Bridging Worlds: Integrating Māori Health Models into Psychological Practice

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Abstract

The clinical literature highlights the importance of incorporating Māori worldviews and Māori-based mental health models into psychological practice to enhance cultural responsiveness. However, empirical research on this topic remains scarce. This qualitative study explored how Māori health models are integrated into psychological practice in Aotearoa New Zealand. Twenty-four practising psychologists participated in semi-structured interviews, and thematic analysis identified seven key themes: (1) Te Whare Tapa Whā: Still a Foundational Model of Practice, (2) Creative Translation of Theory into Clinical Practice, (3) Culturally Responsive Application & Client-Led Practice, (4) Navigating the Meihana Model: Balancing Utility and Complexity, (5) Impacts of Using Māori Health Models in Practice, (6) Blending Māori and Western Therapeutic Approaches, and (7) Reported Challenges Applying Models. Together, these findings provide insights into the ways psychologists are currently engaging with Māori health models in their everyday psychological therapeutic practice, the opportunities and challenges this presents, and the implications for advancing bicultural psychological practice in Aotearoa New Zealand.

Keywords: Māori health models, Te Whare Tapa Whā, Meihana Model, culturally responsive practice, client-led practice, bicultural psychology.

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Glossary of Terms

Aroha. Love, compassion, empathy, and concern for others.

Hauora Māori. Māori perspectives of health and wellbeing.

Iwi Katoa. Broader collective networks, including hapū, iwi, and community resources.

Karakia. Prayer or incantation used for spiritual guidance and protection.

Kaupapa Māori. Māori principles, philosophies, and approaches grounded in te ao Māori.

Kōrero. Conversation, discussion, or narrative.

Mātauranga Māori. Māori knowledge systems derived from whakapapa, environment, and experience.

Mauriora. Cultural identity and access to cultural resources.

Meihana Model. A Māori clinical assessment framework incorporating cultural, historical, and systemic factors.

Ngā Hau e Whā. The four winds; often symbolising influences from all directions or diverse experiences.

Ngā Manukura. Leadership, particularly in health and wellbeing contexts.

Pūrākau. Traditional Māori stories, narratives, or teachings.

Rangatiratanga. Self-determination, autonomy, and leadership.

Taha Hinengaro. Mental and emotional wellbeing.

Taha Tinana. Physical wellbeing.

Taha Wairua. Spiritual wellbeing.

Taha Whānau. Family and social wellbeing.

Tāngata Whaiora. People seeking health or mental health support; clients or service users.

Te Ao Māori. The Māori world, worldview, and ways of understanding.

Te Pae Māhutonga. A Māori health promotion model based on the Southern Cross stars.

Te Whare Tapa Whā. A holistic Māori model of health represented as a wharenui with four interdependent walls.

Tikanga. Customary practices, protocols, and correct ways of doing things.

Te Tiriti o Waitangi. The Treaty of Waitangi

Wairua. Spiritual essence or connectedness to self, others, environment, and ancestors.

Whakawhanaungatanga. Relationship-building and establishing connection.

Whānau. Family, extended family, or community of belonging.

Chapter 1: Introduction

"He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata"

What is the most important thing in the world? It is people, it is people, it is people.

(*Māori proverb, n.d.*)

Culturally responsive psychological practice in Aotearoa New Zealand acknowledges the importance of integrating Māori worldviews and Māori-based health models into practice (Durie, 1994; McLachlan, Waitoki, Harris, & Jones, 2021; Wilson, 2021; Wise Group, 2010). Population-level research indicates that Māori experience disproportionately higher rates of psychological distress and mental health challenges than non-Māori (Baxter et al., 2006; Marie et al., 2008; Paterson, 2018; Sheridan et al., 2024). These patterns have contributed to greater attention on how psychological services can incorporate Māori perspectives on wellbeing. Consequently, culturally responsive practice is now widely recognized as essential for delivering care that aligns with Māori needs and lived realities (Curtis et al., 2019; Durie, 2001; Waitoki & Levy, 2016).

Building on this recognition, psychological scholarship and policy in Aotearoa New Zealand have increasingly emphasised the incorporation of Māori knowledge systems into theory and practice as a pathway toward more equitable outcomes (Durie, 1994; McLachlan et al., 2017; Wilson, 2021; Wise Group, 2010). Māori models of health aim to provide culturally informed frameworks that can better align with the perspectives and experiences of tāngata whaiora (Māori clients), thereby helping to inform and support the development of culturally responsive approaches in clinical practice (Durie, 1999, 2001; Pitama et al., 2007; Ratima et al., 2019; Waitoki et al., 2018). However, the practical application of Māori models of health in everyday psychological practice remains underexplored, with limited empirical research investigating how clinicians incorporate and navigate these frameworks in their everyday psychological practice and therapeutic work.

The present study addresses this gap by examining how psychologists in Aotearoa New Zealand apply Māori health models in their everyday practice. To situate this thesis within the broader disciplinary context, the next section outlines how psychology developed in Aotearoa New Zealand and the knowledge systems that have shaped current practice.

1.1 Psychology in Aotearoa New Zealand

Psychological knowledge has developed through diverse cultural, philosophical, and scientific traditions (Groot et al., 2018; Pickren & Fareras, 2020; Pickren & Rutherford, 2010; Tan et al., 2023). Much of what is now referred to as Western psychology was shaped by European scientific and philosophical thought during the nineteenth century and later expanded through American developments in experimental psychology, behaviourism, and the growth of clinical and applied practice in the twentieth century (Pickren & Fareras, 2020; Pickren & Rutherford, 2010). This intellectual heritage has influenced the development of professional psychological practice, including the establishment of the scientist–practitioner model, which emphasises the integration of research and clinical application as core to the discipline (Jones, 2007; Pickren & Rutherford, 2010). However, some clinicians have observed that the application of Western knowledge systems in culturally diverse contexts can be challenging, drawing attention to the importance of adapting psychological practice to local cultural contexts (Adames, Comas-Díaz, & Chavez-Dueñas, 2022; Hwang, 2011; Tan et al., 2023).

In Aotearoa New Zealand, the Psychologists Board's Code of Ethics acknowledges the importance of recognising both Māori and Western systems of knowledge (New Zealand Psychologists Board [NZPB], 2002). Within this context, He Awa Whiria (the braided rivers metaphor) provides a framework for integrating these epistemologies while maintaining their distinctiveness (Macfarlane et al., 2011), illustrating how Indigenous and Western knowledge streams can flow alongside one another, inform each other, and contribute to shared

understandings of wellbeing. While conceptual frameworks such as He Awa Whiria offer important guidance for integrating Indigenous and Western knowledge systems, Heffernan et al. (2024) note that their translation into everyday clinical practice remains underexplored. They require further elaboration to be operationalised in practice, and it is not yet clear how this is being achieved (Heffernan et al., 2024). Accordingly, empirical research is needed to explore how Māori health models are being applied in real-world psychological practice in Aotearoa New Zealand. This gap highlights not only a research priority but also an ethical responsibility under Te Tiriti o Waitangi, which grounds psychological practice in principles of partnership and equity (New Zealand Psychologists Board, 2002).

After outlining the wider disciplinary and historical context of psychology, the next section examines the ethical and legal responsibilities under Te Tiriti o Waitangi and how these shape expectations for culturally responsive practice.

1.2 Te Tiriti o Waitangi and Ethical Responsibilities in Psychology

Psychologists in Aotearoa New Zealand are professionally and ethically responsible to uphold Te Tiriti o Waitangi obligations (Mulholland & Tawhai, 2017; New Zealand Psychologists Board, 2002; Orange, 2017). The signing of Te Tiriti o Waitangi (the Treaty of Waitangi) in 1840 established a partnership between Māori as tangata whenua (the Indigenous people of Aotearoa) and the Crown, intended to ensure equitable participation, protection, and self-determination for Māori (Mulholland & Tawhai, 2017; Orange, 2017). However, subsequent breaches of Te Tiriti led to extensive land loss, the marginalisation of Māori language, knowledge, and healing systems, and the imposition of Western social and legal structures (Mulholland & Tawhai, 2017). These processes are understood to have contributed to inequities experienced by Māori across social, economic, and health domains, including mental health (Came et al., 2023; Ellison-Loschmann & Pearce, 2006).

In light of this historical context, the principles of partnership, protection, and participation derived from Te Tiriti inform professional and institutional commitments to equity and cultural responsiveness within psychology (New Zealand Psychologists Board, 2002; Orange, 2017). In practice, these principles require psychologists to engage with Māori worldviews and uphold biculturalism as a professional responsibility by developing the cultural awareness, knowledge, and competencies necessary to provide culturally safe, effective, and responsive services for Māori (New Zealand Psychologists Board [NZPB], 2002). However, research indicates that a substantial proportion of psychologists in Aotearoa New Zealand report feeling underprepared in terms of cultural competence (Heffernan et al., 2024; Johnstone & Read, 2000; Sawrey, 1993; Waitoki et al., 2024).

