suit their needs; that Maori may be distrustful of Pākehā; that Maori may be welcoming; that language barriers may exist and preparing oneself to prevent misunderstandings (this also includes consultation and self-directed learning).

> Different processes for conducting pōwhiri and whakatau for each iwi, and hāpu; gender roles on the marae; [44]Belief in the importance of mihimihi as a way of establishing a relationship; of the potential for clients to perceive actions as disempowering, or threatening; clients perceptions of authority and Pākehā.

> Clients will have their own way of meeting a person for the first time; the importance or lack of importance of Māori identity for some clients; awareness that psychologist and client will be changed by the experience of therapy.

Competency statements: Engaging with pōwhiri, whakatau and mihimihi

  j. Psychologists can identify the "mana whēnua"[45] of the area in which the pōwhiri/whakatau is held

  k. Psychologists know the purpose and meaning of pēpeha, waiata

  l. Psychologists can say a pēpeha, karakia, and sing a waiata

  m. Psychologists know the roles that exist within whānau and can adjust their behaviour to maintain each person's integrity[46]

---

[44] This reflects the view that it is not enough to use language or a cultural process if the psychologist does not believe in its importance. Buy-in or engagement requires that a psychologists understand the client's socio-cultural context in which therapy occurs, and the experiences of clients as Maori, and as client.

[45] Mana whēnua refers to the iwi, or hapu who are considered by Maori to be the paramount tribe of that area.

[46] This includes: kuia, koroua, mātua, tuakana, teina, tūpuna, whāngai, mokopuna, kōka, and kaihana. Gender considerations are implicit within these relationships.

n. Psychologists can participate in the arrangement of a pōwhiri and or whakatau while enabling Maori to retain control of the process

o. Psychologists know the roles of tāngata whēnua, manuwhiri, kuia and kōroua and are prepared to be flexible

p. Psychologists understand the stages of pōwhiri and whakatau, are aware of their purpose and can respond appropriately

q. Psychologists demonstrate a commitment to participating in pōwhiri/whakatau throughout the entire process[47]

r. Psychologists are able to demonstrate attentiveness during pōwhiri, whakatau and mihimihi even if the language is not understood

s. Psychologists are humble (not whakahihi/boastful) of her/his cultural/clinical knowledge

t. Psychologists and his or her team are fully prepared when attending pōwhiri/whakatau and are able to confidently participate

u. Psychologists understand that care must be taken with Māori tikanga processes to avoid misunderstandings

v. Psychologists bring koha that are appropriate for the occasion

w. Psychologists are able to share close physical space (i.e., hongi, kissing cheeks, hugging, holding a client who is crying)

x. Psychologists are comfortable with helping to prepare food and/or to clean up the wharekai (dining room)[48]

---

[47] Sometimes this is not always possible; however I refer here to the propensity for some psychologists to not attend pōwhiri or whakatau and arriving later without making any attempt to engage using Maori processes.

[48] Helping to clean up is not easy as it requires a degree of confidence to mix with the host people.

y. Psychologists knows that tribal variations exist when visiting different rohe and can respond flexibly

z. Psychologists have developed links with the community and local hāpu that are based on tauutuutu/reciprocity

aa. Psychologists respect that kaumatua have other commitments when asking for assistance

bb. Psychologists use language competently or conveys that they are making a genuine attempt (the language competency applies here)

cc. Psychologists who are related to clients discuss potential conflicts and boundary issues with their clients and/or cultural advisors/supervisors

dd. Psychologists recognise that clients may resent, or not wish to engage in mihimihi using a Maori framework and can offer an alternative

ee. Psychologists are able to monitor the level of disclosure to determine the nature of the relationship and if there are problems, being able to convey this to the client while maintaining the client's integrity[49]

ff. Psychologists can form cultural links (gender, age, religion etc) and takes care not to marginalise, redefine or ignore what the psychologist does not understand[50]

gg. Psychologists apply Maori processes only after consultation by cultural advisors, supervisors and/or clients

---

[49]The psychologist or client may identify that a relationship would be counterproductive, or possibly unethical. In this instance, the interest of the client takes precedence.

[50] The principle of looking for connections is antithetical to standard clinical training where the psychologist asks "who are you" and "what is your problem?" A Maori worldview asks the same questions but also involves sharing information about oneself so that connections and "a right, or mana" to ask the client questions is established.

hh. Psychologists are willing to share power and can recognise when power issues are present in therapy.

Theme 2: Using Te Reo/Language

Table 29: Scenario Misunderstanding of Client's Hapu and Iwi Affiliation

Situation 4: Male psychologist, Pākehā, mid-30s. I was interviewing a client and discussing his background. He described himself as being of Kahungunu descent. In my report I reported him to be of Kahungunu (misspelled) and misattributed the region (out of ignorance).
Behaviour: He corrected me during the report debrief and coached me on the pronunciation.
Outcome: He appeared mildly annoyed and I was majorly shamed. In the future I worked at being clearer upfront with clients when they reported iwi and rohe with which I was unfamiliar.

Table 30: Scenario Pronouncing Client's Name Correctly

Situation 1: Female psychologist, Pākehā, (55 years-old), (Jean). Family meeting with MDT – psychiatrist; psychologist; two others – to convince the father to allow his son to go to a health camp. The father did not engage with them – his head was downcast and he would not talk. The psychiatrist mispronounced his name each time he spoke to him. It was a difficult meeting for the father.

Table 31: Scenario Greeting Client in Te Reo

Situation 47: Male psychologist, Pākehā, (mid 50s). A senior public servant referred himself with his Pākehā partner. He often stayed out late drinking and his partner felt peripheral and discounted.
Behaviour: I greeted him (in Māori) and connected with his area and his commitment to things Maori in his work. He spoke of his fear of failure and fear of commitment in relationships which he said was the result of a brutal childhood. He had put much of his effort into being successful in his work at the expense of his relationships to prove he could achieve. He realised that this was not what he wanted – we drew on the wisdom of those from his earlier years who were "life giving" and he decided he needed to get more balance in his life.
Outcome: He talked of continuing to build his life more on a solid foundation – with honesty as one of the foundation stones. He talked of actions to drain

the "swamp" in order to build the strong foundation – stopping heavy drinking and having more honesty in his relationships – building an ecosystem of support – via his work, spirituality, children and his tribal land.