Early survey research found that 77.5% of psychologists (n = 163) reported lacking sufficient knowledge of Māori culture and Māori perspectives on mental health, and 88.4% felt unprepared to work effectively with Māori clients (Sawrey, 1993). Despite this, the majority recognised that such competence is essential for positive therapeutic outcomes (85.2%). A later national survey of psychiatrists (n = 247) reported comparable patterns, with only 40% indicating confidence in their ability to work effectively with Māori (Johnstone & Read, 2000).

More recent findings show these challenges may still exist within current professional psychology settings. The WERO (Working to End Racial Oppression) report found that fewer than one-quarter of respondents (23%) rated their preparation as “good” or “excellent” for developing cultural competence in practice (Heffernan et al., 2024; Waitoki et al., 2024). When considered alongside efforts to integrate Māori health models, these findings suggest that practitioners’ confidence in applying these frameworks remains limited. The same report (n = 293) noted that fewer than one-third of respondents (33%) felt “confident” or “very confident” in using Hauora Māori models within their therapeutic work (Heffernan et al.,

2024; Waitoki et al., 2024). Similar patterns have been noted in other areas of psychological practice. For example, Heffernan et al. (2024) examined challenges and opportunities for bicultural psychology through interviews with practitioners working in correctional settings (n = 20). A key theme identified was the practical difficulty of incorporating Māori knowledge into everyday practice (Heffernan et al., 2024). Some participants perceived Māori health models as more complex than Western frameworks, which they felt made integration more challenging (Heffernan et al., 2024). Participants in the same study also emphasised the need for clearer, practice-oriented guidance to support the confident and effective application of Māori health models (Heffernan et al., 2024).

While bicultural practice is a central goal for psychology in Aotearoa New Zealand, evidence suggests it is not yet fully realised (Heffernan et al., 2024; Johnstone & Read, 2000; Sawrey, 1993; Waitoki et al., 2024). Accordingly, examining how Māori health models are applied in everyday therapeutic practice remains important to strengthening culturally responsive care. Extending this focus on the practical realisation of bicultural psychology and the use of Māori health models, the next section introduces Indigenous psychology and outlines key pathways through which Indigenous approaches inform psychological theory and practice.

1.3 Indigenous psychology

Indigenous psychology is defined as the scientific study of human behaviour grounded in the cultural traditions, values, and knowledge systems of Indigenous peoples (Bennett et al., 2014; Enriquez, 1992; Kim & Berry, 1993; Pe-Pua, 2020). According to Enriquez (1992), Indigenous models can develop through two primary pathways: (1) adaptation "from without," which involves modifying existing Western psychological models to integrate Indigenous concepts, and (2) adaptation "from within," which grounds psychological models in Indigenous knowledge systems, independent of Western frameworks

(Enriquez, 1992). Literature suggests that both pathways are reflected in developments within Aotearoa New Zealand psychotherapy frameworks (Bennett et al., 2014; McLachlan et al., 2017; Waitoki et al., 2018).

A documented example of the "from without" pathway is provided in Bennett's (2014) adaptation of Cognitive Behavioural Therapy (CBT) for tāngata whaiora experiencing depression. In this adaptation, the theoretical structure of CBT was retained, while aspects of its delivery were adjusted to reflect Māori cultural values and practices. These adjustments included the incorporation of whakawhanaungatanga (relationship-building), te taha whānau (family and social wellbeing), and te taha wairua (spiritual wellbeing). The inclusion of these elements positioned the therapeutic process within a wider relational and spiritual context.

Bennett (2014) also described the use of karakia (Māori prayer) during sessions as one way of acknowledging te taha wairua, with decisions about its use based on the phase of treatment and client preference. In the study, participants who received the adapted CBT reported reductions in depressive symptoms at six-month follow-up (Bennett, 2014). These findings were interpreted by the author as consistent with the idea that cultural adaptation can occur while the underlying CBT framework remains the same. In this example, the indigenisation process involved modifying the mode of delivery rather than altering the core theoretical components of CBT, allowing the approach to align more closely with Māori worldviews.

By contrast, the "from within" pathway refers to the development of psychological frameworks that emerge from a culture's own epistemological foundations (Enriquez, 1992). Within Aotearoa New Zealand, Te Whare Tapa Whā, developed by Sir Mason Durie (1994), represents a foundational Māori health model that has had enduring influence across health and psychological practice. Grounded in Māori epistemology, the model conceptualises

health as a wharenui (meeting house) supported by four interrelated pou: taha tinana (physical health), taha hinengaro (mental and emotional health), taha wairua (spiritual health), and taha whānau (family and social wellbeing) (Durie, 1994). These dimensions rest upon whenua (land and belonging), which provides the foundation for relationships between identity, place, and collective wellbeing (Durie, 1994). The model presents wellbeing as dependent on balance across these domains, noting that changes in one area may influence the integrity of the whole (Durie, 1994). By drawing directly from te ao Māori, Te Whare Tapa Whā offers a framework for understanding wellbeing that is holistic and relational, and situated within Māori knowledge systems, providing an alternative to Western health conceptualisations (Durie, 1994; Wilson, 2021).

In addition to Te Whare Tapa Whā, Māori researchers and clinicians have developed further models informed by Māori epistemology and intended for use in clinical settings (Durie, 1994; Durie, 1999; Pitama et al., 2007). These approaches can help inform different aspects of clinical practice, including assessment, formulation, and intervention, by offering culturally grounded frameworks for working with Māori clients. For example, the Meihana Model is a comprehensive Māori health framework used to guide clinical thinking and practice, building on Te Whare Tapa Whā by incorporating broader relational, historical, and systemic influences on wellbeing, including whānau and iwi connections and the effects of colonisation and inequity (Pitama et al., 2007).

Similarly, the Te Pae Māhutonga framework conceptualises health through the metaphor of the southern cross stars (Durie, 1999). This includes Mauriora (cultural identity), Waiora (environmental wellbeing), Toiora (healthy lifestyles), and Te Oranga (societal participation) (Durie, 1999). These stars are supported by Ngā Manukura (leadership) and Te Mana Whakahaere (autonomy), which facilitate wellbeing (Durie, 1999). A unifying theme across these models is the recognition that health and wellbeing are multifaceted and shaped

by many interconnected factors (Durie, 1999; Pitama et al., 2007). Despite the development of these culturally grounded models, there is a relatively small body of empirical research examining how they are applied in therapeutic settings. The following section reviews available empirical studies that have explored the use of culturally adapted interventions in clinical and therapeutic contexts.

1.4 Empirical Research

Although research directly evaluating the efficacy of Māori health models remains limited, existing studies suggest that the incorporation of Māori values and practices into psychological practice may support client engagement, strengthen therapeutic relationships, and contribute to positive outcomes for tāngata whaiora (Williams et al., 2018; Muriwai et al., 2015).

A qualitative study by Goldsbury (2004) examined the therapeutic alliance and outcomes for Māori tāngata whaiora who had engaged with non-Māori psychologists. Using semi-structured interviews with 10 participants, the study found that Māori service users were able to form positive therapeutic relationships with non-Māori clinicians. However, the strength of these alliances appeared to depend on several factors. Therapists who acknowledged cultural differences, demonstrated respect for cultural identity, and incorporated Māori values and tikanga into their practice were more likely to foster trust and relational connection. These findings suggest that culturally responsive practice may support stronger therapeutic relationships and, as a result, likely contribute to improved wellbeing outcomes for Māori clients. Further empirical research has examined culturally adapted psychological interventions that align with Māori worldviews.

Matheson (2012) developed and evaluated a culturally adapted cognitive behavioural therapy (CBT) programme for tāngata whaiora experiencing depression. The intervention was group-based and delivered over three sessions, with follow-up assessments at 2 weeks, 6

weeks, and 3 months post-intervention. Nine participants completed the programme. Key cultural adaptations included the use of Māori imagery and metaphors to explain cognitive and emotional processes, culturally grounded vignettes reflecting Māori lived experiences, selective therapist self-disclosure to support whakawhanaungatanga, and the explicit valuing of relational processes within the group. Outcomes indicated reductions in psychological distress, and the cultural adaptations were evaluated positively by both participants and clinicians (Matheson, 2012). However, the absence of a control group limits conclusions about the extent to which these changes were attributable to the intervention (Matheson, 2012). Matheson (2012) also noted that flexibility remained important, as clients differed in their cultural knowledge, identity, and preference for engaging with Māori concepts.

Similarly, Hatcher et al. (2016) conducted a randomised controlled trial to evaluate Te Ira Tangata, a culturally informed treatment programme for Māori individuals presenting to hospital following self-harm. The intervention was delivered by Māori practitioners and incorporated cultural assessments of iwi affiliation, problem-solving therapy, regular postcards, patient support, risk management, and improved access to primary care (Hatcher et al., 2016). The sample included 95 participants in the intervention group and 72 in the control group to take part in the study (Hatcher et al., 2016). Hatcher et al. (2016) reported that participants receiving the intervention showed reductions in hopelessness, suicidal risk, and emergency department re-presentations for self-harm at three-month follow-up. However, these improvements were not maintained at the one-year assessment (Hatcher et al., 2016). The authors concluded that while the culturally informed approach demonstrated short-term benefits, further research is needed to examine its long-term effectiveness and sustainability in clinical practice (Hatcher et al., 2016).

More recent empirical work has focused on bi-cultural practice in a corrections setting. Heffernan et al. (2024) conducted qualitative interviews with 20 rehabilitation

practitioners employed by Corrections to explore how Western and Māori approaches are conceptualised and used in practice. The study identified several ways forward to support bi-cultural practice, including more cultural training, access to practical resources, clear guidance on applying Māori models, and ongoing organisational support to enable practitioners to integrate Māori knowledge effectively into everyday work (Heffernan et al., 2024).

Collectively, these studies illustrate ways in which psychological interventions have been adapted to reflect Māori values and ways of understanding wellbeing (Goldsbury, 2004; Hatcher et al., 2016; Matheson, 2012). They suggest that culturally responsive and Māori-centred approaches may support therapeutic relationships and contribute to positive clinical outcomes for Māori clients' wellbeing (Goldsbury, 2004; Hatcher et al., 2016; Matheson, 2012). At the same time, questions remain regarding long-term effectiveness, generalisability, and the extent to which such approaches are consistently implemented in routine practice (Goldsbury, 2004; Hatcher et al., 2016; Matheson, 2012). These considerations provide important context for examining the broader role of Māori health models within psychological practice in Aotearoa New Zealand.

1.5 The Importance of Māori Models in Psychological Practice

This section discusses the broader significance of Māori health models for culturally safe practice, therapeutic alliance, and holistic wellbeing. It explains their relevance for both Māori and non-Māori clients in Aotearoa's diverse mental health landscape.

The relevance of Māori health models extends beyond symptom reduction. From a client-centred perspective, these models can contribute to culturally safe and identity-affirming care (Durie, 2003, 2004; Wilson et al., 2021). Evidence suggests that when clients' cultural worldviews are recognised and integrated into therapy, they experience greater

cultural safety, validation, and therapeutic engagement (Durie, 2003; Sue & Sue, 2016). Empirical studies further demonstrate that interventions incorporating Māori worldviews are associated with greater trust and strengthening of therapeutic relationships (Williams et al., 2018). These findings are consistent with broader research identifying the therapeutic alliance as a key predictor of positive treatment outcomes across modalities and populations (Goldsbury, 2004; Horvath et al., 2018; Sue & Sue, 2016). Within culturally diverse contexts, the quality of this alliance appears to depend in part on therapists' ability to understand and work within clients' cultural identities and practices (Sue & Sue, 2016). Collectively, this literature positions Māori health models as a potentially useful foundation for culturally responsive psychological practice.

In addition, the principles underpinning Māori models correspond with broader international discussions in psychology and mental health that emphasise holistic, relational, and spiritually informed perspectives on wellbeing (Gone, 2010, 2016; Kiyimba & Anderson, 2022; Kirmayer, 2012; Kirmayer et al., 2014; Sundararajan, 2020). Across diverse cultural settings, clients have increasingly expressed preferences for therapeutic approaches that reflect collective, relational, and spiritual values (Ratts et al., 2016; Sue & Sue, 2016). Within Aotearoa New Zealand's multicultural context, Māori health models illustrate these holistic principles and could contribute to understandings of culturally attuned care across communities (Ratts et al., 2016; Sue & Sue, 2016). As psychological practice continues to adapt to an increasingly diverse population, Indigenous frameworks can offer perspectives that inform discussions about inclusive and contextually relevant models of wellbeing (Gone, 2010; Kirmayer et al., 2014; Sundararajan, 2020). Nonetheless, translating these conceptual and cultural perspectives into consistent clinical application remains a recognised challenge. The following section considers factors that have been identified as constraining the integration of Māori health models within clinical and applied settings.

1.6 Barriers to the integration of Māori health models in clinical practice.

Research has identified a range of factors influencing integration, including practitioner-related concerns, organisational constraints, and broader systemic conditions (Heffernan et al., 2024; Hotere-Barnes, 2015; Rakuraku, 2019). In a mixed-methods study involving a survey of 29 custodial staff and follow-up interviews with five participants, Rakuraku (2019) reported that some participants expressed apprehension about making cultural errors, such as mispronouncing te reo Māori or misapplying tikanga, which sometimes resulted in avoidance of Māori-informed practices. This response, sometimes referred to as "Pākehā paralysis," reflects relational and structural tensions in cross-cultural engagement, including anxieties about tokenism, error, or cultural misappropriation (Hotere-Barnes, 2015). Comparable themes were identified in a qualitative interview study by Heffernan et al. (2024), which included 20 rehabilitation practitioners (both Māori and Tauiwi) employed by Corrections New Zealand. Some Tauiwi practitioners reported uncertainty about the appropriateness of using Māori approaches, raising broader questions of cultural identity and professional boundaries (Heffernan et al., 2024). Participants also noted that limited opportunities for cultural training and supervision reduced their confidence in applying Māori frameworks in practice (Heffernan et al., 2024).

In addition, several interventions (Bennett, 2009; Matheson, 2012) report promising outcomes for Māori-adapted therapies but are often small-scale or time-limited, limiting conclusions about long-term sustainability and generalisability. The literature has also examined incorporating elements such as karakia and te reo Māori into therapy; however, many adaptations occur within existing Western modalities rather than reorienting practice around Māori worldviews and epistemologies (Chino & DeBruyn, 2006; Hirini, 1997). This pattern is noted across multiple studies (Chino & DeBruyn, 2006; Hirini, 1997; Muriwai et al., 2015; Wilson et al., 2021) and indicates an ongoing shift from culturally adapted practices toward approaches explicitly grounded in mātauranga Māori. However, empirical

understanding of how Māori models are integrated into everyday therapeutic work remains limited, indicating an area where further investigation could contribute to the evidence base for culturally responsive practice.

1.7 Aim of the Present Study

The current study is situated within an increasing focus on supporting culturally responsive psychological practice in Aotearoa New Zealand. While professional guidelines emphasise the importance of culturally responsive and bicultural practice, limited empirical research has examined how Māori models of health and wellbeing are applied in clinical settings. Given the barriers outlined above, it becomes essential to investigate how psychologists currently understand and use Māori health models in their everyday work. The current study aims to address this gap by exploring how registered psychologists describe integrating Māori health models into their therapeutic practice with clients. This study was guided by the following research question:

Research Question

How do psychologists describe integrating Māori health models into their therapeutic practice with clients?

To address this research question, the following Method section outlines the approach taken to generate and analyse the data.

Chapter 2: Method

2.1 Research Design

This study used a qualitative, exploratory design to investigate how registered psychologists in Aotearoa New Zealand use and integrate Māori health models in their therapeutic practice. A qualitative approach was appropriate because the research aimed to understand practitioners' experiences and perspectives, which are best accessed through in-depth, interpretive methods (Braun & Clarke, 2013). An exploratory design was also justified because this area of practice is not yet well studied, and exploratory approaches are well suited to building initial understanding without relying on pre-existing theoretical models (Stebbins, 2001). An inductive, data-driven approach therefore allowed themes to emerge from participants' perspectives rather than imposing predetermined frameworks (Swift, 2022).

The research was further guided by a kaupapa Māori methodological framework, which shaped the study design, procedures, and interpretation of findings (Ahuriri-Driscoll et al., 2007). In line with these principles, early consultation was undertaken with a Māori-registered psychologist experienced in both clinical and qualitative research. Tikanga-informed practices, including processes such as karakia and whakawhanaungatanga within interviews, were incorporated to ensure that the research was conducted in a culturally responsive manner consistent with kaupapa Māori research guidelines (Ahuriri-Driscoll et al., 2007).

2.2 Participants

Eligible participants were registered psychologists aged 18 years or older who were proficient in English, registered with the New Zealand Psychologists Board, and currently providing one-to-one therapy to clients, and who had experience working therapeutically with

Māori clients A total of 24 registered psychologists from across Aotearoa New Zealand took part in in the study. As shown in Table 1, participants varied across several demographic and professional domains, including gender, age, ethnicity and years of practice. Sixteen participants identified as female and eight as male. Ages ranged from the mid-20s to late 50s (M = 39.5 years, SD = 10.2). Participants represented a range of ethnicities: Māori (n = 8), New Zealand European (n = 9), Other European (n = 3), South African (n = 1), Sri Lankan (n = 1), Asian (n = 1), and Iranian (n = 1). In terms of experience, four psychologists (n = 4, 16.7%) were recent graduates with less than six months of practice, nine (n = 9, 37.5%) were early-career practitioners with up to five years of experience, three (n = 3, 12.5%) were mid-career practitioners with up to ten years in practice, and eight (n = 8, 33.3%) were later-career psychologists with more than ten years of experience. Experience working with Māori clients varied among participants. Some reported n = 11, extensive n = 8, limited n = 3, and very extensive experience n = 2.