Table 32: AKS: Te Reo/Language

Knowledge: The philosophy and practices of the psychologist's organisation towards Māori language; meaning of biculturalism and its history; literature on the impact of language loss; legislation related to land loss and the breakdown of family structures; importance and occurrence of non-verbal language; language related to death and grieving.

Common Māori words (greetings); elementary level Māori; basic singing ability; whakatauki (proverbs) whakatauāki (maxims), marginalisation of Māori language, media representation of Māori language, Māori Language Act, Māori education systems (kura kaupapa Māori, kōhanga reo); Māori Language Commission; micro-aggressions – deliberate mispronunciation; institutional racism. That correct usage or attempts to use Māori language demonstrates an understanding of the importance of language to Māori.

Māori language revitalisation and how psychologists can facilitate this process; social justice principles related to indigenous language; racism or cultural encapsulation that occurs with monolingual societies.

Skill: To learn basic reo, actively promote te reo, demonstrate a competent level of pronunciation; demonstrate a willingness to try the language; being able to spell Māori correctly; willingness and humbleness to correct mistakes using Māori in oral or written form; using language to provide verbal and non-verbal feedback; looking for language similarities, confidence to use language no matter how much is known; accept being greeted in Māori; to greet clients in Māori.

Comfort to have a session conducted entirely in Māori; knowing when use of te reo has a positive or negative effect. Establish and maintain relationships with translators; not be defensive at being called Pākehā; being prepared to try and accept mistakes; using Māori language as a way of power sharing – asking for translations; being able to "pick" when Māori language use is appropriate; checking language for correct pronunciation and spelling.

Awareness: The importance of language to Māori; importance of language skills as a professional development goal; that Māori is misinterpreted by non-Māori on a daily basis (micro-aggression); that Māori experience discrimination for choosing to raise their children speaking Māori, or being educated in total immersion schools. That some Māori are uncomfortable with the use of Māori language by non-Māori and that its use can be disempowering; using language is sharing power and demonstrates respect

for client's culture.

Competency statements: Using te reo

a. Psychologists are aware of the micro-aggressions that occur for Maori due to mispronunciation

b. Psychologists are aware of prevalent societal attitudes to speaking and using Māori

c. Psychologists are aware of the dominance of the English language and the importance of Maori language to clients

d. Psychologists are aware of the prejudice towards oral cultural and the privileging of written forms of communication

e. Psychologists can correctly pronounce client's name, iwi, hapu, pēpeha[51], whakatauāki, mihimihi or karakia and place names and checks correctness with others, and with the client

f. Psychologists know about and can locate client's iwi, hapu, and places of significance for Maori (i.e., maunga, or awa) and knows the relevance of tribal, or whānau connections [52]

g. Psychologists can apologise if language attempts are incorrect and attempts to get it right

h. Psychologists incorporate te reo/language into their workplace with Maori and non-Maori (ideally this should occur in everyday speech)

---

[51] The psychologist will have developed a relationship with a cultural supervisor or advisor who assists them with the acquisition of this competency (see cultural advisor).

[52] This competency is expanded on in whakawhānaungatanga but it is stated here because of the cultural context of these particular words.

i. Psychologists recognise that some Māori mistrust professionals and Pākehā, and that correct language use can establish a link between client and psychologist

j. Psychologists have considered his or her status as a bearer of cultural dominance (as a psychologist and/or Pākehā) and can adjust accordingly[53]

k. Psychologists understand that some Māori find Pākehā who speak Māori as "mana-crushing"

l. Psychologists know about the different forms of communication and their impact and can recognise the ways that clients use verbal and non verbal language to convey emotions, or thoughts, and have the confidence to question self or client about its meaning

m. Psychologists know the historical policies designed to eradicate the Maori language and can identify the significant points in history when attempts were made to preserve the language

n. Psychologists can also locate the governmental and/or educational institutions that exist to preserve the Maori language

o. Psychologists know about the development and purpose of Te Kōhanga Reo, Wharekura, Kura Kaupapa Māori and Whare Wānanga educational institutions

p. Psychologists are able to demonstrate knowledge rather than rote-learning facts and steps (such as karakia, te reo).

Theme 3: Acceptance of Wairuatanga/Spirituality and Karakia

Table 33: Scenario Managing Wairuatanga/Spirituality

---

[53] This competency underpins all the desired attributes of a competent psychologist (see the NZPB cultural competency definition).

Situation 13: Female psychologist, Pākehā/Samoan, (Masipa). Recognising Māori spirituality. Client disclosed that she could see spirits, hear waiata and voices which she attributed to a "hara". She lived for most of her adult life with guilt and shame about the death of a significant person in her life. The death occurred when she was a child.

Table 34: Scenario Using Karakia to Settle a Client

Situation 21: Female psychologist, (late 20s). Using karakia. Effective (Stacey). Male, 38. Referred for MH – not keen to have him in the groups. Bipolar flare-up. When I met him he greeted me in Maori. I asked him if he wanted to open with a karakia. Identified straight away as Maori (strongly). I always open with a karakia. I asked him if he preferred to work with the BTM and work with a tohunga. Client believed he had a makutu on him. His presentation was fidgety, and seemed to be responding to something (not present) although he denied this.

Table 35: Scenario Using Karakia to Whakanoa/Deconsecrate a Workplace

Situation 51: Female psychologist, Māori (aged 40) (Julia): Cleansing the work environment Julia believed that her workplace (Forensic services) was "loaded with spirits of previous clients". She was uncomfortable going to work knowing that "bad spirits lingered and could harm me or my clients".

Behaviour: I spoke with family members who advised me to get a cultural advisor to do a karakia in my office, and to have one present when I felt that unfriendly spirits were present.

Outcome: I spoke with a cultural advisor who performed a karakia for me. I also did a karakia when I felt uncomfortable when seeing clients. Sometimes I did this with clients, or on my own. I think that some clients could tell there were spirits present. Because it was a forensic service, those clients would probably not be believed.