Table 1. Participant Demographics

Variable	Category	n	%
Gender	Female	16	66.7%
	Male	8	33.3%
Age	25–34	10	41.7%
	35–44	5	20.8%
	45–54	6	25.0%
	55+	3	12.5%
Ethnicity	Māori	6	25.0%
	Māori & New Zealand European	2	8.3%
	New Zealand European	9	37.5%
	Other European	3	12.5%
	South African	1	4.2%
	Sri Lankan	1	4.2%
	Asian	1	4.2%
	Iranian	1	4.2%
Years of Experience	Recent graduate (< 6 months)	4	16.7%
	Early-career (≤ 5 years)	9	37.5%
	Mid-career (≤ 10 years)	3	12.5%
	Later-career (> 10 years)	8	33.3%

As shown in table 1, Psychologists worked across multiple service settings. The largest group practised in community mental health services (41.7%, n = 10), followed by private practice (33.3%, n = 8) and the Department of Corrections (25.0%, n = 6). Smaller numbers worked in government organisations (8.3%, n = 2), schools (4.2%, n = 1), hospitals (4.2%, n = 1), or other settings (12.5%, n = 3). Participants reported using a range of therapeutic approaches, often combining more than one according to client needs. The most common were cognitive-behavioural therapy (CBT; n = 16), eclectic approaches (n = 10), and acceptance and commitment therapy (ACT; n = 8). Other approaches included dialectical behaviour therapy (DBT; n = 7), family systems therapy (n = 5), psychodynamic therapy (n = 1).

Table 2. Professional Practice Characteristics of Participants (N = 24)

Variable	Category	n	%
Service Setting	Community mental health	10	41.7%
	Private practice	8	33.3%
	Department of Corrections	6	25.0%
	Government organisation	2	8.3%
	School	1	4.2%
	Hospital	1	4.2%
	Other	3	12.5%
Therapeutic Approach	Cognitive-behavioural therapy (CBT)	16	66.7%
	Eclectic	10	41.7%
	Acceptance & commitment therapy (ACT)	8	33.3%
	Dialectical behaviour therapy (DBT)	7	29.2%
	Family systems therapy	5	20.8%
	Psychodynamic	1	4.2%

Note: (Multiple responses allowed for service settings and therapeutic approaches)

2.3 Procedure

Ethical approval for this project was granted by the Human Research Ethics Committee (Approval Number: FS2025-05). A purposive sampling strategy was employed to recruit psychologists who met the inclusion criteria. Recruitment materials were disseminated via professional social-media platforms (e.g., Facebook groups for psychologists), and relevant organisations identified through online searches were contacted directly by email. In addition, Master's students used their personal and professional networks to promote the study and share the research invitation with potential participants working in psychology. Interested participants contacted the research team by email and were subsequently sent an information sheet outlining the study's purpose, procedures, and ethical considerations, along with a written consent form and a link to a Qualtrics demographic questionnaire. Written informed consent was obtained prior to scheduling interviews.

Data were generated through semi-structured interviews conducted via Zoom videoconferencing between April 2025 and July 2025. Interviews ranged from approximately 20 to 50 minutes in duration. Participants received a NZD $100 electronic gift voucher in recognition of their time. Each interview was informed by kaupapa Māori principles, such as beginning interviews with whakawhanaungatanga (relationship building). Interviews were conducted in accordance with participants' preferences, with the option to begin and conclude with karakia (prayer).

All interviews were audio-recorded with participant consent and transcribed verbatim. Identifying information was removed to ensure anonymity and confidentiality. Member checking, a process in which participants review their interview transcripts to confirm accuracy and clarify meaning (Creswell & Poth, 2016), was offered to all participants via email, with transcripts sent for review and any desired edits noted. Three participants reviewed and edited their transcripts, and requested changes were implemented to remove

any information that could identify participants or their workplaces. The next section details the materials used to gather demographic and interview data.

2.4 Materials

Participants completed a Qualtrics demographic questionnaire that collected information on age, gender, and ethnicity, as well as professional background, including years of practice, area of specialisation, therapeutic approach, client base, and confidence in bicultural practice. The semi-structured interview protocol used in this study was collectively developed in consultation among the research teamwhich comprised academic and practising psychologists, psychology trainees, and higher degree research students. The interview questions consisted of open-ended questions designed to elicit in-depth information from respondents. It is important to note that other research questions were asked in the study as it was part of a broader project. However, for the purpose of this study, the relevant interview questions were as follows:

Do you integrate any Māori health models into your practice? If yes, which ones?

How do you integrate Māori health models into your therapeutic practice with clients? *Can you share any examples that illustrate how you do this?*

2.5 Data Analysis

With 24 participants, the study exceeded Braun and Clarke's (2006) recommended sample size for achieving data saturation. Participant interview data were analysed following Braun and Clarke's (2006) six-phase framework for thematic analysis. This involved familiarisation with the data, generating initial codes, developing themes, reviewing themes, defining and naming themes, and producing the final themes. Consistent with the study's aim to explore psychologists' experiences of integrating Māori health models into therapeutic practice, a critical realist orientation was adopted to capture both the descriptive content of

participant accounts and the broader contextual influences shaping practice. Coding was primarily semantic, focusing on what participants explicitly reported, rather than applying latent interpretations beyond their stated meanings (Vaismoradi & Snelgrove, 2019).

1. Familiarisation: All interview transcripts were compiled into one Word document to enable student investigator to read their part of the interview questions. The student investigator read and re-read each transcript, making written notes for recurring concepts. This iterative immersion in the data reflects recommended qualitative practice for developing early analytic insights (Nowell et al., 2017). Early observations were grouped under broad provisional headings (e.g., models, assessment, formulation, client-led practice), which served as preliminary foundation for later coding.

2. Generating Initial Codes: Coding was conducted manually in Word by highlighting relevant text segments and noting the codes underneath the participant lines. Codes reflected the explicit content of participants' accounts, focusing on what was said (Vaismoradi & Snelgrove, 2019). This process was informed by guidelines for systematic, descriptive coding aimed at staying close to participants' language. To support the trustworthiness of the analytic process, a second member of the research team independently reviewed approximately 20% of the coded transcripts, focusing on the transparency and suitability of the coding in relation to the underlying data, as well as the consistency of the developing interpretations. No substantive discrepancies were identified. Any minor points requiring clarification were addressed through reflexive discussion, leading to modest refinements to code definitions and analytic interpretations where appropriate.

3. Constructing Initial Themes: Following the generation of initial codes, the researcher began organising and clustering codes into early themes. All codes were imported into an Excel workbook, where they were sorted, grouped, and visually mapped. Colour

coding was used to support pattern recognition, with similar or related codes highlighted in shared colours. Such visual mapping techniques are widely recognised for enhancing analytic clarity and supporting theme construction (Castleberry & Nolen, 2018; Bazeley, 2021). This helped to visually organise the dataset and make early clusters more apparent; for example, codes relating to the use of Te Whare Tapa Whā in assessment and intervention gradually formed one group. This process involved moving back and forth between data and codes. Weekly research team meetings were used to review these developing clusters, discuss interpretations, and check that emerging themes remained consistent with the data. While theme development remained the responsibility of the primary researcher, these discussions supported reflexive thinking and strengthened the clarity and credibility of the early themes.

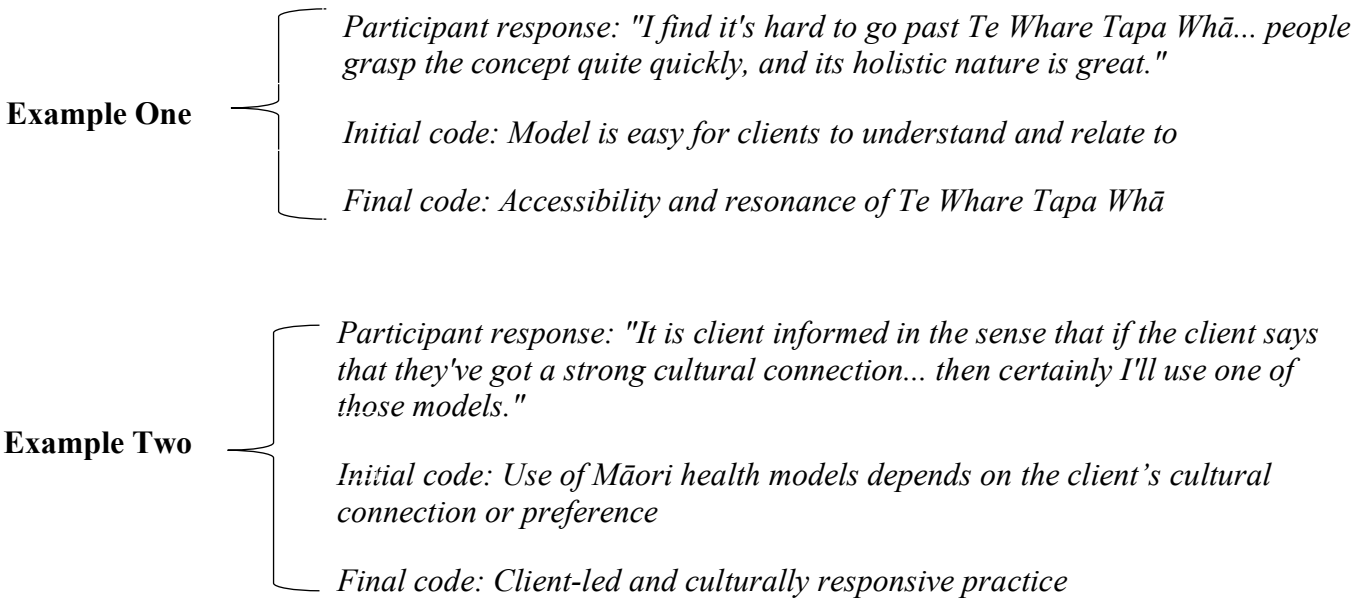
4. Reviewing Themes: Themes were refined and validated against the entire dataset and across the research question. Following Braun and Clarke's (2021b) guidance, themes were developed based on their frequency. However, only themes supported by a substantive portion of the data (at least 20% of participants) of psychologists' accounts were retained.