Table 36: Scenario Using Māori Metaphors to Explain Behaviour

Situation 49: Female psychologist, Māori, (Emere). Effective – A young woman was referred for suicidal ideation, and "cutting" behaviour. She was a young mother from another country who lived with her in-laws despite the fact that the father of her baby abandoned her in NZ. The grandfather (Maori) of the baby was unable to understand why she was cutting herself and feared that his grandchild might find his mother dead. The grandfather believed that

the young woman was "pōrangi" (mad).
Behaviour: The clinician explained to the grandfather that historically Maori women in mourning often cut themselves to release their emotional anguish. She described to him how some women "cried tears of blood" because of the facial cuts.
Outcome: The grandfather immediately understood this concept and the behaviour and was able to support and help the young woman appropriately.

Table 37: Scenario Using Māori Processes as Therapy

Situation 53: (Emere). Effective - A young man whose grandparents passed away was often found sleeping at their graveside. He did not have any blankets.
Behaviour: The clinician encouraged the young man as part of her treatment (under a wider multidisciplinary approach, as he was quite unwell) to talk with his grandparents about his grieving. He often talked with his grandparents at the urupā (cemetery).
Outcome: He continued to visit his grandparents at the urupā. He also spoke to them when he was at home and needed guidance.[54]

Table 38: Scenario Connecting Client to Whānaunga/Relatives to Help with Dreams

Situation 43: Female psychologist, Pākehā. My client's father died (the client was in prison). Client dreamed about his father. The client was connected to a prison officer by whakapapa.
Behaviour: I suggested that he talk to the prison officer. He did this and the prison officer contacted the prisoner's family. They went to the prison and conducted karakia over several weeks[55].
Outcome: The prison officer said that as psychs we had done all we needed to do.

---

[54] The practice of talking to the deceased as a therapeutic practice bears some resemblance to the psychoanalytic practice of "talking to chair".

[55] This theme also connects to themes 4, 5 and 7.

Table 39: AKS: Wairuatanga/Spirituality and Karakia

Knowledge: Knowing own values and assumptions about religion and recognition that the client's views may differ; care not to psychologist may impose religious and psychological worldviews onto the client.

Māori concepts of spirituality - cosmology, astronomy, mythology, theology; oral traditions and oral histories; whakapapa connections – that some Māori call on ancestors for support and guidance; kēhua/spirits, wairua; that paranormal experiences are stereotyped in movies and on television.

Gender and age related roles in religious processes; that some information (such as clients beliefs, spirituality) won't be shared and being ok with that; the connection between language and spirituality; the colonising influence of religion on Māori, that some Maori view religion as a tool for colonisation.

The spiritual basis of hongi; beliefs about whakamōmori – suicidality, haehaetanga/self-cutting, self-harm; paranormal experiences; hara (individual and collective), matekite/clairvoyance; Māori beliefs about marae, maunga, awa, whēnua, tangata whēnua, ancestral figures.

The purpose of karakia, types of karakia (e.g., meals, openings, closings, tapu lifting, settling clients); appropriate times to conduct karakia; not assuming all Māori want karakia (importance of checking whether a karakia is wanted).

Māori tangihanga/funeral and wake practices, role and practices of whānau pani/bereaved whānau, beliefs about the afterlife, importance of roimata/tears; the role of food in religious rituals; Maori concepts – pain; Maori concepts of death and dying; language related to death and grieving; whether the departed can communicate with the living; beliefs about where people go in death; Māori oral histories of Te Reinga (Cape Te Reinga); that grief-stricken clients may want to join the person who has passed away; suicide risk.

Skill: Being able to present traditional concepts in modern ways or to present modern concepts in traditional ways; being able to balance training with paranormal experiences; relationship building with church members; comfort and confidence with using karakia; to show respect for spiritual processes pronunciation; willingness to try different methods.

Competent use of language (at any level); comfort with not doing a karakia and negotiating an alternative process, or allowing the client to conduct an alternative process; being able to talk about the nature of the client's relationship with deceased loved ones; alternatives to grieving that do not impose risk on the client (i.e., cutting).

Willingness to work with a cultural advisor or colleague; memorising pēpeha, karakia, songs; ability to discuss religion; having a process for own safety;

being able to educate an elder in a humble and non-threatening way; being able to present concepts in different ways; to convey a sense of humility and not come across as a whakahīhī/boastful; to appear sympathetic and trustworthy; respecting information that is not part of "empirical psychological theory".

Awareness: Religious beliefs of psychologist or client about spirituality and potential clashes; of societal beliefs and stereotypes about paranormal experiences; Māori beliefs about spirits and "guides" spiritual advisors; that clients may want to, or may already converse with the deceased; potential religious biases; respect for clients beliefs about religion, spiritual or cosmological beliefs.

The imposition of western religious values onto Maori spiritual beliefs; the positive and negative impact that religious institutions have had on Maori (such as: Salvation Army, church-based schools, and church groups[56]); that psychologists safety is important (spiritual, emotional and physical).

Competency statements: Māori processes: Wairuatanga and Karakia

   a. Psychologists reflect on his or her belief system and its potential to conflict with that of the clients[57].

   b. Psychologists understand that Māori spirituality differs from a Western Christian worldview

   c. Psychologists know the history of religion and Māori culture[58] and the relationship that Maori have with religious groups[59]

   d. Psychologists understand and can respond appropriately to criticism about his or her attempts to offer Māori processes

---

[56] I am referring here to abuses committed by caregivers in foster homes, and clergymen and women, the appropriation of Maori land and the denigration of pre-European Maori spiritual beliefs.

[57] Attention should be paid to cultural characteristics such as age, gender, social status, sexuality.

[58] This includes western and Maori theology/cosmology teachings.

[59] In particular, Maori developed special relationships with missionaries and subsequently religious schools that continue to this day. This relationship included the gifting of land, buildings, donations, and the education of Maori children in religious schools.

e. Psychologists can offer alternatives to religion that serve a similar purpose (whakatau/to settle, open, close, whakanoa/deconsecrate)

f. Psychologists consider that wairuatanga/spirituality factors may pre-empt misunderstandings or misdiagnoses

g. Psychologists seek assistance when wairuatanga issues are present

h. Psychologists are aware that some Māori have strong beliefs relating to the presence of wairua/spirits who may be related

i. Psychologists are comfortable and non-judgmental when talking about wairuatanga

j. Psychologists are comfortable with cultural differences in how clients cope with grief and loss.

GENERAL-CULTURAL THEMES AS TRAINING NEEDS

Theme 4: Accepting Challenges

Table 40: Scenario Fear of Working with a Māori Client

Situation 50: Female psychologist, Māori, (36). Ineffective – I received a phone-call from my supervisee who said that had a Māori client. She did not know what to do with the client because he was Maori and she did not have any experience working with Maori. She was unable to move past her fear of making a mistake with the client.
Behaviour: The supervisor decided that the client should be referred to another psychologist as he was at risk with an incompetent psychologist.
Outcome: The client was referred to another psychologist.

Table 41: Scenario Challenged About Being Able to Empathise

Situation 6: Psychologist, male, Pākehā (Stephen). Challenged on the basis of ethnicity. I was challenged in group therapy by a Maori client that I didn't understand what it was like to be Maori.

Table 42: Scenario Decision to Ban a Haka

Situation 35: Psychologist, male. Decision to ban a haka[60].
Behaviour: Teenagers aged 15-18 in a Māori focus unit in prison. They were learning and performing a haka. When I received a translation of the haka lyrics, my instant reaction was to ban the haka on the basis that it was violent and was not appropriate for incarcerated adolescents.

Table 43: Scenario Using Karakia/Blessing

Situation 40: Female psychologist, Pākehā (mid 50s). Māori female referred by her workplace for a death that had occurred at work.
Behaviour: She asked to do a karakia – testing me. Blessing the room and us. I knew if I didn't it would extinguish any chance of building rapport with her[61].
Outcome: She agreed to continue sessions with me.

Table 44: Scenario Threatening the Psychologists

Situation 65: Male psychologist, Māori, (aged 42). Client got angry, did a pūkana and kicked the door.
Behaviour: I moved around the room to ensure there was a table between us; stood up – big enough to get attention.
Outlook: Deescalated the situation.

Theme 4a: Sharing Power

Table 45: Scenario Conducting Interviews in Clients Home

Situation 50: Female Psychologist, Māori, 35 – Sharing power, visiting a client in the home (Toni). Conducted the initial assessments in the client's home.

---

[60] This scenario should be considered with theme 2 Using te reo.

[61] This scenario could also be used for themes 1 and 3.

Behaviour: I arranged to meet my client at her home as I got a sense from her file that she distrusted the DHB system despite seeking help from the CAT (Crisis assessment team). I spent half of the first session talking to Ngaruiti about her family, my family, why I was there, and where we went to school. We also discussed kura kaupapa Māori education. We talked about what she hoped to gain from our meeting. In the second half of the session we delved into her presenting problems. I spent 3 sessions of at least 2 hours interviewing and talking with her. When we discussed difficult issues, she made us a cup of tea and smoked while she kept talking. It seemed to me that it helped Ngaruiti to be in her home environment with her husband who was close-by, as her initial mistrust of me quickly disappeared. I also interviewed her husband in the third session. He commented that no-one had ever asked him for his opinion on what was happening to his wife and how it affected his whānau

Table 46: Scenario Sharing Power Sharing Stories

Situation 37: Female psychologist, 33, American, (Sienna). Client, Amy (age 22) self-referred to the Adult Mental Health Service with Social Phobia. She was a very outspoken and friendly young woman, and she was proud of her Māori heritage.

Behaviour: Amy told me about her whakapapa early in therapy. We discussed openly our different cultural backgrounds, and any possible connections. We both formed and maintained links between our separate communities, with me meeting some of her family and her seeing photos of mine and hearing stories about them (as appropriate), and her natural support systems (whānau, hapu) were utilised by her as well. She agreed to me consulting with kaumatua during therapy. We agreed that the world-view of Amy, not me, was the important thing in that it was the cultural context for what brought her to therapy.

We agreed that I would maintain a stance of cultural naiveté and respectful curiosity; that is there was an open recognition that my cultural awareness was limited, but that I was very interested in learning as much as possible, especially if it would be helpful in working with Amy (and it was acknowledged that this was the primary motivation). We had an understanding and sharing of values from each of our cultures. We acknowledged the potential power differential between us in differing credentials, status, wealth, and theories.

We openly discussed sharing power in decision-making, and a strong rapport grew from mutual respect. It was agreed that the focus of therapy was not to change her patterns of behaviour, social interaction, beliefs, or values. Amy was very proactive and almost demanded that the "3 Ps" (partnership,

protection, and participation) be a template for therapy, such as when she chose to incorporate parts of her culture into therapy to achieve her desired outcomes.

Outcome: Amy achieved her goal of overcoming her Social Phobia and is now attending university courses and working toward her PhD.

Table 47: AKS: Accepting Challenges & Sharing Power

Knowledge: Power and privilege; worldviews of client and psychologist; client and psychologists beliefs about impact of ethnicity, gender, age, religion, disability; body language and communication styles; that barriers exist based on socio-political and organisational structures; impact of education level, economic status; subcultures and the role they play in clients lives;

That whanau should be included in assessment and treatment where possible; limitations of psychologists training; indigenous psychology – theories of illness assessment of treatment; western assumptions about indigenous helping theories and methods; that the client is the arbitrator of culturally competent practice.

Clients right to access culturally appropriate psychological services; principles of social justice; clients may use a variety of techniques to air their concerns; daily hassles of being Māori (micro-aggressions); problems clients experience with government agencies; knowledge of code of ethics; Te Tiriti o Waitangi/The Treaty of Waitangi; source of anxiety – whether related to lack of knowledge and experience with Māori, or lack of ability to work with what is perceived as a difficult case; knowing how to open and close sessions in a way that empowers clients – when you are not the best person for the job; how to terminate sessions bearing in mind the connections made.

Skill: Recognising body language – lack of eye contact, irritation, facing away; crying, confidence to suggest to the client what could be possible barriers; confidence to use personal disclosure; consciously looking for ways to engage; to not be defensive; to adapt psychological training to suit the client; being able to accept criticism, or praise; acting to minimise the effect of privilege that comes with ethnicity, education level or economic status; ability to acknowledge ancestors possible wrongdoings.

Checking to see if the agency support biculturalism; advocating for socially unjust government, or agency policies; displaying confidence; developing further competencies to work with Māori; being able to develop a specific skill set to work with a client population.

Being able to engage with Māori outside of a therapeutic relationship;

contacting a cultural advisor using a Te Tiriti/Treaty model; developing a tuakana/teina (mentor/learner) relationship with experienced psychologist to observe Māori client/psychologists interactions.