5. Defining and Naming Themes: Each theme was clearly defined and named to capture its core meaning. Weekly group supervisory meetings provided opportunities for review and refinement.

6. Writing Up: The final stage involved integrating the thematic structure into a coherent narrative supported by illustrative participant quotes. Themes were woven together to reflect the diverse ways Māori health models were applied and adapted within psychological practice. Weekly supervisory discussions continued throughout this stage to ensure representativeness of the data. The final themes were thus both robust and reflective of the diversity of participant experiences, capturing the ways in which Māori health models are

incorporated into psychological practice in Aotearoa. An example of the coding process can be seen in Figure 1.

Figure 1. Example of the Coding Process



To ensure the quality and rigour of this analysis, the following section outlines the strategies used to enhance trustworthiness.

2.6 Trustworthiness

This study was guided by Tracy's (2010) criteria for excellent qualitative research. Three of the eight criteria were applied: sincerity, resonance, and meaningful coherence. Sincerity was achieved through reflexivity, honesty, and transparency. The research team included three Master's students, one research assistant, and a academic supervisor who had varying levels of familiarity with Māori health models. The team recognised that these positions may have influenced recruitment, interviewing, and analysis. To support reflexivity, the student investigator kept a journal that recorded assumptions and decisions, which were discussed during weekly supervision meetings.

Credibility was supported by engagement with the data through repeated reading of transcripts, iterative coding, and the organisation of codes into categories and themes. Coding decisions and interpretations were reviewed in weekly team meetings, and member checking at the transcript stage enhanced accuracy.

Resonance was strengthened by describing participant characteristics such as ethnicity, service settings, therapeutic approaches, client composition, and experience working with Māori clients. Honesty and transparency were maintained through clear documentation of recruitment, consent, interviewing, transcription, member checking, and analysis. All research procedures were attentive to Te Tiriti o Waitangi principles of partnership, participation, and protection, and to Māori data sovereignty through careful removal of identifying details. The next section explains how transparency and openness were incorporated into the study's methodological approach.

2.7 Transparency and Openness

In line with transparency and openness practices, the study was not preregistered, reflecting its exploratory qualitative design (Miguel et al., 2014). Consistent with recommended standards for reporting qualitative research (Tong, Sainsbury, & Craig, 2007), key study materials including the interview schedule, participant information sheet, and consent form are available from the project supervisor upon reasonable request, subject to ethical approval conditions (Approval: FS2025-05). Full interview transcripts are not publicly accessible to protect participant confidentiality, in line with best practices for ensuring trustworthiness in qualitative research (Tracy, 2010)

Collectively, these measures support a transparent and trustworthy account of how the data were generated, analysed, and interpreted. Furthermore, the reflexivity section outlines the researcher's positionality and acknowledges how their assumptions and experiences

influenced the analytic process, consistent with recommendations for reflexive thematic analysis (Braun & Clarke, 2021).

2.8 Reflexivity

As a non-Māori researcher trained primarily in Western psychological frameworks, I acknowledge the potential limitations and biases that may shape my interpretations. I approach this research as a guest within te ao Māori. My intention is not to speak on behalf of Māori but to create space where Māori voices, knowledge, and perspectives are centered within psychological practice. To maintain reflexivity, I kept a journal throughout the research process, particularly during and after interviews. This provided a space to record observations, emotional responses, and reflections on my own assumptions or reactions. Engaging with this reflexive practice enabled me to critically consider how my positionality as a non-Māori researcher may have influenced interactions with participants and informed the ways in which I interpreted the data. With the methodology established, the results of the thematic analysis are presented next.

Chapter 3: Results

This section presents the findings from thematic analysis. It begins with a descriptive overview of participants' reported use of Māori health models, followed by seven themes that capture various aspects of practice. While some themes directly relate to the integration and impacts of Māori health models, others highlight broader challenges and contextual factors influencing practice.

Participants were asked to describe how they engage with Māori health models in their professional practice. This included whether they use such models and, if so, how these are applied within therapeutic practice with clients.95% of psychologists reported using at least one Māori health model, with 79% incorporating more than one. Te Whare Tapa Whā was most frequently reported (n = 22; 91.7%), followed by the Meihana Model (n = 15; 62.5%). Other frameworks such as Te Pae Māhutonga, He Awa Whiria, Hua Oranga, and Te Wheke were mentioned less frequently (each cited by 1–2 participants, 4.2–8.3%). Psychologists' selection and use of these models varied depending on factors such as their training exposure, confidence, knowledge, and the characteristics of the clients they were working with. Many clinicians described combining different models depending on client needs and practice contexts

In response to the question, "How do you integrate Māori health models into your therapeutic practice with clients?", thematic analysis of interview data identified seven interrelated themes that capture how participants engaged with, adapted, and integrated Māori health models within their therapeutic work. An overview of these themes is provided in Table 3. Having outlined participants' overall use of Māori health models, these initial descriptive patterns provide the context for the first theme.

Table 3. Themes

Themes
1. Te Whare Tapa Whā: Still a Foundational Model
2. Creative Translation of Theory into Clinical Practice
3. Culturally Responsive Application & Client-Led Practice
4. Navigating the Meihana Model: Balancing Utility and Complexity
5. Impacts of Using Maori Health Models
6. Blending Māori and Western Therapeutic Approaches
7. Challenges Applying Māori Health Models

Te Whare Tapa Whā: The Foundational Model of Practice

The majority of participants (92%, n = 22) identified Te Whare Tapa Whā as the Māori health model most consistently integrated into their therapeutic practice. Psychologists described using it as a key framework to guide assessment, psychoeducation, collaborative goal-setting, and intervention planning. Across accounts, the model supported attention to the interconnected spiritual, physical, mental, and social dimensions of wellbeing within a culturally grounded approach.

Participants consistently described Te Whare Tapa Whā as an accessible and relatable framework for a wide range of clients. They spoke about its visual structure and metaphor as helping clients to grasp the model more easily and engage with it in session. As Participant 22 explained, “I find it’s hard to go past Te Whare Tapa Whā, mostly because of how accessible it is to people I work with. They grasp the concept quite quickly.” Similarly, Participant 15 reflected, “I've used Te Whare Tapa Whā a lot… just a lot of people can relate

to it… it's easy to understand as a model." For these psychologists, the model offered a clear and non-technical way of introducing broader concepts of wellbeing into therapy.

Psychologists also emphasised the model's adaptability and relevance across diverse client groups. While grounded in te ao Māori, Te Whare Tapa Whā was described as meaningfully applicable with both Māori and non-Māori clients when used in culturally responsive ways. Participant 23 noted, "I use Te Whare Tapa Whā a lot, and it doesn't matter whether they're Māori or what their cultural background is."

A further function of Te Whare Tapa Whā described by some participants was its role in opening up conversations about wairua with clients in their practice. They described how using the model created space to explore spiritual aspects of wellbeing that were not always explicitly addressed and may otherwise have been overlooked in therapy. As Participant 20 explained, "We rely heavily on Te Whare Tapa Whā… We use the four dimensions to assess what's going on for people in their lives. It gives a much broader insight into things like wairua, which I wouldn't typically talk about."

Creative Translation of Theory into Clinical Practice

Most psychologists (70.8%, n = 17) described using Māori health models in creative and varied ways within their therapeutic practice. For example, Participant 22 explained how the model structured their treatment planning: "So I might then start a treatment plan… let's say we agree to have eight sessions after that, it might then be setting two sessions for each taha of Te Whare Tapa Whā… What we might do in those… might be getting out and doing some physical activity with the young person, or helping them problem-solve how to implement healthy practices… Using [Te Whare Tapa Whā] as the foundation for the treatment plan."

Some psychologists developed individualised tools to support the model's use in practice. These included self-monitoring worksheets and check-in templates that enabled clients to map their experiences across the four taha. Participant 6 shared, “Te Whare Tapa Whā is a standard for me… I employ it as a really good check-in point… He records his Te Whare Tapa Whā in his own book… mapping his thoughts, feelings, and engagement with whānau and wairua across days… he’s starting to see how he underrates or overrates himself, and what’s happening when he does so.”

Other clinicians employed simpler strategies such as numerical ratings. As Participant 8 described, “One very basic way I use it is to get people to rate themselves across the four domains [from Te Whare Tapa Whā] from zero to ten.”