Managing anxiety as an avoidant strategy; being flexible – judge the situation – "oh here is a Māori, must talk about power and privilege"; being prepared, but also willing to be flexible; being able to educate another person in a humble and non-threatening way; not letting fear impact negatively on your work; seeking supervision to manage anxiety, fear, or resentment when working with Māori; regard for personal safety. Show empathy and understanding; show that you understand the context of their lives; ability to take risks.

Awareness: Of where clients come from: their socioeconomic background, sociopolitical history and their impact; that client may reject psychologists ethnicity when there is a shared whakapapa; historical and current relations between Māori and Pākehā; the effect of anxiety on performance; anxiety as a barrier to assessment and treatment; gender differences and role confusion (kaumatua, younger person); recognising that role confusion does not help the client and supervision or cultural advice is needed.

Clients presenting problem may override their status as – kaumatua, religious leader, tuakana/teina; clients may be too embarrassed to challenge a psychologist; importance of integrity of the client and the psychologist; awareness that psychologist and client may have historical connections that may negatively impact on therapy and how to manage these.

That some clients have little choice when seeing a psychologist and that this can be disempowering and may cause resentment; cultural issues with psychological testing, assessment and treatment; that clients test psychologists.

Theme 4 b: Modifying General-cultural practices

Table 48: Scenario Using Māori Metaphors

Situation24: Female Psychologist - Chinese, 30 (Chan-Ju). Providing information 'Shane' 40 years old. History brain injury – did not know the extent. Relapse prevention training. Individual treatment due to cognitive deficits.

Table 49: Scenario Using Te Whare Tapa Wha

Situation 61: Male psychologist, South African. A 46-year old male, with serious suicidal intent and fixed plan came in for urgent assessment. During interview he related being half Maori and half Pākehā. He physically appears to be of Pākehā extraction.
Behaviour: I discussed the Tapa Wha Model and referred to Te Korowai Hou Ora (TKHO), the Maori Mental Health Service. He explained that he felt alone, out of place, with no connection to iwi, hapu or whānau. He has not had any contact with his tamariki for 10 years. Explained that he lived "more in the Pākehā side", but felt that he belonged in the Maori side.
Outcome: Was admitted for 24-hour period to inpatient unit. Had cultural assessment and 1 follow-up appointment with TKHO. Is currently being followed with psychological intervention. He has not since indicated any desire for further cultural input. This will be explored as further options.

Table 50: Scenario Cultural Formulation

Situation 64: Male psychologist, Māori (aged 41). Working with a tangata whaiora and his whanau. Anxiety disorder diagnosis.
Behaviour: Formulation included church beliefs and Maori ethnicity. His symptoms were exacerbated by church beliefs. Used te whare tapa wha model.
Outcome: Collaborated with whānau and church members (held a wānanga/working group) church elder support.

Table 51: AKSs: Modifying Western-Cultural Practices

Knowledge: Clients may not want to talk about illness using Māori concepts, or may prefer to use only Māori concepts; that there is a lack of normative data for Maori clients in psychometric tools; of the technical aspects of their instruments and are also aware of the cultural limitations; when to seek help to identify cultural variables and when conceptualising clients' problems; how the therapy environment impacts on the information obtained; purpose/function of pūkana.

Māori models of health e.g., te whare tapa wha, te wheke; expressions of |

Maori culture (i.e., art, media, literature); the purpose of threats, intimidation, and passive-aggressive behaviour; that young men in the prison population may present with symptoms that result from head injuries[62].

Skill: Ability to identify whether the use of cultural concepts are appropriate; to appear confident and relaxed when modifying practices; correct use of Māori metaphors (maunga, awa, waka); using Māori concepts and story-telling to advance therapy; managing client tensions when using Māori and non-Māori psychological constructs to explain illness, and wellness.

Ability to manage suicide risk taking culture factors into account; using cultural assessment tools with caution; being able to incorporate cultural variables into the case conceptualisation; doing a cultural formulation; identifying values, beliefs and practices of client.

Applying Māori models of health to explore functioning across multiple domains; being able to suspend judgment; managing threats; how to deescalate a situation; importance of integrity; the ability to negotiate the meaning of cultural practices for the client and psychologist; working through fears and lack of confidence to work with Māori.

Awareness: Of culture-bound nature of psychological practice; that the use of Māori concepts is not appropriate for all Māori; alienation of Māori processes and its appropriation by non-Māori for unclear purposes; that Māori cultural processes can convey closeness that is superficial; that cultural competency in an ongoing process. Limitations of psychologists knowledge, or skill; that it is ok for client to be angry, upset, sad; that physical closeness is ok – hugging, touching (hands, arms, shoulders, back).

Competency statements: Accepting challenges, sharing power and modifying Western-cultural psychology

   a. Psychologists know the characteristics that constitute their identity and the potential impact on clients (including power and privilege that comes with certain characteristics)

---

[62] This relates to knowing about male Māori, youths and their risk taking behaviours (i.e., drink driving, sports, fighting, and impulsivity and education level).

b. Psychologists know the characteristics that constitute client identity and the potential impact of these on building and maintaining the therapeutic relationship

c. Psychologists are aware of their personal biases and assumptions about others and where these originate

d. Psychologists are aware that personal biases may affect decisions and seek advice

e. Psychologists recognise the significance of Māori identity or heritage, cultural alienation and acculturation

f. Psychologists are aware of the socio-political, or cultural histories of clients that provide the context for their clients' everyday experiences

g. Psychologists are able to show humility and grace

h. Psychologists respect clients preference for a Māori psychologist, process or service

i. Psychologists recognise the small number of Māori available to provide bicultural, or Māori specific services, and respond to the concept of shared responsibility[63]

j. Psychologists (Māori and non-Māori) recognise that Māori are mistrustful of Māori psychologists in ways that do not occur for non-Māori and provide support[64]

---

[63] Shared responsibility refers to the notion of partnership where non-Māori take responsibility for learning bicultural practice that extends beyond asking the nearest Māori to do it for them, or asking Māori to help them. Psychologists tend to err on the side of caution, or ignorance about the necessity to actively participate thereby alienating Māori who may have reached saturation point with such requests.