Visual and creative methods were also used to operationalise the models. Participant 13, for instance, described drawing the whare with clients and using this as a shared reference point throughout therapy: “I will use Te Whare Tapa Whā, draw a whare… ‘One side of your roof has collapsed… how are we going to rebuild it?’… We check in over time… are we rebuilding that roof?”. Overall, participants’ accounts illustrate that Māori health models, particularly Te Whare Tapa Whā were regularly integrated into everyday clinical practice, with psychologists using them in diverse and creative ways to guide assessment, formulation, and therapeutic engagement across a range of therapeutic contexts.

Culturally Responsive Application & Client- Led Practice

Many psychologists in this sample (41%, n = 10) highlighted that the application of Māori health models was shaped by the client’s cultural identity, preferences, and presenting needs. Psychologists described adopting a flexible, client-led approach in which Māori models were introduced only when they were relevant, welcomed and meaningful to the individual. As Participant 20 explained, “It is client-informed in the sense that if the client

says that they've got a strong cultural connection… then certainly I'll use one of those models."

Some psychologists emphasised the importance of not assuming that Māori clients would automatically wish to engage with Māori health models. Instead, participants described approaching each client with openness and curiosity. Participant 24 noted, "That's my starting point as always, I guess, to just ask or be curious and not to assume." For these clinicians, responsiveness meant allowing the client to determine whether and how a Māori framework might support their therapeutic work.

Other participants described adapting the way Māori models were used based on what clients or groups brought into the session. This included modifying the presentation, focus, or level of structure to ensure cultural concepts felt accessible and relevant. As Participant 14 reflected, "It depends on what the client's bringing, or the group is bringing… What do I need to do to create something tangible [from Māori models] that they will be able to relate to?"

Psychologists also highlighted the significance of recognising a client's level of cultural confidence. This involved attending not only to cultural identity but also to how comfortable clients felt engaging with Māori models within a therapeutic context. Participant 6 explained, "I pick and choose when I apply Meihana because it depends on the client's own cultural confidence and competence."

Navigating the Meihana Model: Balancing Utility and Complexity

The Meihana Model was used by 62% of psychologists in this sample (n = 15) and was another commonly used Māori health model in practice. The models were widely used to conceptualise broader influences on wellbeing, guide assessment and formulation, and engage with Māori clients and their whānau. Psychologists described differing levels of

familiarity and comfort with using the Meihana Model, which shaped how the framework was taken up in clinical practice.

As Participant 20 explains, "I personally prefer the Meihana model because I think it's just, it's a lot broader. And it takes a lot more into consideration. It's also a really good way for the client to conceptualize the therapeutic journey in terms of navigation, right? As opposed to kind of trying to steer. Yeah, the client's in charge in terms of where we go. But as the clinician, it's our role to help the client navigate."

Similarly, Participant 22 commented: The principles of it, the Meihana Model, I use... quite a lot when just thinking broadly about... wider, social, cultural things going on within the whānau.

At the same time, some participants (25%, n = 6) described still developing their understanding of the Meihana Model, noting its conceptual complexity and the challenge of translating it into therapeutic practice. As Participant 1 explains: I think with the Meihana model, I just can't seem to grasp it very well. I have a lot of trouble sort of applying it. Similalry, Participant 21 reflected: With clients… understandably the Meihana Model is complex when you get into it.

Impacts of Using Maori Health Models

Although the interview schedule did not explicitly focus on client outcomes, a number of psychologists (29%, n = 7) spontaneously reflected on the effects they observed when using Māori health models in practice. Participants described these models as supporting greater openness in therapy, creating culturally safe spaces, and offering ways to reframe client challenges. Psychologists noted that Māori health models often enabled clients to engage more openly in sessions. As Participant 8 explained,"When I get people to rate themselves across the four domains… it opens up kōrero about things they wouldn't usually share."

Some participants observed that incorporating Māori concepts made therapy feel less formal and more comfortable. Participant 3 described, “Introducing Māori concepts and models… I find using those sort of concepts with my clients who are open to it can be more helpful than a Western model of like cognitive behavioural therapy… it kind of relaxes them… it makes the space feel less clinical”.

Participants also described how the models reframed client experiences in empowering ways. Participant 21 said,“I think the Meihana model does really well to reframe that thinking… instead of viewing it as cognitive distortions and this is a problem, as how can we use this thinking to empower someone?… it can be quite empowering, but in a way that’s not complacent to the issues that are still present.”

Finally, the models provided opportunities for clients to connect their experiences with their own cultural knowledge and language. Participant 6 reflected, "Once I explained the frames, he mapped it to Ngā Hau e Whā [the Meihana model]… He said, ‘You’re talking about my four winds.’… It gave him a way to connect his whānau, fears, and… feelings of marginalisation to the model.”

Blending Māori and Western Therapeutic Approaches

Some psychologists (25%, n = 6) described their experiences integrating Māori health models alongside Western therapeutic modalities in their clinical work. Across accounts, psychologists emphasised that combining these approaches supported culturally responsive practice while still allowing them to deliver structured psychological intervention. They described practical, session-based adaptations that enabled Māori models to sit alongside Western therapeutic techniques. Participants spoke about drawing on Māori frameworks and concepts alongside therapeutic modalities such as Acceptance and Therapy (ACT), Cognitive Behavioural Therapy (CBT), schema therapy, 5Ps formulation, and safety planning.

As Participant 9 described adapting ACT values work through the use of Māori resources: “He Puna Whakaata… values cards, which are all te ao Māori. So, if I'm using ACT style therapy and doing values-based work, using those instead of the traditional ACT values cards.” Participant 13 similarly explained incorporating Māori frameworks within CBT: “I’ll draw a whare on the whiteboard… then link CBT strategies like behavioural activation to rebuilding the roof of Te Whare Tapa Whā.”

Challenges Applying Māori Health Models

Some psychologists (25%, n = 6) spoke about some of the challenges they experienced when integrating Māori health models into their therapeutic practice. They described factors that influenced their confidence in using these models in everyday clinical work, including training, access to practical resources, and uncertainty about how to operationalise the models in specific therapeutic contexts.

Participants noted that although Māori health models are introduced during professional training, this exposure did not always translate into a sense of preparedness for implementation. As Participant 4 explained, "You're coming out of the training with the same understanding, which doesn’t leave you feeling ready to implement anything in a different way.”

Some psychologists also described a lack of clear guidance and accessible resources to support the consistent use of Māori health models. Participant 5 captured this challenge, commenting, “I think the main challenges are like the lack of specificity and resources, perhaps, around the models that are available to guide us in bicultural practice.”

Chapter 4: Discussion

The current study was situated within a continuing need to develop and support culturally responsive psychological practice in Aotearoa New Zealand. This study explored how Māori health models were integrated into everyday psychological practice and applied within therapeutic settings, drawing on psychologists' accounts of their clinical work. Through qualitative analysis of 24 interview transcripts with registered psychologists, a series of themes emerged that captured clinicians' approaches to integrating Māori health models, including the translation of theory into practice, culturally responsive and client-led application, and the perceived impacts of using these models in therapeutic work. The findings also highlighted engagement with specific Māori health models, particularly Te Whare Tapa Whā and the Meihana Model, as well as the blending of Māori and Western therapeutic approaches. Themes relating to challenges in applying Māori health models were also identified. The discussion that follows offers a critical examination of these themes, situating the findings within relevant literature, reflecting on the strengths and limitations of the study, and identifying implications and directions for future research and practice.

Key Māori Health Models in Psychological Practice

Almost all psychologists reported drawing on at least one Māori health model in their everyday practice, with several describing engagement with multiple frameworks in their clinical work. One theme that emerged across psychologists' accounts was the widespread use of Te Whare Tapa Whā as a foundational Māori health model within everyday clinical practice across a broad range of mental health settings. Psychologists consistently described the model as familiar, accessible, and easy to use, with sufficient versatility to support assessment, formulation, and intervention. These accounts suggest that psychologists' use of Te Whare Tapa Whā reflects a convergence of factors, including its practical utility in

clinical settings and its integration across service provision and a range of professional psychology organizations.

Psychologists also emphasised the inclusion of wairua as a particularly valued dimension of the model, noting that it enabled discussion of spiritual aspects of wellbeing that might otherwise remain unaddressed in therapy. This finding aligns with literature suggesting that spiritual and existential dimensions of wellbeing can be minimised within mainstream psychological models, despite their relevance to many clients' understandings of health and healing (Kirmayer et al., 2012 ; Koenig, 2012). By positioning spiritual wellbeing alongside physical, mental, and whānau dimensions, Te Whare Tapa Whā appeared to support more holistic and culturally responsive clinical conversations.

As the earliest published Māori health model, Te Whare Tapa Whā has been in use for over four decades, and its longstanding presence within health and education systems may have contributed to its widespread recognition and uptake among psychologists, alongside these other considerations (Bright & Boyd, 2024 ; Durie, 2001; Macfarlane & Macfarlane, 2011). At the same time, the findings raise the possibility that the widespread use of Te Whare Tapa Whā within psychological practice may contribute to an over-reliance on this model as the primary framework for engaging with Māori wellbeing. While the model is valued for its clinical utility, existing scholarship also suggests that it may not always function as a sufficient standalone framework for capturing the diversity and complexity of Māori experiences (McNeill, 2009). As Durie (1994) observed, Te Whare Tapa Whā is "simple, even simplistic," with the same features that support its accessibility also shaping its limitations (p. 74).