[64] Māori psychologists are considered by some community groups to be brainwashed into thinking like Pākehā. The pressure on Māori psychologists to meet dual expectations can result in burn-out (Milne, 2005).

k. Psychologists manage their fears and anxieties to minimise harm to clients

l. Psychologists can describe and explain concepts using language that is accessible and includes client worldviews where appropriate[65]

m. Psychologists minimise relying on psychometric tests when alternative means of assessment are available (i.e., interviewing, observation)[66]

n. Psychologists do not use psychometric tests to avoid engaging with clients

o. Psychologists are aware of the socio-political issues that impact on their clients presenting problems (i.e., incarcerated, male, Māori youth)

p. Psychologists are aware of the status of clients and the inherent power imbalance in the relationship which may also be affected by age, gender, ethnicity, education level and economic status including the reasons they present for therapy (i.e., prisoners, mental health, disability, CYFS (Child Youth and Family Services))

q. Psychologists are aware of the dangers of appropriating Māori concepts and practices into western psychology

r. Psychologists know the importance of seeking consultation when making decisions that may be seen as culturally insensitive

s. Psychologists are able to consult widely to ensure any decisions made are robust

---

[65] Māori models of health or Māori metaphors are used to explain psychological terms.

[66] I added these AKS(s) despite the fact that no scenarios specifically mentioned them as competencies. The literature talks extensively about the use of psychometrics and I am aware that some psychologists tend to avoid asking difficult questions by using tests.

t. Psychologists know the differences between etic and emic factors when considering applying psychological models of assessment and treatment

u. Psychologists recognise the ability of clients to understand the psychological concepts and can adjust when necessary

v. Psychologists are able to use Māori models of health

w. Psychologists recognise the potential to be in an unsafe environment and take appropriate precautions

x. Psychologists are able to develop cultural formulations

y. Psychologists recognise the limits of their cultural competencies and actively seek opportunities to develop

z. Psychologists take care not to marginalise Māori cultural practices

aa. Psychologists are able to adjust assessment and treatment where necessary.

Theme 5b: Considering Identity

Table 52: Scenario Importance of Identity

Situation: 6 Female, psychologist, Pākehā, (aged-27). A 21 year-old male extreme anxiety/psychosis. I contacted a cultural advisor to discuss potential cultural issues. Noted from the report that ethnicity was important to him. The client had previously attended a kura kaupapa secondary school.
Behaviour: I proceeded slowly with the client offered him food and drinks; talked about his identity; asked him where he was from and what events were significant to his people. Talked about my whakapapa even though it is not obvious. I also told him that he could bring his family if he wanted to. Involved cultural advisor as the sessions progressed.
Outcome: I established a working relationship; client attended all 10 sessions. Psychotic diagnosis was not proven, and his anxiety was no longer a problem.

Table 53: Scenario Conflict with Māori Identity

Situation 23: Female psychologist, Pākehā. Ineffective: Adult sex offender: Issues with women. Huge belief thing with women (built up over the years as a result of his father's tangi.
Behaviour: I offered to open with a karakia. He would not start with a karakia if his mood was low. When there was no karakia, it took longer for him to open up. I asked him about how he saw his cultural identity. He felt whakama/ashamed to be Māori. He said it was wrong to do haka and waiata in prison. When his father died he was forced to speak at his tangi because he was the only fluent one in the family. His older brothers married Pākehā women and they did not support Māori culture. He said he was losing respect for his elders. His sisters had pressured him and his brothers shamed him. There were also issues around land alienation. His brothers had been left land, but not him. He felt that as the youngest, he should have been protected.
Outcome: I involved the cultural advisor. We convened a hui with his case officer and organised a reintegration hui. I did not work with him again so I don't know what happened to him.

Table 54: Scenario Ethnicity Identity: Whakama/Shame

Situation 22: Male psychologist, Pākehā, (aged-40). I asked my client about his identity and how he saw himself. He did not respond. This client was less open with his cultural identity.
Behaviour: We talked about the similarities with my language and his. Some of the letters in my language is pronounced the same. He commented on that. I disclosed where I was from. This openness strengthened the therapeutic alliance. He said he was whakama and did not deserve to be Māori.
Outcome: Outcome: From here we were able to talk about his feelings of shame that stemmed from his crime. This was useful as these thoughts precipitated his low mood.

Table 55: Scenario Identity Issues as a Priority

Situation 4: Male psychologist, Pākehā. Client, male, late 40s. He was passive aggressive, anti-Pākehā. 10 minutes into the session he said he didn't like Pākehā; "not you though. You go beyond "true" (term for trustworthy). Part Māori. He wanted to explore identity. Self-identified as Māori and identified by others as Pākehā – he didn't want that. Background exploration revealed that he rejected aspects of Maori self-determination – land claims, Treaty issues.

Behaviour: Rapport building - Both human beings. I know what it feels like to be angry – it's a good platform. If there is a connection you can pick it - there is a space between you if there is no connection. If there is space, I try a karakia".
Outcome: He was open to begin exploring cultural identity and then work on other psychological processes affecting his offending behaviour.

Table 56: Scenario Assumptions About Physical Characteristics

Situation 48: Female psychologist, Māori (Emere). Assumption that a woman who looked obviously Māori would want to participate in a whakawhanaungatanga.
Behaviour: I assumed that a Maori woman, Jehovah Witness, (dark-skinned) from Ngāti Porou wanted to go through a whakawhanaungatanga process of describing her own whakapapa, and mine. I started to go through her whakapapa and then she laughed derisively. This was the only time the client had smiled or laughed throughout the relationship to date. I could pass for Pākehā, and perhaps this is why she laughed.
Outcome: I asked if I had made a mistake in opening this way and asked if the client preferred to open the session in another manner. She said a prayer.

Table 57: Scenario Exploring Māori Identity

Situation 55: Male psychologist, Māori, (aged 33). Long-term female client with chronic history of moderate to severe depression and relatively notional identity as Maori discloses sensitive personal information related to childhood sexual trauma. This disclosure resulted in ++ emotional expression. Historically this client had declined the use of whakatauki/karakia to open and/or close sessions.
Behaviour: In the context of clients level of emotional arousal during session discussed the importance of "emotionally grounding" oneself before ending the session. Discussed different ways that this goal could be achieved and suggested to the client that whakatauki/karakia could be a useful way of "bookending" sessions at the beginning and end.
Outcome: Client liked the metaphor of bookends and agreed to clinician finishing the session with a whakatauki. At the next session the client commented that she appreciated this process and that after she left the session she felt "really good" which was not usually the case after she had been discussing this kind of material. Requested that whakatauki and karakia be used at every session. This also became an avenue through which

the client began to explore and acknowledge her Maori identity more strongly.[67]

Table 58: AKS Considering Identity

Knowledge: Models of Māori identity and their limitations; emotional reactions associated with loss of identity; cultural alienation; the limitations of acculturation models; the impact of socio-political context on identity formation; impact of mixed-ethnicity of parents on children, or adults; others forms of identity – youth, age, gender (including transgender), gay and lesbian, religion; iwi and hapu, gangs.