These findings highlight the continuing value of Te Whare Tapa Whā within contemporary psychological practice, while also pointing to the importance of supporting

engagement with a broader range of Māori health frameworks. Training and supervision that encourage reflexive and context-responsive practice may assist psychologists to draw flexibly on multiple Māori models in ways that best support both practitioners and client needs.

Another theme that emerged was the widespread use of the Meihana Model among psychologists who reported engaging with multiple Māori health frameworks in their clinical work. Across their accounts, the model was frequently valued as a comprehensive framework for guiding assessment and formulation. It was seen to support a holistic understanding of wellbeing that extends beyond the individual to include whānau, environmental, and broader sociocultural factors. These accounts suggest that psychologists' use of the Meihana Model reflects its capacity to situate presenting concerns within broader contextual factors, supporting more culturally grounded understandings of wellbeing. As Pitama et al. (2014) explains, the Meihana Model is designed to be used "from the first point of contact to develop a comprehensive picture of whānau circumstances and how presenting issues fit within this wider context" (p. 120).

Psychologists also highlighted that the model is particularly valuable in collaborative therapeutic contexts. They noted that it provides culturally grounded language to explore interconnected dimensions of health and wellbeing in ways that resonate with Māori worldviews. Moeke-Maxwell (2008) highlights that a key strength of the Meihana Model is its capacity to support clinicians in understanding clients' beliefs, values, and experiences from their own cultural perspective. In this sense, the Meihana Model appeared to function as a framework for supporting culturally responsive practice.

At the same time, the literature highlights important considerations regarding the model's application across diverse identities and clinical contexts (McNeill, 2009; Moeke-Maxwell 2008). As Moeke-Maxwell (2008) notes, although the model avoids fixed or

simplistic constructions of Māori identity, its application may be more challenging when working with clients who have complex, mixed, or multiracial backgrounds. In these situations, clinicians may require additional cultural knowledge and reflexivity to ensure the framework remains aligned with a client-centred approach (Moeke-Maxwell, 2008). This suggests that while the Meihana Model provides a strong foundation for holistic support, its effective use depends on practitioners' ability to navigate the nuances of contemporary Māori identity in flexible and context-responsive ways.

Reflections from psychologists also highlighted practical challenges in translating the Meihana Model into everyday clinical practice. Some psychologists described difficulties in operationalising the model in time-limited contexts or when working primarily with individual clients. Psychologists also noted that navigating the multiple domains of the model could feel complex, which at times limited its practical use during therapy sessions. Research by Heffernan et al. (2024) echoes these experiences, finding that psychologists sometimes struggled to apply Māori health frameworks because their cultural concepts were perceived as more complex than familiar Western models. In high-demand service environments, this perceived complexity may limit consistent use, highlighting the need for applied training and practical support to support the translation of culturally grounded models into clinical practice.

These findings highlight the continuing value of the Meihana Model within contemporary psychological practice, particularly in supporting culturally responsive practice. At the same time, they point to the importance of applied training, supervision, and practical resources to support its consistent and confident integration.

From Framework to Practice

The third theme that emerged centred on the translation of Māori health models from theory into everyday therapeutic practice. While almost all psychologists described engaging with Māori health models, their accounts revealed considerable variation in how these frameworks were operationalised across settings and clients. Some psychologists described consistently using Māori health models to guide their clinical work, such as incorporating them into assessment questions, case formulation, and treatment planning. Others reported using these models more occasionally, referring to particular aspects only when they felt they were relevant to a client's situation.

At an interpretive level, these findings suggest that Māori health models function as flexible guiding frameworks rather than prescriptive clinical protocols. Psychologists appeared to draw on these models in ways that aligned with their therapeutic approach, client needs, and practice context, resulting in diverse forms of clinical enactment. This supports the view that culturally informed frameworks are not transferred directly into practice in rigid ways but are actively translated through clinicians' judgement and professional positioning (Gone, 2010; Kirmayer, 2012). This pattern is consistent with wider literature on culturally informed and Indigenous frameworks, which recognises that culturally based models are intended to support meaningful, contextually grounded, and culturally responsive practice (Bernal & Domenech Rodríguez, 2012; Dudgeon et al., 2014; Durie, 1994; Gone, 2010; Kirmayer, 2012).

Participants' accounts further suggest that the variation with which Māori health models are enacted in practice is shaped not only by responsiveness to client needs and practice contexts, but also by psychologists' training experiences and access to ongoing

professional support. Differences in exposure to Māori health models during training, opportunities for applied learning, and availability of culturally responsive supervision appear to influence how confidently clinicians translate these frameworks into practice. Where such supports are uneven or limited, psychologists may rely more heavily on individual interpretation, contributing to variability in how Māori health models are understood and enacted.

From this perspective, some of the variability in translation practices reflects the fact that applying culturally based frameworks requires psychologists to make context-specific decisions based on the client, setting, and clinical circumstances. While such flexibility can support responsiveness and client-centred care (Gone, 2016; Kirmayer, 2012), research also suggests that adaptation in the absence of sufficient knowledge, cultural guidance, and supervisory support may lead to partial or inconsistent enactment of cultural frameworks (Castro et al., 2010). Over time, this may dilute the depth and coherence with which Māori health models are enacted in practice, potentially weakening their capacity to support holistic understandings of wellbeing across services and settings (McNeill, 2009 ; Moeke-Maxwell 2008).

Taken together, these findings suggest that flexibility in translating Māori health models can support responsive and culturally attuned practice, without requiring rigid or standardised application. At the same time, they highlight the importance of supporting psychologists to develop the knowledge, confidence, and guidance needed to translate these models effectively. Ongoing opportunities for training and culturally informed supervision appear critical for sustaining coherent and meaningful enactment over time. Similarly, collaborating with Māori practitioners to co-create practical resources can help operationalise these models in practice. Such resources might include applied tools, case examples,

reflective guides, and supervision frameworks that support psychologists in engaging with Māori health models in ways that are both accessible and adaptable to diverse clinical contexts.

A further theme highlighted how psychologists integrated Māori health models with Western therapeutic approaches in their clinical practice. Participants described combining Māori frameworks with modalities such as Acceptance and Commitment Therapy and Cognitive Behavioural Therapy, describing this integration as a practical way to deliver culturally responsive care. Literature examining psychological practice in New Zealand similarly documents bicultural approaches that involve working across Māori and Western knowledge systems within mainstream service environments (Crozier & Pizzini, 2020; NiaNia & Bush, 2023; Reeves, 2018). Psychologists in this current study described weaving Māori concepts and frameworks into therapy sessions while retaining the structure and evidence base of traditional psychotherapies. This pattern of practice can be understood through the lens of the He Awa Whiria framework, which conceptualises Māori and Western knowledge systems as distinct yet able to flow alongside one another in applied contexts (Macfarlane & Macfarlane, 2019). Participants' accounts reflected this braided approach, whereby neither system replaced the other; rather, both were drawn upon in ways intended to support culturally grounded practice.

This integrative practice described by participants also sits within wider discussions of cultural adaptation in psychotherapy. Research in this area suggests that evidence-based treatments are typically modified rather than replaced when used in culturally diverse settings (Bernal & Domenech Rodríguez, 2012; Castro et al., 2010). For instance, Matheson (2012) developed and evaluated a culturally adapted Cognitive Behavioural Therapy programme for tāngata whaiora experiencing depression, incorporating Māori imagery and culturally

grounded vignettes to better reflect Māori worldviews. These forms of adaptation demonstrate how Western modalities can be reshaped to incorporate cultural elements while maintaining their therapeutic structure. However, tensions within this approach have also been noted. Kirmayer (2012) notes that Indigenous models of wellbeing are often grounded in holistic and relational perspectives that may not always align easily with Western psychotherapeutic approaches. Participants' reflections suggested awareness of these tensions, describing integration as requiring ongoing clinical judgement, reflexivity, and cultural learning.

Overall, these findings suggest that integrating Māori and Western approaches offers a practical strategy for supporting culturally responsive practice. One key implication is the potential development of bicultural frameworks that intentionally combine elements from both knowledge systems. Such frameworks could provide clearer guidance for applying Māori and Western models across assessment, formulation, and intervention. Future research could evaluate the effectiveness of these integrated frameworks in clinical settings, including their influence on practitioner confidence and client outcomes. This work has the potential to contribute to the creation of evidence-informed bicultural models that strengthen culturally responsive psychological practice in Aotearoa, New Zealand.

A subsequent theme highlighted psychologists' emphasis on using Māori health models within a client-led approach to care. Their use of these models was consistently guided by clients' identities, preferences, and readiness. Māori frameworks were positioned as resources to support clients' goals, with psychologists emphasising the importance of inviting discussion rather than making assumptions. Reflecting this principle, Morice and Fay (2013) emphasise that clinicians should not assume "the client's familiarity with Te Ao Māori or … any particular attitude towards the Māori world" (p. 14), highlighting the

importance of approaching cultural engagement with openness and humility. Participants' reflections demonstrated this approach in practice, showing a deliberate effort to avoid essentialising Māori identity while responding flexibly to each client's cultural context.