That psychologists should not attempt to impose models of identity (as per the literature); the experiences of client "that do not look Māori", or "look Māori" but identify as Pākehā; tuakana-teina (older/younger siblings, or relatives) roles; kaumātua roles; whanau/marae roles on a marae; gender issues between women and men; whakama concepts in Maori and English; Maori concepts of utu/payment, revenge; whakama/guilt/shame[68].

That Māori expression of identity is actively discouraged in some institutions: schools, agencies, courts, religious groups (i.e., Jehovah's Witnesses). That some whānau do not want their whānau members to identify as Māori.

Skill: Being able to talk about identity; asking questions in a non-threatening manner; showing empathy; being able to put yourself in the clients position; having the confidence to support clients to accept their cultural identity.

Respect when clients do reject Māori-cultural input; seeking to understand self as racial and cultural beings and actively seek an anti-racist identity; the use cultural identity questionnaires/tools or interviews questions; ability to ask about ethnicity and identity; not to make the client the cultural expert; working with cultural advisor. Being comfortable with Maori processes; karakia; whakatau; carefully questioning issues about women; respectful.

Managing own or client's emotional distress; being able to build the relationship using very little information.

Awareness: How whānau view dark-skinned or light-skinned whānau members, issues related to dual-identity; impact of gender and age on

---

[67] This scenario could also be used for themes 1, 3 and 6

[68] Emotional or cognitive reactions to events, people or experiences can impact on identity. Scenario 44 is an example of the issues for Māori who are seen by others as being Pākehā, yet they are anti-Pākeha.

identity; adoption and whāngai, taurima, atawhai/adopted.

Societal attitudes about mixed marriages; identity loss; not being able to fit in either culture and the resulting consequences; culture may be misused to avoid therapy; different worldviews of client to psychologist; individualism and collectivism; connection that Māori have to whānau and extended whānau and its impact; racism amongst Māori for Pākehā-looking children.

Competency statements: Considering identity

iv. Psychologists are aware of their identity and any biases and assumptions they may hold about others

v. Psychologists recognise the construction and classification of Māori identity by non-Māori and the resulting social and psychological impacts

vi. Psychologists are aware of Western perceptions of identity as individualised and their contrasts with Māori perceptions of identity

vii. Psychologists can talk about ethnicity with clients in a respectful manner

viii. Psychologists recognise, and can critically reflect on their reactions to being called Pākehā

ix. Psychologist are aware of the potential impact of mixed-parentage on identity formation

x. Psychologists do not make assumptions about clients worldview and know the etic and emic differences between Māori as a group and as individuals

xi. Psychologists seek to know the cultural values that underpin their client's identity

xii. Psychologists know the historical, social, and political actions of governments that diluted or eradicated notions of Māori identity

xiii.   Psychologists know theories on the construction and deconstruction of race, ethnicity, and identity

xiv.   Psychologists know and can manage the stages of identity that clients are likely to experience in relation to changes in worldview

xv.   Psychologists recognise the aspirations of Māori to define their identity as iwi, or hapū based rather than as collectively Maori based (i.e., Tuhoe, Ngāti Hako)

xvi.   Psychologists recognise that clients have the right to determine their own identity which may include possible inconsistencies

xvii.   Psychologists understand that not all clients will readily understand their historical and social experiences

xviii.   Psychologists can adapt to multiple identities that clients may hold.

Theme 6: Managing socio-political and cultural influences

The scenario below is the only specific example that I could see, of the importance of recognising socio-political influences. However, the theme and the AKS(s) underpinning what psychologists did, or did not do "jumped out" all over the place. I cross-checked the AKS(s) with the literature, and confirmed the necessity to include socio-political and cultural influences in cultural competency training.

Table 59: Scenario Recognising Power

Situation 7: Male psychologist, Pākehā, (Stephen). Wearing a belt that symbolised a prison hierarchy.
Behaviour: I wore my prison issue belt to group for sometime before a Maori resident commented that he had taken a lot longer to trust and get to know me because he identified me with the prison hierarchy when seeing that belt.
Outcome: I no longer wear the belt.

Table 60: AKS Socio-Political and Cultural Influences

> **Knowledge:** Te Tiriti o Waitangi/Treaty of Waitangi; role of the Waitangi Tribunal, kaupapa Māori theories and matauranga Māori/Māori knowledge; Code of Ethics; relevant legislation governing psychologists training and practice; the influence of socio-political events and policies on client's daily life; socio-economic history of client and own ethnic group; Māori grievances; the impact of mainstream schooling on Māori education rates and family structures; purpose and philosophy of Māori services and institutions; knowledge of kōhanga reo, socio-political histories of clients iwi and hapu links; historical significance and current meaning of Māori-cultural concepts.
>
> History of Māori interactions with Social Welfare/CYFS (Child Youth and Family Services), Work and Income New Zealand (WINZ), courts, police, health and education officers; that psychologists represent those systems (i.e., symbols, language).
>
> Public perception and stereotypes of: Māori language and Maori schools, health services, models of health, Māori health, education, employment, unemployment, Māori child abuse, poverty, partner violence and crime. Knowing and understanding the effects of oppression, racism, discrimination, and stereotyping; sociological explanations of psychological disorders; barriers to health services.

> **Skill:** Managing issues that arise from the above; seeking assistance, supervision, or professional development; how to consult and gather more information about Māori worldviews; open discussion of power differences and being able to find where the power is reversed – power sharing; using "partnership, protection and participation" as a template for therapy; advocating for clients; challenging discrimination or racism.