Psychologists also highlighted shaping therapeutic practice around client preferences when using Māori health models, reflecting broader evidence that culturally grounded interventions are most effective when practitioners engage with clients' own frameworks and integrate these understandings into care planning (Bennett et al., 2014; Durie, 1998; Wilson & Neville, 2009). While participants prioritised client autonomy, they also emphasised their responsibility to ensure that cultural dimensions of wellbeing were addressed and not overlooked. In Aotearoa, this responsibility is reinforced by the New Zealand Psychologists Board (2002), which requires psychologists working with Māori to seek guidance and undertake appropriate training to ensure their practice respects the dignity, values, and needs of Māori clients. Accordingly, familiarity with and application of Māori health models are an important part of psychologists' professional responsibilities when working with Māori.

At the same time, psychologists acknowledged that balancing client autonomy with active cultural engagement could present challenges in practice. Without clinician facilitation, cultural aspects of a client's experience may remain unspoken, potentially limiting the effectiveness of therapy, particularly for clients who strongly identify with their culture (Lee & Horvath, 2013). This tension between respecting client preference and initiating cultural dialogue is widely noted in Indigenous and cross-cultural literature (Gone, 2013; Kirmayer, 2012). On one hand, Lee and Horvath (2013) argue that culture should not be treated as a peripheral context in therapy, as it shapes how distress is understood and what is experienced as healing. On the other hand, for some clients, cultural dimensions may be less central (Morice & Fay, 2013). Together, these perspectives suggest that while assumptions must be

avoided, failing to actively address culture may similarly undermine culturally responsive practice.

Overall, these findings suggest that the incorporation of Māori health models is primarily shaped by clients' identities, preferences, and readiness, while practitioner capability influences how these conversations and frameworks are initiated and sustained. As expectations for culturally responsive practice continue to expand within psychology, strengthening training, supervision, and applied learning opportunities may be essential to support psychologists in engaging confidently with Māori health models. Such support is particularly important for navigating the balance between respecting client autonomy and ensuring that practice remains culturally responsive.

Therapeutic Impacts and Implementation Challenges

Although the interview schedule did not explicitly examine therapeutic outcomes, some psychologists reflected on the impacts they observed when using Māori health models in practice. Psychologists described Māori health models as providing structured yet flexible approaches to exploring multiple dimensions of wellbeing, which were positively received by clients and supported their involvement in therapy. In this way, the models appeared to enable therapeutic conversations that might otherwise not have occurred. These observations align with existing literature indicating that culturally grounded frameworks can enhance engagement by introducing concepts that resonate with clients' own understandings of health and wellbeing (Hatcher et al., 2016; Matheson, 2012; Waitoki & Levy, 2016).

Beyond shaping the content of therapeutic conversations, psychologists also described how the incorporation of Māori health models influenced the relational tone of sessions. They described therapy as feeling less formal, more collaborative, and more attuned to client

preferences. Introducing Māori concepts was reported to support clients' willingness to engage, particularly for those receptive to culturally grounded approaches. In this way, participants' reflections suggest that Māori health models may not only guide what is discussed in therapy but also how therapeutic relationships are formed and experienced. This finding aligns with research indicating that connection, communication, and trust are key to positive therapeutic experiences for Māori clients (Komene et al., 2024; Wilson et al., 2021). For example, Komene et al. (2024) found that establishing whakawhanaungatanga was fundamental to Māori patients' satisfaction with health care encounters and shaped their ongoing engagement with services. Similarly, reviews of Māori health models highlight that building relationships inclusive of whānau and wairua is essential for effective practice (Wilson et al., 2021). Taken together, these findings suggest that integrating Māori health concepts may contribute to therapeutic environments that feel more collaborative, relational, and culturally safe for some clients.

While psychologists described positive experiences when using Māori health models, these findings do not provide evidence of their effectiveness in improving client wellbeing outcomes. Instead, they offer insight into how these models may support therapeutic processes in practice. Further research including client perspectives and outcome measures is needed to determine whether their use supports sustained engagement and improved wellbeing outcomes.

The final theme concerns psychologists' perceptions of challenges associated with applying Māori health models in therapeutic practice. Participants reported that these challenges were largely related to limited training and the availability of practical support, including opportunities for applied practice and access to practice-based resources.

A central barrier identified was the limited opportunity for applied training. Psychologists reported having a strong conceptual understanding of Māori frameworks, including key principles and concepts, but few opportunities to practice applying this knowledge in clinical settings. Consequently, they felt confident in theory but uncertain about translating this knowledge into assessment, formulation, and intervention. This aligns with research showing that, although clinical education can increase awareness of Māori perspectives, opportunities to practice and apply this knowledge in clinical settings are often limited (Heffernan, 2024; Sawrey, 1993; Waitoki, 2024). Without such applied practice, psychologists may struggle to implement Māori models in real-world settings, impacting both competence and confidence. Pitama et al. (2007) emphasise that modelling and supervised practice are essential for embedding these frameworks into clinical work. Collectively, these findings suggest that expanding applied training opportunities should be a core component of professional development.

In addition to training, psychologists highlighted the limited availability of accessible practice-based resources. While familiar with Māori health models conceptually, they often lacked practical tools to guide their application. Heffernan et al. (2024) similarly note that clinicians frequently struggle to access examples demonstrating how Māori frameworks can be operationalised in therapy. Participants in their study described how conceptual differences between Māori and Western frameworks can increase uncertainty and that, without practical supports, clinicians may hesitate to use these models for fear of misinterpretation (Heffernan et al., 2024). These challenges may be further compounded by broader system-level constraints. Oetzel et al. (2024) note that structural barriers, including funding pressures and limited organisational resources, can restrict the development and dissemination of Māori tools that support culturally responsive practice. Consequently,

practitioners are often left to integrate Māori health models independently, which can reduce consistency and confidence in clinical applications.

Overall, these findings indicate that system-level investment in resource development, combined with targeted professional development and supervision, is essential to support the effective and consistent use of Māori health models. Future research could investigate which types of organisational support and training most effectively enable practitioners to integrate these frameworks.

Strengths, Limitations & Future Directions

A key strength of this study is its contribution to empirical literature on bicultural psychology in Aotearoa New Zealand through providing practice-based insight into how Māori health models are integrated into everyday psychological work. By examining psychologists' reported use of Māori frameworks, the study extends existing research by describing how bicultural engagement is enacted across therapeutic contexts.

The diversity of clinical settings represented, including Kaupapa Māori services, community mental health, private practice, and correctional settings, strengthened the relevance of the findings by illustrating how Māori health models were engaged with across varied organisational contexts and client populations. The inclusion of psychologists from both Māori and non-Māori backgrounds further reflected a range of experiences and levels of engagement with bicultural practice.

Despite these strengths, several limitations should be considered when interpreting the findings. Participants self-selected into the study, which may have resulted in a sample biased toward psychologists who are already interested in bicultural practice, potentially overrepresenting engagement with Māori health models; future research could address this by using purposive or stratified sampling to capture a broader range of perspectives. The reliance

on self-reported data also presents a limitation, as accounts of practice may have been influenced by social desirability, suggesting that observational or practice-based research designs could provide a more robust assessment of how these frameworks are enacted in clinical work. In addition, because this study focused on psychologists' perspectives, it does not capture how Māori health models are experienced by tāngata whaiora or whānau. Future research that includes these perspectives would provide valuable insights into how such models are perceived in practice and how they support culturally responsive practice.

Chapter 5: Conclusion

This study contributes to the emerging literature on bicultural psychological practice in Aotearoa New Zealand by offering insights into how Māori health models are used within everyday clinical work. While the findings are presented as distinct themes, they reflect an interconnected process through which psychologists interpret, introduce, and apply Māori frameworks within therapeutic practice. Collectively, these findings suggest that psychologists view Māori health models as relational frameworks that support a holistic understanding of wellbeing. If Māori health models had limited relevance for clinical practice, this would likely have been evident in the data. Instead, psychologists described them as valuable for supporting tangata whaiora and for guiding practice.

The insights from this study invite reflection on how Māori health models can be more intentionally integrated to support psychologists in working confidently within a bicultural framework. They highlight the potential of these models to strengthen therapeutic relationships and improve client outcomes. Future research could further develop the evidence base and provide clearer guidance for psychologists on how to apply these models in practice, supporting psychological practice that is both clinically effective and culturally responsive.

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Appendix A

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THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

Dr Simone Mohi

School of Psychological and Social Sciences

3 March 2025

Dear Simone

Re: **FS2025-05:** Bicultural Principles Applied in Psychological Practice

Thank you for submitting your revised application to the ALPSS Human Research Ethics Committee. We have reviewed the final electronic version of your application and the Committee is now pleased to offer formal approval for your research activities.

We encourage you to contact the committee should issues arise during your data collection, or should you wish to add further research activities or make changes to your project as it unfolds. We wish you all the best with your research. Thank you for engaging with the process of Ethical Review.

Kind regards,

Dr Amy Bird, Convenor
Division of Arts, Law, Psychology & Social Sciences Human Research Ethics