> **Awareness:** That Māori mistrust government agencies; micro-aggressions that occur for Māori – hassles with government organisations, schools, medical clinics, being followed or ignored in shops, hassles with the police, privilege, power.
>
> Negative media representation on a weekly basis, low visibility of Māori in the media doing well; that Pākehā culture is the dominant, taken-for-granted culture.
>
> That the psychologist's family may have colonised the clients land; valuing and respecting differences; societal attitudes to Māori. The appropriation of Māori culture for the purpose of implementing psychological treatment and its effects.

Competency statements: Managing socio-political and cultural influences

d) Psychologists know the socio-political influences (e.g., poverty, stereotyping, stigmatising, land and language loss and marginalisation) that impinge on Māori (e.g., identity formation, and manifestations of illness)

e) Psychologists are aware of the implications of the Treaty of Waitangi, the Code of Ethics, the HPCCA, and Code of Health and Disability for Consumers

f) Psychologists are aware of legislation (current, recent and historical) which has breached Te Tiriti o Waitangi/The Treaty of Waitangi and disenfranchised Maori

g) Psychologists recognise the ability of client to access their services and are aware of possible barriers that may occur in their organisation

h) Psychologists know the impact of stereotyping, stigma, discrimination and social exclusion that occurs for Māori[69]

i) Psychologists know the concept of "micro-aggressions" and can manage the impact on clients (and self)

j) Psychologists are aware of sub-cultural variations that form client experiences and can recognise potential conflicts, or connections (i.e., gang culture, poverty)

k) Psychologists are knowledgeable about the principles of social justice and seek to monitor their practice accordingly

l) Psychologists can confidently advocate for client across a range of institutions or organisations.

---

[69] For example gang culture, low SES, low educational achievement, disability, mental health status

Theme 7: Maintaining relationships with cultural advisors/supervisors

Table 61: Scenario Conducting Therapy in Te Reo Māori

Situation 16: Female psychologist 32 (Sophie) – Client request for a BTM Bicultural Therapy Model cultural advisor. Client wanted to conduct session entirely in Māori.
Behaviour: Offered to open with a karakia to begin a session, which he accepted. I consulted with a cultural advisor and supervisor, and arranged to have the session done in Māori with me present.[70]
Outcome: The client was able to discuss in detail the issues confronting him. At later sessions it was easier to develop a relationship with him.

Table 62: Scenario Boundary and Safety Factors

Situation 32: Female psychologist, Pākehā, (Anna) Māori/ Samoan, 22, female. I usually had a BTM provider in sessions, but then she missed one, and the client was quieter, less talkative, more distracted. I commented on her distractibility. Session went ok but would have been better if BTM was there.

Table 63: Scenario Implementing Learning from Cultural Supervision

Situation 30: Female psychologist, Pākehā 30s. Male offender. I arranged to take Bicultural Training Model (BTM) provider with me. But the provider was late. I was left with the client. He asked me to describe who I was. I was really unsure about whether to talk to him. I told him where I was from.
Behaviour: I had just had a cultural supervision session where we talked about whakawhānaungatanga and making connections. I talked about who I was and where I came from.
Outcome: He was happy to come back for additional sessions.

Table 64: Scenario Client and Support Person

Situation 51 (Emere). Ineffective - An older, male Maori client (offender) convicted of sexual offences brought a Maori minister to the initial interview.

---

[70] This scenario was also used for themes 2, 3 and 4.

Behaviour: I felt powerless to educate the offender and the minister about his offending. I talked generally rather than about the offending and made them both a cup of tea. I was able to state that he needs to stay away from children even if the church had forgiven him.

Outcome: I referred him to another psychologist.

Table 65: Relationships with Cultural Advisors and Supervisors

Knowledge: How to develop relationships with cultural consultants, advisors or supervisors; power differences in knowledge held by psychologist and by the cultural advisor; Western assumptions about indigenous helping theories and methods; models of supervision including cultural supervision. The importance of mentors for personal cultural issues that may arise from practice (i.e., Māori psychologists supervising a Pākehā supervisee; or Pākehā client).

Of communication styles between cultural-advisor and client (language, hugging, kissing cheeks, hongi); iwi and hapu histories that might impact on advisor and client; gender and age roles; kaumātua role; tuakana-teina roles; limits of own competencies; that Māori are in a disadvantaged group when seeing psychologists without support.

Skill: Comfort sharing power; work in a partnership with advisor; not assuming that client want to be seen by an advisor; to not create a dependency on the cultural advisor; seeking assistance from specific hapu and iwi individuals or groups; comfort with supernatural or alternative explanations for health and illness; being able to recognize the limits of their competencies.

When faced with complex issues: (a) seek consultation, (b) seek further training or education, (c) refer out to more qualified individuals or resources, or (d) engage in a combination of these. Power sharing: ability to proceed without knowing is going on (i.e., language barriers, cultural practices); to trust in others; asking for clarification; being able to consult when client engages in a cultural practice that is unknown to the psychologist; confidence to make difficult decisions.

Developing and maintaining a relationship with an advisor, or kaumatua, showing a keen interest in culturally relevant activities; ability to juggle both psychological treatment issues and cultural issues related to gender, age, status in the community (i.e., to put aside beliefs about how a young, female, Māori behaves in the presence of an elder and minister).

Awareness: Of the importance to allow another process to guide the relationship; socio-political issues that may impact on the relationship with

the cultural expert; personal biases, stereotypes and worldview; that Māori knowledge is undervalued and marginalised in comparison with Western knowledge; that cultural advisors are often overworked in other domains; recognition that psychologists Māori-cultural values may impact on service; awareness that deferring to cultural roles can be detrimental to a clients progress.

Competency statements: Maintaining relationships with cultural advisors and supervisors

a. Psychologists are familiar with models of supervision, including cultural supervision

b. Psychologists establish a respectful and mutually beneficial relationship with cultural advisors

c. Psychologists recognise the potential for privilege and power issues to present when working with cultural advisors, supervisors and support people

d. Psychologists are responsible for their learning and are prepared to consult with cultural advisors

e. Psychologists recognise that cultural dynamics also occur within the supervision/consultation relationship[71]

f. Psychologists are prepared to discuss alternative explanations for client health and wellness

g. Psychologists do not make assumptions that other Māori psychologists, client, or allied health professionals are qualified and readily available to assist them with their learning

---

[71] I am referring here to the fact that cultural dynamics are also present in the advisor/supervisor relationship.

h. Psychologists recognise that there may be shared values and behaviours between clients and cultural experts that they may not understand.